Health Care Reform: Why Not Best Practices?

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L'homme est bon par nature, c'est la societe qui le corrompt.
(Man is good by nature, society corrupts him).
--Jean-Jacques Rousseau

ABSTRACT

The passage of the Affordable Care Act ("ACA" or "Obamacare") in 2010 promises to bring about significant changes in the way that health care is provided and paid for in the United States of America (USA). Supporters of ACA point to a 2000 WHO study of worldwide health care systems in which the USA ranked 37th as justification for proposed changes, and many of them have expressed a preference for ultimately implementing a single-payer or single-provider system (such as currently exists in Canada or the United Kingdom). Detractors, who generally label the act Obamacare, have expressed concerns about whether the act can achieve its stated objectives, whether it represents a negative step instead of a positive one, and whether the ultimate goal of a single-payer or single-provider system is desirable one or even an achievable one. In the context of the ongoing debate over health care in the USA, this paper reviews the WHO study and subsequent comparative analyses of world health care systems to address the following questions:

- *Does the USA really have the 37th best health care system in the world?*
- *Does either a "single-payer" health care system or a "single-provider" health care system offer prospects for significant improvement?*
- *What model or models for delivery of health care services represent "best practices" and how can and should they be emulated?*

Keywords: Healthcare; Health Insurance; Affordable Care Act; Bismarck; Beveridge; Single-Payer; ObamaCare

INTRODUCTION

The debate over health care reform in the United States of America ("USA") started with claims that the then-existing health care system was flawed ("37th best in the world" according to one sound byte) and led the passage in 2010 of the Affordable Care Act ("ACA" or "health care reform" to its supporters or "Obamacare" to its detractors). There are several factors suggesting that further change is in store, including:

1. Legal and constitutional challenges by opponents. Possible bases for legal and constitutional challenges include the mandate that individuals purchase health care, the special deals brokered by individual senators (Cornhusker Kickback, Louisiana Purchase, Gator Aid) in exchange for votes, challenges to the "deem and pass" procedure (the Slaughter Rule) used to obtain passage in the House of Representatives, and attempts by states to nullify the act pursuant to the Tenth Amendment to the Constitution (Barnett, 2010). More than twenty legal challenges have been filed. The primary cases include (Hayes and Rosenbaum, 2010):

    - *Commonwealth of Virginia v. Sibelius* , in which Virginia Attorney General Kenneth Cuccinelli argues that Congress exceeded its Constitutional authority granted to it under the U.S. Constitution by requiring individuals to maintain health insurance, and additionally that the federal law is an unlawful

exercise of congressional authority which violates Virginia's sovereignty because it invalidates a Virginia law protecting individuals from being forced to purchase health insurance.

- *Florida et al. v. HHS*, in which 20 states (a figure that grew to 26 states following the mid-term elections), the National Federation of Independent Businesses (NFIB), and two uninsured individuals similarly argue that the individual requirement to purchase health insurance coverage exceeds the authority granted to the federal government under the U.S. Constitution, and challenge the tax penalty associated with the individual requirement, the Medicaid expansions and the establishment of state health insurance exchanges, the insurance market reforms, and the employer responsibility provisions of the act.
- *Thomas More Law Center et al. v. Barack Hussein Obama et al., and Liberty University et. al. v. Geithner et. al*, have been filed by non-profit organizations, individuals, and Republican legislators to challenge the constitutionality of the individual responsibility requirements and other provisions of the ACA.

The plaintiffs and the Obama administration have moved to have the Supreme Court review Florida, bypassing the normal review by the 11th Circuit Court of Appeals, and it is expected that the Supreme Court will hear argument during the fall 2011 term, with a decision by mid-2012 (Pecquet and Baker, 2011).

2. The stated preference among many of the proponents fo ACA for a single-payer system along the lines of Canada's Medicare or a single-provider system such as the United Kingdom ("UK") National Health Service ("NHS"). President Barack Obama has previously stated his preference for a single-payer system ("If I were designing a system from scratch, I would probably go ahead with a single-payer system," campaign speech quoted in Washington Wire, Wall Street Journal, August 19, 2008; "I happen to be a proponent of a single-payer universal health care plan," speech to AFL-CIO Civil, Human, and Women's Rights Conference, 2003), as have other members of his party (Rep Jan Schakowski, D-IL, "Many of you here today are single-payer advocates—and so am I," speech April 18, 2009; Jacob Hacker, "Someone told me this was a Trojan horse for single-payer. Well, it's not a Trojan horse, right? It's just right there. I'm telling you. We're going to get there, over time, slowly," speech in July 2008.).

3. Reasonable expectations that ACA will fail to attain its stated goals of universal care and reduction in the growth of health care costs.

   - If the individual mandate is ruled unconstitutional, the objective of universal coverage will clearly not be achieved. Even if the mandate is upheld, there will still be coverage gaps among undocumented aliens and others. The Congressional Budget Office (CBO) has estimated that the bill would reduce the number of people who are uninsured but would leave about 23 million nonelderly residents uninsured (CBO Director's Blog, 2010).
   - There are also doubts as to whether ACA will achieve its targeted cost savings. It has been widely reported that CBO found that ACA fully pays for itself and contributes $143 billion to deficit reduction during the period 2010-2019 (CBO, 2010), with additional reductions in subsequent years. But in calculating that number CBO was instructed by the congressional leadership to assume that the so-called "doc fix" adjustment in Medicare reimbursement levels would not be continued, so that ACA without the "doc fix" was compared to then-existing policy with the "doc fix." Shortly after passage of ACA, the "doc fix" was renewed, at an estimated cost of $276 billion (Suderman, 2011). The CBO scoring also includes $72 billion (Senate bill version) in revenue from the CLASS act during the first decade, but that revenue is merely an up front collection of fees to cover costs of providing elderly care in later years, and the ultimate cost of CLASS is expected to exceed the amounts collected up front (Suderman, 2010). Additionally, it has been widely noted that projections for the first decade include ten years of increased tax revenues, but only six years of expenditures. Savings in the second decade are largely attributable to revenues from the tax on so-called "Cadillac" health insurance plans, and projected reductions in the growth of health care costs. The tax on the "Cadillac" plans takes effect in 2018, and in its current version is expected to raise $90 billion over ten years (CNN Politics 2010). Various commentators have suggested that such plans will simply be revised to escape the tax, producing little or no revenue. With respect to cost containment, it should be noted that in his letter to

> Senate Majority Leader Harry Reid on 19 December 2009, CBO Director Douglas Elmendorf noted that Medicare spending per beneficiary under the legislation was assumed to increase at an average annual rate of less than 2 percent during the next two decades—about half of the roughly 4 percent annual growth rate of the past two decades. Elmendorf further noted, "It is unclear whether such a reduction in the growth rate could be achieved, and if so, whether it would be accomplished through greater efficiencies in the delivery of health care or would reduce access to care or diminish the quality of care" (Elmendorf, 2009, p. 19).

The likelihood that ACA will be the first in a series of changes to healthcare in the USA is thus high. The ultimate direction that those changes lead is unclear. In that context, this paper examines the results of efforts to compare and evaluate worldwide health care systems, with three primary questions in mind:

- Does the USA really have the 37th best health care system in the world?
- Does either a "single-payer" health care system or a "single-provider" health care system offer prospects for significant improvement?
- What model or models for delivery of health care services represent "best practices" and how should they be emulated?

DOES THE USA REALLY HAVE THE 37TH BEST HEALTH CARE SYSTEM IN THE WORLD?

The above-mentioned 37th ranking was reported in a study prepared by the World Health Organization ("WHO") in 2000, based on data from the 1990s. Five criteria were used to calculate what WHO called Goal Attainment, as follows (WHO, 2000):

- 25.0% Health level, basically the average healthy lifespan of a nation's residents, measured using the concept of disability-adjusted life expectancy (DALE)
- 25.0% Equality/inequality in health-care outcomes
- 12.5% Responsiveness, such as the system's speed, choice and quality of amenities
- 12.5% Equality/inequality in responsiveness
- 25.0% Financial fairness

Goal Attainment is clearly more a measure of universality and equality (62.5%) than of quality (37.5%). Goal Attainment was combined with what WHO called Performance Ranking On Level, a measure of financial efficiency and cost effectiveness determined by comparing actual DALE to what DALE "should" be given the level of spending, to produce the Overall Performance Ranking. The US health care system ranked 1st in Responsiveness (the measure that most closely reflects the level of care provided to seriously sick or injured people), and 15th in Goal Attainment (with lack of universal access lowering the score), but its overall ranking dropped to 37th because the US has the highest health care cost in the world, thus ranking 72nd in financial efficiency (WHO, 2000). Rather than saying that the USA has the 37th "best" health care system in the world, it is probably more reasonable interpretation to say the USA provides high quality of care, but not to everyone and not without great cost, so that it might more accurately be considered the 37th most efficient health care system in the world. One implication is that an ideal health care system for the USA would correct deficiencies in the current system by expanding access and lowering cost, while keeping the advantages with respect to care for seriously ill and injured people.

Critics have pointed out that there were some significant issues regarding methodology and reliability of the WHO study results (cf. Bialik, 2009), including:

- Since the WHO study dates from 2000 (with data from 1997-99) and has not been updated since then (to some extent, apparently because of the methodological issues discussed here), there is some question as to what extent do its findings still apply today.
- The rankings do not consider social, cultural, and economic factors, which may impact general population health to a greater extent than the quality of the health care system.
- As noted in the discussion of methodology above, the WHO rankings were weighted more toward fairness,

equality, and cost effectiveness than quality, and thus should not be interpreted to mean something which they do not. A nation where some people are healthy and some are not could actually rank lower than a nation where nobody is healthy, because conditions would be more equitable in the latter.

- Quality of data was problematical, particularly for a study with such broad scope, requiring that surrogate measures had to be used for some attributes and that there is something of an "apples and oranges" problem because data purporting to measure the same thing are not determined in the same way for all countries. The inability to obtain quality comparable data is a main reason why the study has not been repeated.
- Having so many small systems ranked near the top suggests that there may have been some inherent methodological biases which skewed the results in favor of smaller systems, and consequently that any resulting conclusions may not be directly applicable to very large systems.

Given the fondness of ACA supporters for the Canadian and UK systems, it is worth noting that in the WHO rankings, Canada placed 30th, and UK 18th. Given further that the WHO study clearly emphasized equality and cost, areas where Canada and the UK enjoy clear advantages over the USA, the somewhat mediocre performances by Canada and the UK provoke two obvious questions:

- In making wholesale changes to a health care system that placed 37th, does it make sense to emulate a model that placed 30th, or even 18th?
- What can be learned about best practices from the systems that out-performed not only the USA, but also Canada and UK?

In addressing those questions, this paper seeks to identify the various conceptual approaches and see how those countries using each approach ranked, and review subsequent studies, and determine how each of the approaches compared in each of those studies.

IS "SINGLE-PAYER" OR "SINGLE-PROVIDER" THE BEST MODEL TO EMULATE?

The four primary approaches are listed below, together with the countries using each approach (and their ranking in the WHO study), and a brief explanation of how each approach operates:

- Single-Provider or Beveridge Systems
  Italy (2nd), Spain (7th), Norway (11th), Portugal (12th), Greece (14th), UK (18th), Ireland (19th), Sweden (23rd), Finland (31st), Denmark (34th), New Zealand (41st).
  "Single-provider" systems are based on the Beveridge model, named for William Beveridge, who designed the UK's NHS. Health care is paid for by the government and financed through general tax revenues. This may be done at the national level (as in UK) or regional/local level (as in the Nordic countries). The government owns most hospitals and clinics, and most doctors are government employees, with the government determining what they can do and how much they are paid. There is normally a private health care option, with private doctors who are paid directly by patients or by patients' private insurance, a useful alternative when the government provider fails to deliver adequate service (Pomey and Poullier, in Raffel 1997, p. 50).
- Single-Payer, or National Health Insurance, or Modified Beveridge Systems
  Canada (30th), South Korea (58th) and Taiwan (not a member of WHO and not rated)
  "Single-payer" systems follow the National Health Insurance model, which is a Beveridge variant in which private-sector providers are paid directly by a universal government-run health insurance program (Reid 2008). Canada's Medicare varies slightly from province to province, but in general there is no private health care option, at least not for any services that Medicare provides.
- Bismarck "Social Insurance" Systems
  France (1st), Austria (9th), Japan (10th), Luxemburg (16th), Netherlands (17th), Switzerland (20th), Belgium (21st), Germany (25th).
  "Social insurance" systems follow the Bismarck model, named for Prussian Chancellor Otto von Bismarck, father of the reunification of Germany in the 19th century. Unlike the Beveridge or NHI models, this is a multiple-payer (multiple insurance companies which may be government-owned or privately-owned, and may be non-profit or profit-seeking) and multiple-provider (generally, private doctors and hospitals)

approach. All residents receive basic health insurance, financed through payroll taxes paid jointly by employers and employees. The basic insurance is typically provided by non-governmental insurance providers, such as the non-profit Lander in Germany. Residents typically have the unlimited right to supplement the basic insurance by purchasing policies from private insurers in a free market. In France, for example, over 99% of the population is covered by basic insurance and about 90% have private supplemental insurance (Pomey and Poullier, in Raffel 1997, p. 50).

- "Pay-as-You-Go" Systems in most of the undeveloped world (approximately 160 countries out of roughly 200), where access to a doctor is available if and only if you can pay the bill out-of-pocket at the time of treatment, meaning that the rich get medical care and the poor stay sick or die.

Pluralistic systems, which combine two or more approaches, include the "Opt-Out" systems in Singapore (6th) and Australia (32nd), which combine the Bismarck and Beveridge approaches, and the "mixed" USA model. The USA system is unlike every other country because it maintains so many separate systems (Medicare, Medicaid, Veterans Administration, TriCare, state-run insurance, private insurance, pay-as-you-go) for funding health care for separate classes of people. One distinguishing characteristic is that health insurance has been linked to employment since shortly after the end World War II, as a result of certain tax incentives. Raffel and Raffel describe the USA health care system as one where each level of government (federal, state, local) and the private sector have a role to play; some have exclusive rights and responsibilities, while some share responsibilities. Most money for the support of health care comes not from any level of government but from the private sector (Raffel and Raffel, in Raffel 1997, p. 264). T. R. Reid has described the USA system as a mix of approaches, as follows (Reid 2008):

- For veterans, like a Beveridge single-provider or Communist system.
- For those over the age of 65 or on Medicaid, like an NHI single-payer system; however, the availability of supplemental private insurance differentiates USA Medicare from Canadian Medicare.
- For those who work and get health insurance on the job, like a Bismarck system.
- For those who have no health insurance, essentially a pay-as-you-go system, although those individuals do have the availability and use of emergency room (ER) care.

Table 1 contains an adaptation of a chart prepared in 1995 by William C. Hsiao, now K.T. Li Professor of Economics at the Harvard School of Public Health (Hsiao, in Dunlop and Martens, 1995, p. 18), which summarizes some of the basic differences between the above approaches.

Table 1 – Basic Characteristics Of Various Health Care System Types

System Type	Financing	Ownership	Expenditure Controls	Organization	Private Insurance?
Beveridge/Single-provider (UK, Italy, Spain, New Zealand, Greece, Portugal, Norway, Sweden, Denmark, Finland, Ireland)	General taxation, central (UK) or local/regional (Nordic) government	Public	Global budget	Services integrated	Yes
NHI/Single-payer (Canada, South Korea, Taiwan)	General taxation, central and/or regional government	Mixed public and private	Global budget and single channel	Services not integrated	No
Bismarck/Social insurance (France, Germany, Holland, Switzerland, Belgium, Luxembourg, Japan)	Mandated social insurance, typically funded by payroll taxes	Mixed public and private	Global budget and single channel	Services not integrated	Yes
Communist/ Command and control (Cuba, North Korea)	General taxation	Public	Global budget	Services integrated	No (but extensive black market)
Pay-go (third world)	Out of pocket	Mixed public and private	No limit on expenditures	Services not integrated	Yes
Pluralistic/Opt out (Australia, Singapore)	Universal public provided with private opt-out	Mixed public and private	No limit on expenditures	Services not integrated	Yes
Mixed (USA)	Pluralistic, mixed	Mixed public and private	No limit on expenditures	Services not integrated	Yes

Within the general parameters outlined above, practices vary somewhat from country to country. Table 2 summarizes the rankings obtained by the USA system and by the Beveridge, NHI, and Bismarck systems, on average, in the WHO study. The data posted are averages for groups of countries. While arithmetic averages have obvious limitations in presenting such data, review of the supporting detail supports the assertion that such averages are not misleading in this event, and therefore the data are presented this way for ease of viewing and comprehension.

Table 2 – Rankings By Component Area In The Who Health Care Study
(smaller number = better, except expenditure per capita; best performance in bold)

System Type	Health (Dale)		Responsiveness		Financial Fairness	Goal Attainment	Expenditure Per Capita	Performance Ranking	
	Level	Distri-bution	Level	Distri-bution				On level	Overall
Beveridge Single-Provider	16.9	16.0	22.3	23.6	22.7	17.6	18.8	28.8	19.3
NHI Single-Payer	31.5	27.5	21.3	31.8	35.5	21.0	**20.5**	71.0	44.0
Bismarck Social Insurance	**12.2**	**13.7**	8.8	**20.5**	**15.4**	**7.4**	6.9	**21.6**	**14.9**
USA	24.0	32.0	**1.0**	**20.5**	54.5	15.0	1.0	72.0	37.0

Notes: Where two countries tied, the average for the tied positions is reported for both. If two countries tied for 7th and 8th, the result is reported as 7.5 for both. In particular, 36 countries tied for 3rd through 38th in responsiveness distribution, and that result is reported as 20.5 for each of them. Goal attainment evaluates performance without considering cost; on level performance represents cost effectiveness; overall performance includes both.

Overall, the Bismarck systems outperformed the Beveridge and NHI systems, as well as the USA. The Bismarck countries as a group did better than the USA in every category, and better than NHI and Beveridge in every category but cost. The argument could be made that the Beveridge group includes countries that are less prosperous than the Bismarck countries as a group (specifically, Portugal and Greece) but those countries actually improved the overall average for the Beveridge group.

While the WHO has not updated its work since 2000, subsequent studies, more limited in scope, would appear to confirm these results, as follows:

Euro Health Consumer Index and Euro-Canada Health Consumer Index

The *Euro Health Consumer Index* (EHCI) prepared by Health Consumer Powerhouse AB, in Brussels, Belgium, and Stockholm, Sweden, is an annual ranking of European health care systems (now including 33 countries). The historical components of the EHCI, and their relative weightings and number of component factors included in the 2009 rankings (Bjornberg, Garoffe, and Lindblad, 2009), are as follows:

- Patient rights and information, 17.5%, 9 component factors;
- Pharmaceuticals, 15.0%, 4;
- Waiting time for treatment, 20.0%, 5;
- Outcomes, 25.0%, 7;
- Range and reach of services (added in 2006), 15.0%, 7l and
- E-health (added in 2008), 7.5%, 6.
- Customer friendliness was included as a category prior to 2006.

There are several methodological differences between the EHCI and WHO approaches.

- WHO did not consider waiting time except to the extent that it was implicit in other categories.
- Both studies consider outcomes, but the EFCI approach to evaluating outcomes has far more granularity

than the WHO study, incorporating several factors where WHO relied almost exclusively on DALE (note that this probably reflects a data constraint on the WHO study).

- EHCI does not consider equality of choices or outcomes as separate categories, although they are implicitly considered in waiting times, outcomes, and range and reach of services.
- EHCI does not consider cost as a separate category, although it has begun including a "Bang-for-the-Buck" (BFB) calculation separately (see below).
- WHO did not consider the e-health factor identified and included in more recent EHCI analyses. This may very well simply reflect the more recent dates of the EHCI work. This consideration can be expected to become more important in the future.

Beginning in 2008, the EHCI rankings were expanded with the assistance of the Frontier Centre for Public Policy, Winnipeg, Manitoba, to include Canada. The 2008 Euro-Canada Health Consumer Index (ECHCI) was based on the 2007 EHCI, and the 2009 ECHCI was based on the 2008 EHCI. Results of the EHCI/ECHCI rankings are summarized in Table 3.

Table 3 – Summary of EHCI/ECHCI Rankings by Year
(smaller number = better, best performance bolded)

System type	2005 EHCI (12 countries)	2006 EHCI (26 countries)	2007 EHCI (29 countries)	2008 ECHCI (30 countries)	2008 EHCI (31 countries)	2009 ECHCI (32 countries)	2009 EHCI (33 countries)	Avg rank
Beveridge Single-Provider	8.0	13.5	13.6	13.6	13.2	13.8	14.2	13.3
NHI Single-Payer	NA	NA	NA	23	NA	23	NA	23.0
Bismarck Social Insurance	**3.4**	**4.6**	**5.1**	**5.1**	**6.3**	**5.4**	**6.0**	**5.2**

Similar to the WHO cost-effectiveness ratings, the EHCI authors also prepare a BFB analysis starting in 2006. The EHCI authors seem generally less satisfied with the methodology for the BFB results than they are for the basic rankings, and include the BFB rankings with some caveats because of questions which they believe may limit the accuracy or usefulness of the BFB rankings. Nevertheless, the BFB rankings are worth a look, and are shown in Table 4. With or without the BFB adjustment, these results suggest superiority for the Bismarck approach, as has been noted by the EHCI authors.

Table 4 – Summary Of EHCI/ECHCI "Bang For The Buck" Rankings By Year
(smaller number = better, best performance bolded)

System type	2006 EHCI (26 countries)	2007 EHCI (29 countries)	2008 ECHCI (30 countries)	2008 EHCI (31 countries)	2009 ECHCI (32 countries)	2009 EHCI (33 countries)	Average position
Beveridge Single Provider	16.0	16.8	16.9	16.8	22.0	22.0	18.4
NHI Single Payer	NA	NA	30.0	NA	32.0	NA	31.0
Bismarck Social Insurance	**11.6**	**9.4**	**9.4**	**13.0**	**14.4**	**14.4**	**11.6**

Here, the relatively poorer Greece and Portugal pull down the average Beveridge performance, but even excluding them the Bismarck countries still outperform the Beveridge countries as a group. Within the Beveridge

group, only Sweden (highest placing 4th) placed in the top ten in every year; within the Bismarck group, four of the seven countries (Netherlands, Austria, Switzerland, Germany) placed in the top ten every year and three of the seven (Netherlands, Austria, France) placed first at least once.

What is striking from the ECHCI rankings is the extremely poor performance of Canada when compared to the European systems. In particular, Canada finishes last in both years in the BFB rankings. Table 5 summarizes the average component scores, by system type, for the 2009 ECHCI. The totals as shown excluded the e-health category since Canada was not evaluated based upon that criterion. Canada does achieve the highest score in the Outcomes category, and Beveridge comes out slightly ahead of Bismarck in that category, but both Canada and the Beveridge countries perform so poorly with regard to waiting times that they fall far below the Bismarck countries overall.

Table 5 – Analysis Of Ehci/Echci 2009 Scores By Component Area
(larger number = better, best performance bolded)

System type	Patients' Rights	E-Health	Waiting Times	Outcomes	Range and Reach of Services	Pharma	Total (excluding E-Health)
Beveridge Single-Provider	120.5	**48.0**	105.3	202.3	112.0	107.7	647.8
NHI Single-Payer	75.0	NA	83.0	**229.0**	100.0	63.0	549.0
Bismarck Social Insurance	**139.9**	44.3	**175.3**	200.4	**116.4**	**112.3**	**744.3**

One noteworthy feature of the Swedish system is its "no-fault" malpractice system. Conceptually, this works in somewhat similar fashion to the workers' compensation insurance system in the USA.

OECD Studies

The Organization for Economic Cooperation and Development (OECD) also publishes statistical information regarding health care in various countries. Those data are summarized in Table 6 (OECD, 2011).

Table 6 – Summary Of OECD Health Care Statistical Information
(larger number = better, except cost data; best performance bolded)

System Type Country	Health Care Cost (US$)	Health Care Cost (% GDP)	Life expectancy at birth	M/F Life expectancy at age 65	Infant mortality rate
Beveridge (single-provider)	$3,478	9.8	80.5	17.7/20.9	**3.4**
NHI (single-payer) (Canada)	$4,478	11.3	80.7	18.2/21.3	5.1
Pluralistic (opt out) (Australia)	**$3,445**	**8.7**	**81.6**	**18.5/21.8**	4.3
Bismarck (social insurance)	$4,250	10.5	81.0	18.0/21.7	3.5
USA	$7,960	17.4	78.2	17.4/20.0	6.5

Some observations are as follows:

- Discrepancies between Canada and South Korea are so great that it is potentially misleading to discuss an average for that group, so the NHI data above are for Canada only.
- Australia has the best performance in cost measures (Beveridge second), life expectancy at birth (Bismarck second), M/F life expectancy at 65 (NHI second for males, Bismarck second for females).
- Beveridge has the best performance for infant mortality, slightly ahead of Bismarck.
- USA has the worst performance for all measures (NHI second worst for cost measures and infant mortality rate, Beveridge second worst for life expectancy measures).

OECD does not attempt any ranking of systems, but these data tend to corroborate findings in other studies.

Commonwealth Fund Studies

The Commonwealth Fund describes its mission as "to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults." The fund states further that it carries out that mission by "supporting independent research on health care issues and making grants to improve health care practice and policy". An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries" (Commonwealth Fund, 2011). In carrying out that mission, the Commonwealth Fund has compared up to seven health care systems of various types in 2010, and periodically in prior years, in its, "Mirror, Mirror on the Wall," series. Rankings for 2004, 2006, 2007, and 2010 are summarized in Table 7 (Davis, 2010):

Table 7 – Summary Of Commonwealth Fund Rankings By Year
(lower number = better, best performance bolded)

Year	Australia	Canada	Germany	Netherlands	NZ	UK	USA
Type	**Pluralistic**	**Single-payer**	**Bismarck**	**Bismarck**	**Beveridge**	**Beveridge**	**Mixed**
2010	3	6	4	**1**	5	2	7
2007	3.5	5	2	NA	3.5	**1**	6
2006	4	5	**1**	NA	2	3	6
2004	2	4	NA	NA	**1**	3	5
Average	3.1	5.0	1.7	**1.0**	2.8	2.3	6.0

In summary, the Bismarck systems outperform the Beveridge systems, with the USA last and Canada next to last in every year. The poor performance by the Canada parallels the results of the WHO and ECHCI studies. The component breakdown of the 2010 report is shown in Table 8 (Davis, 2010):

Table 8 – Detail Commonwealth Fund Rankings By Component Factor, 2010
(lower number = better, best performance bolded)

Year	Australia	Canada	Germany	Netherlands	NZ	UK	USA
Type	**Pluralistic**	**Single-payer**	**Bismarck**	**Bismarck**	**Beveridge**	**Beveridge**	**Mixed**
Quality	4	7	5	2	**1**	3	6
Access	6.5	5	3	**1**	4	2	6.5
Efficiency	2	6	5	3	4	**1**	7
Equity	4	5	3	**1**	6	2	7
Long, healthy lives	**1**	2	3	4	5	6	7
Overall	3	6	4	**1**	5	2	7

One noteworthy aspect is that the Netherlands did not place worse than 4th in any category, and that along with Germany, the two Bismarck systems are the only ones that did not place worse than 5th in any category. Generally strong performance across the board seems to be a recurring theme with the Bismarck systems.

The Commonwealth Fund also prepares what it calls the National Scorecard, evaluating the USA health care system. Reports were issued in 2006 and 2008. While the report focuses on the USA health care system, it does contain some comparative data for various other countries, as presented in Appendix VII. In conjunction with the national scorecard, the Commonwealth Fund also reports additional information for a limited number of countries, as presented in Table 9 (Davis, et al, 2006, 2007, and 2010).

Table 9 - Commonwealth Fund Selected Data, 2006, 2008 And 2010
(lower = better, best performance bolded)

	Type	Waiting time (% who could not get appointment on same day)		% In 2010 who wait more than 2 months for specialist or 4 months for elective surgery		% Who had access problems because of cost		% For which test results or coordination problems (2010 measure more comprehensive)	
		2010	2008	Spec	Elec	2010	2008	2010	2008
New Zealand	Beveridge	**42%**	**26%**	16%	5%	14%	25%	23%	14%
UK	Beveridge	55%	43%	19%	21%	**5%**	8%	**19**%	17%
Canada	Single-payer	77%	68%	41%	25%	15%	12%	28%	18%
Netherlands	Bismarck	NA	31%	16%	5%	6%	**5%**	21%	**9%**
Germany	Bismarck	44%	37%	**7%**	**0%**	25%	21%	29%	12%
Australia	Pluralistic	51%	42%	28%	18%	22%	26%	28%	17%
USA	Mixed	70%	54%	9%	7%	33%	37%	37%	22%

The data reported in these areas may be too sketchy to support meaningful conclusions, but the following would appear to be reasonable conclusions:

- Canada and the USA are worst at providing same-day appointments, with the other systems comparable.
- The USA and the Bismarck systems are best at minimizing waits for specialists and elective surgery, with Canada worst.
- UK (Beveridge) and Netherlands (Bismarck) are best at minimizing access problems due to cost, with the USA worst.
- With respect to coordinating and testing results, results for 2008 and 2010 are not directly comparable because the metrics are not identical. Beveridge does best, followed closely by Bismarck, with the USA trailing in both years by either measure.

Public Opinion Polls

The above analyses are all based on some more or less scientific evaluation of hard data. Another approach would be to look at how patients and consumers evaluate their health care systems in public opinion polls. Gallup did a very interesting poll of citizens of developed countries in 2009, asking them to compare their perceptions regarding their national healthcare systems with their satisfaction with the healthcare available to them personally. This particular poll has not been conducted more recently. Results of the 2009 poll are summarized in Table 10 (Brown and Khoury, 2009).

Table 10 – Gallup Health Care Poll Results

System Type	Country	Are satisfied with the availability of quality health care in their city or area	Have confidence in their national healthcare system	Average level of satisfaction with both	More (less) confident of health care in own area than nationwide
Beveridge (single-provider)					
	Sweden	77%	79%	78.0%	-2%
	Denmark	86%	77%	81.5%	9%
	Finland	66%	85%	75.5%	-19%
	Italy	57%	53%	55.0%	4%
	Spain	74%	77%	75.5%	-3%
	UK	85%	73%	79.0%	12%
	Portugal	64%	58%	61.0%	6%
	Norway	80%	68%	74.0%	12%
	NZ	80%	64%	72.0%	16%

System Type	Country	Are satisfied with the availability of quality health care in their city or area	Have confidence in their national healthcare system	Average level of satisfaction with both	More (less) confident of health care in own area than nationwide
	Ireland	64%	40%	52.0%	24%
	Greece	52%	45%	48.5%	7%
Beveridge average		71.4%	65.4%	68.4%	6.0%
NHI (single-payer)					
	Canada	70%	73%	71.5%	-3%
	South Korea	67%	60%	63.5%	7%
NHI average		68.5%	66.5%	67.5%	2.0%
Pluralistic (opt out)					
	Australia	79%	60%	69.5%	19%
Bismarck (social insurance)					
	Netherlands	89%	77%	83.0%	12%
	Austria	93%	84%	88.5%	9%
	Germany	88%	54%	71.0%	34%
	France	83%	83%	83.0%	0%
	Switzerland	92%	86%	89.0%	6%
	Japan	64%	57%	60.5%	7%
	Luxembourg	90%	90%	90.0%	0%
	Belgium	91%	88%	89.5%	3%
Bismarck average		86.3%	74.4%	80.3%	11.9%
Mixed					
	USA	81%	56%	68.5%	25%

From a totally different perspective, Bismarck systems again outperform the rest, with details as follows:

- Bismarck systems as a whole have the highest average in both satisfaction with health care available individually and confidence in national health care, running roughly 12% higher than the combined average for each of the other system types. Japan is considerably adrift from the other Bismarck systems. Without Japan, the average Bismarck results would be approximately 5% higher. Of the eight Bismarck systems, seven rate higher than the highest Beveridge/NHI system in satisfaction with own health care, and three rate higher in confidence in national health care (with a fourth missing doing so by only one percent).
- Canadians and South Koreans (NHI), Australians (opt-out), Swedes, Finns, Spaniards, Portuguese, and New Zealanders (Beveridge), and Japanese (Bismarck) are all more confident in their national health care systems, but less satisfied with their own health care, than are Americans.
- Two Beveridge systems (Denmark and UK) out of eleven and seven Bismarck systems (Netherlands, Austria, Germany, France, Switzerland, Luxembourg, and Belgium) out of eight reported a higher percentage of satisfaction by individuals with their own health care than for the USA system.
- Three Beveridge systems (Ireland, Greece, and Italy) out of eleven and one Bismarck system (Germany) out of eight reported a lower percentage of confidence in their national system than for the USA system.
- A higher percentage of Bismarck system respondents were happy with their own health care than in the USA. In fact, of all countries listed, the six highest rated in terms of satisfaction with local area health care are all Bismarck systems (Austria, Switzerland, Belgium, Luxembourg, Netherlands, and Germany).
- The Bismarck, Australia, and USA respondents seem generally to be more satisfied with their own local health care than confident of their country's health care as a whole. For the Beveridge and NHI respondents, that result is not so pronounced, and in four of the Beveridge/NHI countries (Finland, Spain, Canada, Sweden) respondents are actually more confident of their national system as a whole than of their own local health care facilities. This would suggest that for those four countries, perhaps the performance claimed for their particular national health care approach in theory is not being met in reality.

WHICH MODEL OR MODELS OF HEALTH CARE REPRESENT "BEST PRACTICES" AND HOW CAN AND SHOULD THEY BE IMPLEMENTED IN THE USA?

The recurring theme throughout the above comparisons is that the Bismarck systems do better than the others on a fairly consistent basis. To understand better why the Bismarck systems seem to do better when worldwide systems are compared and ranked requires first understanding what factors are considered in the rankings, and how and why the various health care approaches achieve the results that they do.

The biggest difference separating Bismarck and Beveridge systems in the EHCI rankings has been waiting times. In every year, Beveridge systems have performed worse than European systems overall, and much worse than Bismarck systems, in this area. Since waiting times were not a specifically identifies criterion in the WHO study, it is arguable that the WHO approach overstates the desirability of Beveridge-type systems.

The 2009 EHCI report states, "Bismarck beats Beveridge – yet again!" (Bjornberg, et al, 2009, p. 9). The EHCI authors identify two factors that they believe are responsible for this outcome (Bjornberg, et al, 2009, pp. 9-11):

1. Managing a corporation or organization with 100,000+ employees calls for considerable management skills, which are usually very handsomely rewarded. Managing an organization such as the English NHS, with close to 1½ million staff, which also makes management life difficult by having a professional agenda that does not necessarily coincide with that of management/ administration, would require absolutely world-class management. It is doubtful whether public organizations offer the compensation and other incentives required to recruit those managers.
2. In Beveridge organizations, responsible both for financing and provision of health care, there would seem to be a risk that the loyalty of politicians and other top decision makers could shift from being primarily to the customer/patient. Primary loyalty could become shifted to the *organization* these decision makers with justifiable pride have been building over decades (or possibly to aspects such as the job-creation potential of such organizations in politicians" home towns").

The implications for the US—which is much larger than any existing Beveridge country, and which has a political system where the effects of "pork barrel" politics are well documented—from both these factors should be obvious. First, the difficulties with administration and management suggest that health care may well be a service that is characterized not so much by economies of scale as by diseconomies of scale. Given that CBO his indicated above that the anticipated cost savings from ACA can be achieved through more efficient administration, restriction of access, or reduction of quality, removing efficient administration as a likely source means that we will be left to chose from higher costs, lower quality, or reduced access. Second, the large number of new government agencies being created, and additional powers being given to existing agencies, as part of any of the various health care reform approaches currently being debated in the US Congress, is very troubling in light of the second factor.

Systems may be evaluated based upon their success in achieving various goals. Uwe Reinhardt, now James Madison Professor of Political Economy and Professor of Economics and Public Affairs at Princeton University, has identified three competing goals for any health care system, at least all those in developed countries (Reinhardt, in Dunlop and Martins, 1995, p. 141):

- An equitable/egalitarian distribution of health care, meaning that the medical treatment of patients would be independent of their socioeconomic status;
- Clinical freedom of providers to organize health care activities as they best see fit, meaning that the doctor-patient relationship governs health care, rather than outside parties; and
- Economic and budgetary control, meaning that marginal benefits should justify the cost of health care activities, and that all stakeholders should be able to predict their health care costs with reasonable reliability.

These may be thought of as equity/accessibility, quality, and cost, respectively. Attempting to achieve all three goals simultaneously has resulted in uncontrollable cost spirals. The impact of neglecting each of the three goals is summarized in Table 11:

Table 11 – Summary Of Health Care Evaluation Components

Equity/ Accessibility	Quality	Cost	Result
Yes	Yes	No	Expensive health care, with costs rising rapidly and uncontrollably.
No	Yes	Yes	Inequality in service, with large numbers of people who are not covered or undercovered by the health care system.
Yes	No	Yes	Subverting the doctor-patient relationship, leading to poor outcomes and/or excessive waits due to rationing by fiat

Designing a system to achieve one of the three is relatively simple. It is also possible to design a system to achieve two of the three. Achieving all three simultaneously has heretofore proved impossible.

- Beveridge systems emphasize accessibility and cost controls, resulting in either poor quality or excessive delays, or both. Communist and NHI single payer systems do the same.
- The pluralistic and Bismarck systems function like Beveridge systems with respect to the "free" component, and emphasize quality and cost in the "pay" component.
- The American mixed system emphasizes quality of the services actually performed, and actually provides fairly widespread accessibility, at least for critical needs, through emergency room (ER) care, which must by law be made available to all.

The criticism of using the ER in this fashion is typically that it is the most expensive delivery vehicle for health care. But in reality, that criticism seems somewhat absurd. In an ER in the USA, the patient is typically seen by a resident, maybe an intern, perhaps even a nurse, instead of a more highly paid MD. The ER is part of the hospital, so no stand-alone structure is needed. The ER requires little or no dedicated equipment, as it makes use of hospital equipment, mostly at off-peak hours. Viewed in this way, the ER may be thought of as a "doc-in-the-box with a free box." The marginal cost of ER care should be very low. The reason ER care is so expensive is because in the current Medicare/ Medicaid/insurance reimbursement scheme, the hospital typically benefits by pricing the ER higher, so massive allocations of fixed costs are made to achieve that result.

Providing effective health care at a reasonable cost requires trade-offs in these areas. Essentially there is a population with certain health care needs. Cost rules out meeting all needs for all people, so the options would be to meet all needs for some (but not all) people, or some (but not all) needs for all people, or some (but not all) needs for some (but not all) people.

- Meeting all needs for some (but not all) people produces inequality.
- Meeting some (but not all) needs for all people requires some sort of rationing method and produces poor quality (when services are not provided) and/or poor timeliness (if queues are used to ration care).
- Meeting some (but not all) needs for some (but not all) people produces totally unacceptable health care.

Regarding cost, Uwe Reinhardt (in Dunlop and Martins, 1995, pp. 130-131) discusses alternative health care cost containment strategies, producing the following summary table:

Table 12 – Alternative Cost Control Strategies In Health Care

Target	Micromanagement	Macro management
Supply-side strategies	Encouragement of efficiency through economic incentives; legal constraints on health care facilities	Regional planning intended to limit capacity and ensure desired distribution
Demand-side strategies	Conversion of patients to consumers (cost-sharing); hands-on supervision of decisions of doctors and patients (managed care)	Predetermined global budgets for hospitals and expenditure caps for physicians
Strategies aimed at the market as a whole		Price controls

The ACA probably leans more toward the macro management techniques presented above, while competing proposals focus more on micromanagement tools. Ideally, a mix of both should be implemented.

As noted previously, the optimum approach for the USA would be one that improves the areas where the USA is weakest—universal access and cost—while preserving what the current USA system does best—caring for seriously ill and injured people. The current system falls short of the mark in achieving the former. The single-payer and single-provider systems appear to fall short in achieving the latter, primarily because of excessive delays and problems administering a larger system. The consistently high performance of the Bismarck systems suggests that the best practices lie with that approach. A proposal to implement such a system would include:

- Universal basic insurance funded by the federal government out of payroll taxes, and administered by insurance companies. Let the federal government specify a fixed amount per capita, and let the insurance companies then design plans to compete for customers. This competition would be expected to be very fierce, as even with minimal profits on offer, the insurance companies would get significant cash float and also have a ready-made mailing list to solicit customers for supplemental plans (see below). The German Lander compete fiercely for market share, even though they are technically non-profit organizations, and that same sort of competition would be expected here. As one way to compete, it would be expected that those insurance companies would lead the way in innovating approaches to deliver basic health care services cheaper.
- Implement essentially a free market for supplemental insurance. Policies could be sold across state lines, items covered could be negotiated between customer and insurer, approaches such as high-deductible plans coupled with health spending accounts could be given greater emphasis, as this approach offers more cost-containment potential than many others. It would be expected that most persons would obtain secondary coverage from the same insurer who provides their primary coverage, hence the reason why insurers would be expected to compete intensely to sign up people for primary coverage.
- Allow—but not require—states to supplement the federal program as they saw fit.

In this system the role of the federal government would very nearly approximate that of an employer in the current system—collect taxes, negotiate policies with insurance companies, provide a means to communicate policy options to citizens and give them the opportunity to select one, and pay premiums. If we began at the current French level, the cost of the basic care would be approximately $3,100 per person per year (OECD, 2011), or about $960 billion nationally. Based upon current federal budget numbers (OMB, 2011), about $350 billion of that could come from ending Medicaid, which would be rendered redundant, and another $155 billion could come from offsets to the cost of Medicare for 50 million elderly at $3,100 per person. This would leave $455 billion to fund from other sources, preferably savings in other areas in our current deficit-cutting mode. In a worst-case scenario, if payroll taxes on American businesses were increased to pay for that amount, such businesses would have been relieved of a current annual liability for health insurance in the $700-800 billion range (Johnson, 2010), so that many businesses would see a net reduction in costs. Particularly if that were not the required approach, the result could be to make US businesses more competitive internationally.

CONCLUSION

To summarize, we will return to the questions asked initially:

- Does the USA really have the 37th best health care system in the world?
  A more accurate portrayal of the WHO study would be to say that the USA has the 15th best at achieving "fairness" and "equality" (62.5%) more than "quality" (37.5%), but only the 72nd most cost-effective, resulting in an overall ranking of 37th on all factors combined in the 2000 WHO study.
- Does either a "single-payer" health care system or a "single-provider" health care system offer prospects for significant improvement?
  Neither "single-payer" nor "single-provider" systems stack up particularly well against what are generally accepted as world-class health care systems. In the 2000 WHO study where the USA placed 37th, Canada placed 30th and the UK placed 18th. Subsequent comparisons with other systems have produced generally consistent results. The "single-provider" systems generally outperform the "single-payer" systems, but

both are routinely outperformed by the Bismarck systems. The biggest deficiency is that the "single-payer"/"single-provider" systems consistently encounter unacceptable problems with delays. If "health care delayed" is truly "health care denied," then these models would not be appropriate for the USA to emulate. The second biggest deficiency would appear to be that these systems may perform acceptably in small countries, but management of large systems seems to present major problems. Canada addresses this to some extent by having individual provincial systems, and the Nordic countries (which are relatively small to start) address it by setting responsibility at the regional/local government level, but there are strong implications that managing a "single-payer" or "single-provider" system as large as the USA (or even large states) would be very problematical.

- Are there other models for delivery of health care services which might offer the prospect of better health care than either the current USA system or a "single-provider" or "single-payer system?
  The Bismarck systems consistently rank at the top when compared to other system types, in repeated studies by WHO, EHCI, Frontier Centre, and Commonwealth Fund. The two-tier insurance approach seems to combine the best aspects of universal single-payer/single-provider systems with the choices available to USA patients and their families, enabling these systems to deliver quality care with minimal delays at a reasonable price. The results of recent studies, as summarized in this paper, would suggest very strongly that this is the best route for the future of health care in the USA.

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