REVIEWS

International models of health systems financing

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Abstract

This article examines the various kinds of health care financing models found in selected developed countries. A discussion of health care delivery models is followed by an overview of the national health delivery systems found in European, South America, Asian, and North American. A discussion on health reform focuses on the shift in financial resources from private to public sources in the economies of most nations.

Key words

Health care financing, National health insurance, Health insurance, Health economics

1 Introduction

Health care systems can be described using models of service delivery, financing, and economic policy. Much of the literature depicts health delivery systems in terms of a national health system, social insurance or private insurance model. Within each model there are various forms of financing including general taxation, specific taxation, and private financing. This article surveys the myriad of health delivery systems operating in developed countries. Most of the industrialized countries have established systems while developing nations have in the past decade developed a formal system of health delivery. A nation's health care system cannot be adequately explained with just one model. While no one country's health systems subscribes to one model of delivery and financing there are general categories to which health systems can be placed. Our intent is to identify these types of models that dominate each country's health system.

2 Models of health care delivery

Most countries' health system can generally be described by one of the following three models.

National health model: Also known as the Beveridge model is characterized by universal health care coverage of all citizens by a central government. It is financed through general tax revenues. Providers of care are either own or controlled by central and regional governments. Service distribution and provider payments are controlled by governments. Examples of the national health model include Denmark, Ireland, New Zealand, and the United Kingdom [1, 2]. The national health model was named after William Beveridge who was Churchill's Health Minister. Beveridge's office

developed the concept of a national health insurance program that became operable 1948. It supported universal coverage that was funded through taxation, and with government ownership of most of the delivery of health services [3, 4].

Social insurance model: Also known as the *Bismarck* model is characterized by compulsory coverage that is funded by employer, individual and private insurance funds. Factors of production are controlled and owned by government or private entities. It is also referred to as tax-based insurance. Funding is derived from employment taxes and held in separate funds specifically for the national health program. Examples of the social insurance model include Austria, Belgium, France, Germany, Luxemburg, and the Netherlands [1, 2, 4-6]. Social insurance typically includes elements of tax-based financing systems [5]. Named after Prussian Chancellor Otto von Bismarck, the Bismarck model was a social welfare construct that dates back to the late 1800s and covered the working population for accidents, diseases, disability and retirement. The Bismarck model was based on paid work and greatly influenced the development of social health insurance in Italy, France and Sweden [3].

Private insurance model: This model is characterized by employment-based or individual purchase of private health insurance financed by individual and employer contributions. Service delivery and financing are owned and managed by the private entities operating in an open market economy. Examples of the private insurance model include Switzerland and the United States [1, 2].

Private insurance exists in most countries, however, its application is primarily for supplemental coverage for persons not covered by the national plan or for specific services excluded from the national plan. As most national health plans offer comprehensive coverage without cost at the point of entry, there is little need for private insurance [5]. For example, in Sweden just 2.5% of its citizens purchase private health insurance [7].

Classic economic models

Health systems do not appear to fit neatly into concise economic models of the demand and supply-side axiom.

Demand-side economics considers health care is like any other good where consumers can exercise control over what services to buy and at what price. Customers and suppliers are evenly matched and suppliers of health care have little ability to induce patients' demand for services and to set rates of charge. Competition for patient revenue forces suppliers to produce services efficiently. In time, production occurs at the lowest possible average cost. There is little public concern about the cost of health services as patients decide where and when to obtain services. Demand-side economics assumes allocation of resources according to patients' propensity to pay for services and the willingness of providers to supply health services. Singapore and South Korea are the few examples of countries that have committed to demand-side economics for financing their health care systems [8, 9].

Supply-side economics assumes that health care is a good that needs to be reasonably available to all citizens, is a necessity of life, and therefore an entitlement. Central governments or public agencies exercise control over resources rather than leaving free market forces to determine costs and access to care. Under this approach, government plays an important role both in allocating resources and in setting payment rates for providers. The former health care system of the former Soviet Union is an example of supply-side economics in the delivery and financing of health care [8].

3 Financial modelling

There are four key sources of funds for financing health care: taxation, contributions to social insurance funds, voluntary purchase of private insurance, and out-of-pocket payments. These four sources can be classified as compulsory or social insurance, statutory or taxation, and voluntary or private insurance. Table 1 illustrates the different financing model of several countries. Note that few countries use a single funding system.

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Table 1. Types of healthcare funding systems in several countries

Funding System	Country
General taxation	United Kingdom
Local taxation with local councils managing providers	Denmark
Social health insurance paid by employer and employee, with multiple, noncompetitive, autonomous, third party payers (insurers)	France
Social health insurance paid by employer and employee, with autonomous, competitive third party payers (insurers)	Germany
Compulsory social health insurance for basic care paid by individuals, with competitive third party payers (insurers) and government-defined benefit package	Switzerland
Voluntary health insurance predominantly paid by employers, with tax subsidies for employers and employees	United States
Voluntary health insurance paid by individuals, with tax subsidies	Australia
Catastrophic health insurance and tax-exempt health savings account	Singapore
Compulsory social health insurance for catastrophic illness and long-term care and social health insurance for acute medical services paid by employer and employee	The Netherlands

Note. Content source: Health Policy Consensus Group. *Options for Healthcare Funding*. Retrieved from The Institute for the Study of Civil Society, London, UK website: http://www.civitas.org.uk/pdf/hpcgSystems.pdf Accessed August 26, 2011.

3.1 Western Europe

There are essentially two major types of public health care system in Europe inspired by the Beveridge and Bismarck models: national health insurance, funded by general taxation; and social insurance systems, funded by payroll contributions [3, 5]. Table 2 shows the general delineation of countries between national health and social insurance models.

Table 2. Models of European health systems

National Health Insurance	Social Insurance
Denmark	Austria
The United Kingdom	Belgium
Greece	France
Italy	Germany
Portugal	Luxemburg
Spain	Netherlands
Sweden	

Note. Source: Flood & Haugan, 2010; Saltman & Figueras, 1997; Freeman, 1998.

In Europe, national health systems predominate in the north, south and west (Denmark, Sweden and the UK, Italy and Greece, Spain and Portugal), while social insurance systems in the center (France, Germany and Austria) [6]. Germany, France, Italy, Switzerland, and the United Kingdom have universal coverage. In these countries the central government collects taxes and distributes fund to providers through a network of government bureaus. Social insurance systems manage financial resources through a network of health insurance funds which are independent bodies that operate with their own management, budget and legal status. This arrangement in part keeps funds for health insurance separate from general government control and comingling with general tax revenues [5].

No health system financed predominantly by social insurance has completely universal coverage. Participation is linked to contributions, usually through employment. Most countries cover almost their entire populations through statutory insurance or through a combination of statutory and private insurances [5].

Health care systems financed predominantly through statutory health insurance are marked by the diversity of their arrangements [5]. Germany is an example of social health insurance financing with private health insurance covering wealthier groups. Sweden and The United Kingdom are tax-financed and allow a two-tier system for physician/hospital

care. France is a combination of tax financing, social health insurance funds, and private insurance to cover co-payments and other out of pocket costs [7].

3.1.1 United Kingdom

England, Scotland, Wales, and Northern Ireland came under the National Health Service (NHS) in 1948. The entire population is covered under a system that is financed mainly from general taxation. Services are organized and managed by regional and local public authorities. Primary care physicians are reimbursed through capitation, fee-for-service, and other reimbursements. Hospitals receive appropriations from district health authorities, and hospital-based physicians are salaried. The NHS is accountable to Parliament and financed primarily through taxes [3].

The NHS combines universal, first-dollar, public coverage for a broad range of services with a relatively small, parallel private sector that mainly specializes in a narrow range of elective procedures [10]. The system is primarily tax-financed and the NHS's mandate is to deliver universal and comprehensive access to health care mostly free at point of service [7].

After a decade of above-inflation increases in NHS funding, Britain's healthcare system is experiencing a period of flat or declining funding, while demand for services continues to increase [11]. Patients face waiting lists, have little choice in hospitals and experience increased bureaucracy over the management of primary healthcare providers by the NHS [12]. Rationing is achieved by excluding specific procedures or drugs from the NHS menu and by tightening the criteria for access to treatment [10].

In response to balancing the economics of level funding of the NHS, increase demand and longer queues for services, the NHS has looked to the private sector for control of costs. Beginning in 2012 the U.K. allowed hospitals to earn up to 49% - previously only 2% - of their income from treating private patients as part of recently enacted health reform legislation. And citizens are buying personal medical insurance in response to longer wait times and lack of choice of providers to enter the private sector of Britain's healthcare system. This has led to questions of quality control of services and a move toward payment for services based on outcomes [11, 12].

To ameliorate this situation, major health reform legislation was passed in 2012. The Health and Social Care Act establishes an independent NHS Board to distribute resources, reduces the number of agencies that supervise the delivery of health care, increases the autonomy of primary care providers for ordering services for their patients, and establishes a review system based on clinical outcomes. Additionally, the British Department of Health is considering an option for personal health budgets which would give patients control over their care [12].

News accounts indicate fluctuation in the use of private companies. Private hospital providers are experienced rapid growth in treating non-urgent procedures such as hernia repair and cataract surgeries due to the long wait and narrowing the range of procedures done at government hospitals [13]. In 2012, Britain's largest health insurer experienced a decrease in customers due to increased costs [14]. Urgent care centers operated by private companies closed due to budget cuts from NHS. They were created a decade ago to ease the burden on hospital emergency departments [15].

On the other hand, the NHS is looking for ways to increase private pay patients, such as medical tourism [16] and reduce operating cost through privatization of healthcare facilities and delivery systems. In 2013, the NHS has created a business entity to go into partnership with a private company to buy, build and manage mental healthcare facilities [17].

3.1.2 Germany

The German health care system is based on the social insurance or Bismarck model. Statutory sickness funds and private insurance cover the entire population. Payment from employers and employees finance these sickness funds and participation is compulsorily. Private insurance exists for self-employed individuals. The provider network consists of independent private entities.

Control over financial resources and health care expenditure is fragmented as the German central government is not responsible for managing health expenditure. Finances are managed by the sickness funds and their activity is regulated by law, which guarantees stability to the current health system and offers a safety net to the most vulnerable populations. Payments to providers are negotiated between sickness funds and providers rather than between patients and providers. And citizens can choose their own providers [3, 18].

The German health care system is financed by compulsory contributions from employee and employers to one of several sickness funds. Table 3 lists the sickness funds of the German health care system for 2002 and 2004. In 2004 there were 292 sickness funds as payers for health care are legally divided into seven groups [19]. This was less than the 372 funds in 2002 as reported by [20] which indicates some consolidation of some of the funds. While company based and guild funds decreased, general regional and farmers fund increased. The net loss was 80 funds.

Table 3. Number of sickness funds in the German health care (system 2002 and 2004)

Fund	2002	2004	Change
General Regional (Allgemeine Ortskrankenkassen)	7	17	10
Company Based (Betriebskrankenkassen)	318	229	(89)
Guild (Innungskrankenkassen)	28	20	(8)
Farmers (Landwirtschaftliche Krankenkassen)	5	14	9
Miners (Bundesknappschaft)	1	1	-
Sailors (See-Krankenkasse)	1	1	-
Substitute (Ersatzkassen)	12	10	(2)
Total	372	292	(80)

Note. Source: Altenstetter, 2003; Wörz & Busse, 2005

In 2007, the German government required all citizens to have some form of health insurance, from either public or private sources. It mandated the insurance companies to accept all individuals and provide a basic package of benefits. The new regulations also prohibited insurance companies from rating or charging additional premiums tied to health risk for basic coverage [7].

3.1.3 France

The French health care system is based on the social insurance or Bismarck model. Most of population is covered by a compulsory health insurance plan financed through the nation's social welfare system. There are several plans that act independently from the central government. The system is complex in that both tax and private financing is used to fund insurance plans [7].

There are three insurance funds, one each for farmers, independent professions, and employees. These funds are subjected to governmental regulation. Most citizens are part of the employee fund. Participation is compulsory for all citizens including wage earners, students, pensioners, and beneficiaries of social welfare programs. The level of personal contribution is directly related to income [21].

Employers' contributions account for approximately half of the revenue of the health insurance fund, while the income-related contributions of employee account for a third. Citizens pay their share on their total income, including income from employment, investments, pensions, and social welfare benefits. In addition there are taxes on automobiles, tobacco and alcohol and a tax on the pharmaceutical industry round out the funding sources. Physicians are paid directly by patients on a national fee schedule and then reimbursed by their local health insurance funds. Hospitals are reimbursed on a negotiated per diem basis are paid according to global budgets negotiated with regional agencies and the Ministry of Health [21, 22].

3.1.4 Italy

The Italian health care is a national health system which follows the Beveridge model. It provides universal health care coverage throughout the central government as a single payer. The Italian NHS, unlike the centrally controlled Beveridge

model, is decentralized and manages the administrative and financial processes through a network of agencies. In addition to the central government there are 20 regional ministries and approximately 600 local health agencies responsible for the provision of health care [3]. The central government has overall responsibility for the NHS to assure uniform and essential levels of health services across the country. All citizens are entitled to equal access to essential health care services. Essential health services are provided free or at minimal charge [23].

3.1.5 Sweden

The Swedish national health care system is financed through taxation and governed by the Swedish Parliamentary Priorities Commission which has developed guidelines for the provision of care based on a national ethos regarding government's role in society. Principles include the concept that all persons should receive consideration for health services based on need and capacity for self-advocacy. The provision of health services are held to the principle of cost efficiency [7, 24].

3.1.6 Switzerland

Switzerland's health system is individually-focused and insurance-based. Purchase of health insurance is compulsory and is paid by individuals. The insurance companies are private entities that must offer a benefit package that is defined by the central government and cannot refuse individuals who are considered high risk for medical coverage. The counties 26 cantons or providences are responsible for the delivery of health care. The Swiss constitution limits the involvement of the central government to public health issues and regulation. Citizens are guaranteed access to care and free to choose between health plans and providers [3, 25].

3.1.7 The Netherlands

The Netherlands has compulsory universal health insurance with coverage provided by private insurance companies. The system is regulated to ensure subsidization from higher income populations to poorer ones. Premiums for health plans are community rated thus ensuring all will be covered at similar rates [7, 26].

3.2 Central and Eastern Europe

In Central and Eastern Europe health care was provided and strictly controlled by central governments. Referred to as the *Semashko* model of health care delivery it provided citizens little or no choice when seeking health services. Named after Nikolai Semashko, Russia's Commissar of Public Health in the early 20th century, it is characterized by invariant regulations operated through ministries of health. What resulted were national health care systems that spent a smaller proportion of the economy on health care and paid provider less than their western counterparts [27].

3.2.1 Russia

The Russian government has been transitioning from the Semashko model of central control to devolution to Russia's 88 territories, with the introduction of risk based financing. This has resulted in variation in services in the regions in term of medical sophistication. The transition from the old to the new system of health financing were never established by Russian legislation and implementation of compulsory health insurance funds has been poorly controlled by central government authorities leading to much variation in the conscription of the population for health coverage [28, 29].

The countries of the former Soviet Union and Soviet Block have been attempting to set up health care financing systems in a relatively short period. Most of these efforts are hampered due to fragile economies, unstable governments and institutional infrastructures not suited to a more free market economy [5].

3.2.2 Czech Republic

The Czech Republic re-introduced social health insurance after the fall of the Soviet Union in 1989 [28, 30].

3.3 South America

3.3.1 Argentina

Argentina's health system is a mix of social insurance, private health insurance and providers, and the public health system. Through social insurance, workers and their dependents are covered by compulsory participation through mandatory wage contributions. Traditionally, these not-for-profit institutions have been associated with and administered by the corresponding workers' union and thus the overarching health care system resemble the Bismarck model and contract with private providers of care [31].

3.3.2 Brazil

The Brazilian health system is a mix of public and private entities financed mostly by private funds. There are three sectors. The public sector includes central, providential and municipal entities which finance and provide health services. The private sector includes both proprietary and non-profit entities and finance health services with public or private funds. The private health insurance sector includes companies with different forms of health plans, varying insurance premiums, and tax subsidies. The public and private components of the health care system are distinct but interconnected in that citizens can use services in all three sectors. The Brazilian constitution recognizes health as a citizen's right and a duty of the state, and established the basis for the creation of the Unified Health System, which was based on the principles of universality, integrality, and social participation [32].

3.3.3 Chile

Health insurance coverage in Chile is largely dominated by the public sector. Insured workers and their dependents may channel their compulsory health care payroll contributions to either the publicly managed National Health Fund or to one of the private pre-paid health insurance plans called [31].

3.3.4 Columbia

Columbia's health care system is a combination of compulsory social insurance for the employed and national health programs for those unable to pay for social insurance. The Health Promoting Organizations are the predominant insurance funds and tend to operate as managed care organizations. The insurance funds are required to offer a standard benefits package and to include all citizens [31].

3.4 Asia

3.4.1 Japan

The Japanese health care system is patterned after the Bismarck mode of social insurance and provides universal coverage through 5,000 different insurance plans. These plans are one of three types: one for employer-base population, another for employees of small firms, and another for groups that do not have access to the first two plans. Individuals are assigned an insurer according to their employment status or residence [18].

Physicians and hospitals are paid on a national fee schedule. Physicians practicing in public hospitals are salaried, while those practicing in physician-owned clinics and private hospitals are reimbursed on a fee-for-service basis.

3.4.2 Korea

South Korea has had mandatory social health insurance since 1977 and was modeled after the Japanese system. By 1989 the entire population was covered with universal coverage. National health insurance in Korea used to have over 350 insurance societies covering employees and the self-employed. However, there was centralization of claim processing and payment to providers. In 2000, all insurance societies were merged into one single payer [33]. Jeong characterized the Korean health care system by private management on provider side and mixed public and private financing for the consumer [34].

3.4.3 Singapore

Singapore's government sponsored healthcare system is extremely complicated but only funds a small portion of national healthcare expenditures [35]. Private health expenditures accounts for 65% [36]. As a newly independent state in the early 1960s, government leaders brought primary care services to the citizens through a network of outpatient clinics and dispensaries, and charged a nominal fee for each visit. Medical expertise was enhanced beginning in 1970 with the sending of physicians to foreign medical institutions for training, which in turn created strategic partnerships with healthcare organizations worldwide [36].

Singapore's National Health Plan was outlined in 1983. It promoted a healthy lifestyle, disease prevention, and concentrating the delivery of services on chronic diseases. Competition amount the public hospitals was encouraged by increasing autonomy of their administration and making transparent the cost of services at each facility [36].

Although the government funds less than 10% of total national heal-care expenditures [37], and was estimated at 1.3% [38], there are three government healthcare programs. The largest is Medisave, an individual medical saving plan funded by the individual and employer. The other two are MediShield, a program for catastrophic health insurance, and Medifund for the indigent. Payments to hospitals are managed by a prospective payment system based on 70 common conditions [36]. Medical tourism is a major part of the healthcare business as Singapore is a regional healthcare center with 22 private and public hospitals for Southeast Asia [39].

The 1993 Health Reform legislation promoted good health and reaffirmed the long standing policy of individual responsibility for one's health and to avoid overreliance on government or third-party medical. The government promised to provide affordable basic medical services for all citizens and promote competition to improve services and efficiencies. Government is to intervene only when necessary to correct market conditions such as oversupply of healthcare services, demand fluctuations, and cost control [36].

The future for Singapore's healthcare system is concentrated on the elderly, the electronic medical record and transforming the various types of providers into regional systems. While Singapore's healthcare system is seen as a model for other polities, the country's small size and cohesive political unity has made this possible. What is noteworthy is the central government's ability to instill on the population the mandate for individual responsibility for healthcare spending and personal health maintenance. The emphasis is on benefiting the most number of citizens with cost-effective services and not on providing the latest medical technologies.

3.5 North America

3.5.1 Canada

Canada's national health plan gives its citizens access to medical care regardless of their ability to pay. Most working Canadians receive health care coverage as a benefit of employment. Canada's health system is a network of social health insurance plans and is publicly funded by the central government. The Canadian health care system is administered through its 10 providences and three territories that are required to offer insurance coverage for medical services. These services include doctor visits, hospitalizations, prescription drugs, dental and vision care, as well as discretionary care [40]. Most Canadian hospitals are not-for-profit and are funded based on appropriations determined by the provincial government. Physicians are paid based on a fee schedule. The delivery system is composed largely of community hospitals and self-employed physicians. The central government provides guidelines and oversight of the administration of payment and services. In most cases, services are delivered by private providers [41].

3.5.2 United States

The United States is unlike every other country in its health delivery policy because it maintains so many separate systems for separate classes of people. There is Medicare for the elderly, Medicaid for the poor, private health insurance for most Americans, and government programs for the active and retired military and veterans. This leaves about 15% of the rest of

the population without health coverage [4, 42]. Most other countries gravitate toward one of the two models of health care delivery based on national health or social insurance. The societal norms of the U.S. emphasize individual responsibility, freedom of choice, and pluralism of society. Other nations' governments focus on equitable access to health care for the entire populations. For these reason the U.S. central government is less involved in the delivery of health services than other countries [2]. The US does not offer universal coverage and has poorer health care outcomes on specific parameters than other countries [3].

Health plans can be categorized as providing universal coverage, meaning all citizens are covered. The funding of health plans is accomplished through several funding mechanisms, namely national health insurance – funded by general taxation, social insurance – funded by contributions mandated by government usually from employment, and private insurance – mandated by government that citizen must purchase. Table 4 shows how each country funds it national health plan and whether it constitutes universal coverage.

Table 4. National health plans, universal coverage, and funding mechanisms

	Universal Coverage	National Health Insurance	Social Insurance	Private Insurance
Europe				
Austria			x	
Belgium			x	
Czech Republic			x	
Denmark		x		
France	x		x	
Germany	x		x	x
Greece		x		
Italy	x	x		
Luxemburg			x	
Netherlands	x		x	
Portugal		x		
Russia	x			
Spain		x		
Sweden	x			
Switzerland	x		x	
United Kingdom	x	x		
South America				
Argentina			x	x
Brazil		x	x	x
Chile			x	
Columbia			x	
Asia/Pacific				
Australia				x
Japan	x		x	
Singapore	x		x	x
South Korea	x		x	
North America				
Canada	x	x		
United States				x

4 Health reform

There exist two general health reform initiatives on the world stage. The first focuses on controlling health cost and improving outcomes. The second is concern with ensuring universality of coverage to all citizens.

Recent articles on national health systems discuss their countries' progress in reforming their health system. Many nations are dissatisfied with the fragmentation of their health systems and aspire toward a more integrated system in hopes of steaming overuse of health care services. These reform efforts suggest that control of service utilization by someone other than the providers of care would help to reduce the cost of services [42].

Governments are concerned with the increasing portion of their economic resources that are spent on health care. Table 5 shows the change in health care expenditures as a percentage of a countries' gross domestic product (GDP) for the seven years ending 2008 as reported by the Organization for Economic Co-Operation and Development (OECD). Twenty-eight out of 33 countries (85%) had increases in the percent of their GDP spent on health care. Twenty five out of 32 (78%) had increases in their governments' share of spending. Only 6 out of 31 (19%) had increase in private spending [43].

Table 5. Change in national health care expenditures 2001 to 2008

	Change in Total Expenditures as	Change in Government Expenditures	Change in Private Expenditures
Australia	0.6	0.5	-0.1
Austria	0.3	0.3	0.0
Belgium	1.8	1.3	-0.5
Canada	1.0	0.7	-0.2
Chile	0.7	-0.3	-1.1
Czech Republic	0.4	-0.1	-0.5
Denmark	1.2	1.0	n/a
Estonia	1.2	1.0	-0.3
Finland	1.0	0.9	0.0
France	0.9	0.5	-0.4
Germany	0.3	-0.1	-0.4
Hungary	0.1	0.2	0.1
Iceland	-0.2	-0.1	0.2
Ireland	2.1	1.7	-0.5
Israel	-0.3	-0.5	-0.1
Italy	0.8	0.9	0.1
Japan	0.6	0.4	-0.1
Korea	1.4	0.8	-0.5
Luxembourg	-0.6	-0.5	0.1
Mexico	0.3	0.3	-0.1
Netherlands	1.6	n/a	n/a
New Zealand	1.9	1.8	-0.1
Norway	-0.2	-0.1	0.0
Poland	1.1	0.9	-0.3
Portugal	0.8	0.4	-0.4
Slovak Republic	2.5	0.5	-2.0
Slovenia	-0.2	-0.2	0.1
Spain	1.8	1.3	-0.4
Sweden	0.3	0.3	0.0
Switzerland	0.1	0.4	0.2
Turkey	0.9	0.9	0.0
United Kingdom	1.6	1.4	-0.1
United States	2.1	1.3	-0.9
Average Change	0.8 (n = 33)	0.6 (n = 32)	-0.3 (n = 31)

Note. Source: Organization for Economic Co-Operation and Development (OECD). http://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_STAT Accessed: August 30, 2011

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Many governments have begun to address cost control in their reform efforts and have implemented primary care organizations or PCOs. These mid-level health management entities were developed to allocate resources to provider based on some cost controlling method such as capitation or fixed budgets. In essence, PCOs include primary care physician as a principal part of the management of episodes of care. PCOs become the entity for providing medical care and coordinating other services from the community. Additionally, PCOs provide a framework for addressing population health issues, experimenting with reimbursement systems, conducting quality assurance and accountability studies, and examining the effectiveness of treatment protocols [44].

The concept of universality in health care is a societal norm in many European counties and serves as the guiding principle for reform. Nations of the former Soviet Union and Soviet Block are seeking to include more of their citizens in either the current or emerging health systems. This reform effort is concerned with provision of care equally to all citizens. The term solidarity is used to convey this principle of reform as an attempt to provide universal coverage and to reduce inequalities in their health care delivery systems. According to this notion of solidarity, individual financial contributions should not depend on a person's previous health status, but should be related to his or her ability to pay.

5 Discussion

From this review of nations' healthcare financing systems several themes emerge. The first stems from developed nations with universal healthcare coverage that are looking at ways to reduce costs. This would include Canada, France, Germany, and the United Kingdom. The second stems from nations that are looking to expand services to achieve universal healthcare coverage. This would include Argentina, Chile, Columbia, Russia, and the United States. The third theme stems from countries like South Korea and Singapore that have experienced rapid economic growth and have implemented universal health plans more recently than other developed nations.

Britain's National Health System, established in the 1940s, has undergone a transformation from a mostly public run system to a combination of public and private enterprise with the government maintaining control of services and finance. Canada, France, and Germany have not had to experiment as much with partnerships with private entities but do have private insurance options for citizens who desire to purchase them.

Developed countries looking to expand health services to their entire populations are doing so in less than supportive economic times. Except for the United States, these countries have a political economy history in socialism or dictatorships which has led to a transformation of a healthcare delivery system without experience in the private sector economy. As such social insurance and private funding methods are new concepts and not easily implement. The United States, on the other hand, is reluctant to provide universal coverage due to national norms espousing individual responsibility for health and welfare.

Recently develop nations like Singapore have had the luxury to build a national health systems from the ground up. And South Korea's social insurance program was able to reduce the large number of insurance companies to a manageable few without much economic turmoil.

The structure of a nations' health care system is influenced by its societal norms, economy, customs, economic status, and political history of the polity. What constitutes basic health care in one country may differ from another. Such differences are reflected in how nations constructed their health system. Historically, European nations with organized craft guilds provided social welfare programs to their members. This system gave rise to the social insurance model that was prorogated into law by Prussian Chancellor Otto von Bismarck. Other countries follow this example of social insurance while others look to the British system of proving universal health care through a centrally controlled national health plan.

The discussion is not what is good about a county's health system; rather it is about what works and is acceptable to the governing polity. It is not whether national health insurance is preferable to social insurance or private insurance for

funding a nation's healthcare system; rather it is what can be accomplished given the stability of the economic, political situation of a country. Welfare states have an expectation for publicly funded services and higher taxes to pay for them. States that have a more cohesive culture and politics, such as South Korea, Japan, and Singapore, can achieve universal coverage more quickly than more politically and diverse societies such as the developed countries of Western Europe and the United States.

No country, however, maintains a health care delivery model in its pure form. Few health care systems fit precisely within the parameters of a single model. Except for the United States, most countries embrace three goals for their health care system: equality of access, affordable service, and effective outcomes. Health care systems evolve from converging streams of political and economic influences. Most national health care systems have experience substantial reforms as governments try to balance resources between private and public income streams with the demand for health services. These reform efforts represent an attempt at preserving the best element of their existing systems while selectively adapting techniques and processes that seemed to have been successful in other counties.

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