Chapter 11

비교의료제도론

Comparative Health Care Systems

제 1 부:
주요 선진국의 의료제도

A. 의료제도의 제유형

- National health insurance, government assuming role of third - party payer
- National health care, services provided by the government
- Community sickness funds with government subsidies
- A mixed public and private market system

Note: A good way to organize one's thoughts about comparative health care systems is to ask, what are the incentives for the health care providers and what are the incentives for consumers (patients)?

A. 의료제도의 제유형

Comparative Statistics:

It will be useful before proceeding to look at the following statistics on comparative expenditure, capacity, and health outcomes for the United States and the other three industrialized countries whose health care systems we are about to study: Canada, Germany, and the United Kingdom:

A. 의료제도의 제유형

Expenditure on Health Care and Comparative Health Outcomes

Country	Health Care as % GDP (2000)	Female Life-Expectancy at Birth (2001)	Male Life-Expectancy at Birth	Female Healthy-Life-Expectancy at Age 60 (1999)	Male Healthy-Life-Expectancy at Age 60
Canada	9.2	81.7	76.3	17.9	15.3
Germany	10.6	80.7	74.7	17.3	15.0
U.K.	7.3	79.8	75.0	16.9	15.0
U.S.	13.1	79.4	73.9	16.6	14.9

A. 의료제도의 제유형

Capacity: Physicians and Hospital Beds/1000 Population, 2008

Country	Physicians/1000 Population	Hospital beds/1000 Population	Average length of stay acute-care hospital (days)
Canada	2.1	3.2	7.2
Germany	3.3	6.5	9.6
U.K.	2.0	3.9	6.9
U.S.	2.7	2.9	5.8

B. 캐나다: Universal Health Insurance

1. Origins and Description:

Canadian Medicare was established in 1966. It provides a nation-wide single-payer system. Coverage is portable between provinces (and originally covered services performed in the U.S.)

2. Ways in which the Canadian system resembles the U.S. system:

- Similar training of physicians (similar quality of medical schools)
- Fee-for-service based physician payments
- Patients free to consult any physician of their choice
- Co-payment charges for prescription drugs
- Cost-sharing between provincial and federal government (not unlike our Medicaid)

Note: The health insurance systems of the U.S and Canada were very similar prior to the introduction of Canadian Medicare in 1966.

B. 캐나다: Universal Health Insurance

3. Ways in which the Canadian system now differs from the U.S.:

- A universal single-payer system with no competing private sector option for covered services
- Global budget caps limiting annual spending
- Almost all covered physician and hospital services free
- Less diffusion of high-tech equipment
- Longer hospitalizations for in-patients
- Lower proportion of GDP spent on health care

Note: The notion of bilateral monopoly is a good analogy for the provincial health authorities bargaining with physician and hospital organizations.

B. 캐나다: Universal Health Insurance

4. Problems with the system:

- How to afford the services people expect without rationing through triage (Long waiting periods for elective services are becoming a problem.)
- Provincial governments now pay a higher proportion of costs, but are still mandated to provide basic services for all. (Ontario almost withdrew from the system in the 1990s.)
- A long-term problem: the “physician brain drain” to the U.S.

B. 캐나다: Universal Health Insurance

5. Does the U.S. health care system provide a “safety valve”?

-- Research findings show mixed results about how many Canadians travel to the U.S. to get health care services that they want sooner or cannot have at all at home.

-- The Canadian government does, however, contract out to U.S. providers near the border for certain procedures when there is a shortage of capacity in Canada.

B. 캐나다: Universal Health Insurance

6. Reforms in the Canadian system:

The main changes in Canadian Medicare since its inception have been

- The setting of global provincial budgets is not related to previous levels of health care spending but to population growth and economic growth.
- Provincial budgets are now combined health-care & education budgets.
- Global budgets limit the power of the physicians' and hospitals' associations to bargain. Once capacity is determined, fees paid to physicians and hospitals for services are essentially capped.

C. 독일: The Sickness Funds

1. Origins and Description:

The system dates back to Bismarck's reforms in the late 19th century.

The sickness funds are quasi-public non-profit third-party payers.

The system is now a nearly universal social insurance system, financed by employment-based taxation (payroll tax). All workers and employers must participate and pay the payroll tax.

All workers, except public-sector employees, are members of sickness funds. The self-employed may also join sickness funds.

One can be exempted only if one has a very high income.

C. 독일: The Sickness Funds

2. Providers:

Office-based physicians are paid on a fee-for-service basis, with fees negotiated by the physicians' organizations.

Hospital-based physicians are salaried employees whose salaries are also negotiated by the physicians' organizations.

Note: There is complete separation between office-based and hospital-based physicians. The latter can treat patients only when admitted to the hospital; office-based physicians cannot treat hospitalized patients.

Hospitals are both public and private non-profit as in the United States. Hospitals are also reimbursed by the sickness funds.

C. 독일: The Sickness Funds

3. Similarities to the U.S. system:

- Multiple third-party payers
- Use of a payroll tax: The problems of financing through a payroll tax are compounded since the tax is a much higher proportion of wages than is the Medicare tax in the U.S.

Having high payroll taxes is likely to result in either one or the other of the following effects: Either employment will decline or wages will decline. Which effect dominates depends upon the price elasticity of demand and the elasticity of labor supply.

C. 독일: The Sickness Funds

4. Ways in which the German system differs:

- Strict differentiation between office- and hospital-based physicians
- Mandatory coverage for all but the highest income individuals
- More generous coverage: disability, sick leave, long-term care, etc.
- Much longer average hospital stays
- Everyone except public sector employees can be a member of a sickness fund, including the self-employed

C. 독일: The Sickness Funds

5. System reforms:

- Introduction of competition in the 1990s; individuals now may choose between different sickness funds
- To offset selection bias problems and preserve social insurance goals, funds with low-risk pools of subscribers are required to subsidize funds with higher-risk pools
- More risk sharing with consumers: co-payments on prescription drugs, hospital stays, physical therapy, dental care, stays in spas, and medical transportation

C. 독일: The Sickness Funds

- Risk Sharing with Providers: tighter limits on payments to physicians, hospitals, and pharmaceutical budgets
  - Prospective payment system to hospitals
  - Penalties imposed on physicians who bill for prescription drugs in excess of the targeted amount
  - Risk sharing among physicians is accomplished in the following way: if a physician bills too much, other physicians in the group treating people in the same sickness funds will also have their fees reduced

C. 독일: The Sickness Funds

6. Persistent problems:

- Generosity of benefits which is now straining the system (long-term care, spa visits, disability).
- The difficulty integrating the former East Germany into the system has provided a strain, particularly as many East German firms have had long-run difficulties staying solvent, compounded by their required contribution to the payroll taxes. Medical facilities in the former East Germany were not on a par with those in the West. This has required extensive construction costs.
- The financing system itself has negative effects on labor markets. Payroll taxes discourage expanding the labor force.

D. 영국: National Health Care System

1. Origins and Description:

- The British National Health Care System (NHS) was instituted by the Labor Government after the end of World War II.
- It is a social health care system as opposed to a social health insurance system, like those of Canada or Germany.
- It has long been considered a model of a social health care system which provides basic care quite efficiently relative to cost.
- A lower proportion of GDP is spent on health care in the U.K. than in most other EU nations or in Canada.

D. 영국: National Health Care System

2. Description

- Providers within the NHS can be thought of as employees of the government's health ministry. NHS physicians are paid on a capitation or salary basis. Hospitals receive direct reimbursement from the government.
- Citizens and residents in Britain using the NHS have a primary care physician who refers them to specialists.
- One can also purchase health care in the private market, and there is private supplementary insurance available, but most British residents use the NHS for the majority of their health care.
- People are more likely to "go private" for hospital services or for elective surgery.

D. 영국: National Health Care System

3(a). Reforms in the early 1990s

The creation of the GP Fundholder System gave certain large physician practices their own budgets to use to pay for referral services. Thus the physician groups competed directly with the District Health Authorities for hospital and specialist services.

Problems of Incentives: Here the notion of physician agency is again useful. Studies show some evidence of imperfect agency on the part of fundholder practices.

Hospitals that were given more autonomy, often organized into Hospital Trusts.

D. 영국: National Health Care System

3(b). More Recent Reforms in the 21st Century

Goals include more separation of providers from payers, more assessing of quality of providers, and more cost containment:

- Larger physician groupings organized on a regional basis [Primary Care Trusts]
- A higher level of funding for the NHS, which is intended to help reduce waiting time for services
- A reimbursement system for hospitals that is more similar to our Medicare DRG system

Note: Alain Enthoven, author of the managed competition model, has been and continues to be a consultant to the British government.

D. 영국: National Health Care System

4. Persistent Problems in the NHS:

The NHS is famous for its “rationing by queuing”. Delays in receiving elective surgery may be very long.

There is some evidence that quality of care varies by region and by socio-economic class.

Low salaries lead to a “brain drain” of British physicians to other countries with higher physician incomes (Canada and the U.S.) and to the private sector.

제 2 부:
개도국의 의료제도

A. Health and Health Care in Poor Nations

1. Communicable diseases still play a much larger role in the overall constellation of health problems: about 20 percent of the disease burden in low-income countries vs. about 1 percent of the disease burden in high-income countries.

2. Problems of financing both education and health care:
-especially as there is an interaction between education level and effectiveness of health care.
Examples: low-educated “barefoot doctors” in rural China
illiterate angarwala health workers in Indian villages

Note: High correlation between literacy and infant and child mortality rates are found throughout the world.

A. Health and Health Care in Poor Nations

3.There exists very little insurance. Most people, even the very poor, pay out-of-pocket.

4. A huge disparity between health care in cities and countryside.

5. More reliance on local healers and on private provision of care

6. Importance of NGOs and foreign assistance.

Examples:

- Combating HIV/AIDS: Bill and Melinda Gates Foundation, Harvard Public Health Program in Botswana, etc.
- United States CDC programs throughout Africa
- UNICEF and private NGOs in South Asia

A. Health and Health Care in Poor Nations

5. The cost of HIV/AIDS makes it worthy of special study. Components of costs include:

- Closing of schools, factories and clinics
- Care of Orphans
- Reduction in life expectancy
  - In South Africa from 65-40 years
  - In Botswana from 72-39 years
- One AIDS death is estimated to reduce average per capita income by 18-19 life-years.
- Even in India, where the incidence is much lower than in Africa, it is estimated that there are in excess of 5 million HIV-positive persons.