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Comparing Health Care Systems in Canada/UK, USA and Switzerland to Assess the Direction of US Health Care Reform

Deepti Chinta and Ravi Chinta

***Abstract*- Along the payer continuum ranging from full consolidation of payers to consumer-driven health care, three competing models of health care systems are identified in Canada/UK, USA and Switzerland respectively. These three health care systems are compared and contrasted along 10 analytical dimensions. Trade-offs along three aspects of a health care system, namely, (i) access to care, (ii) quality of care, and (iii) cost of care, are discussed in each of the three systems. Bureaucratic forces in Canada/UK, competitive forces in USA and market forces in Switzerland are noted as dominant. Several state-level mini-reforms in the USA are noted with a view to project the direction of future of US health care system. The paper concludes with an inferential projection of transforming forces impinging on the current US health care system.**

Index Terms: Health care reform; Health care systems; International comparisons; Emergent systems

I. Introduction

Institute of Medicine (2001) exhorted, "*Between the health care we have and the care we could have lies not just a gap, but a chasm*." For the past two decades, the US health care system has been bedeviled by a multitude of problems, including rising costs, uninsured patients, unequal access to care, doctors' frustrations, fragmented structures, lack of transparency and mysterious hospital accounting systems. While the clarion call for US health care reform is getting louder and louder each year, several alternative models across the globe have been suggested for emulation.

II. Conceptual Framework for Health Care Systems

An in-depth discussion of the competing models of health care in U.S., Canada, U.K. and Switzerland would provide the foundation for any discussion on health care reform. This report purports to do just that. Three competing models of health care, that form the backbone of this comparative analysis report, can be positioned along the payer continuum as shown below in Figure 1. At one end of the continuum is a complete consolidation of all payers into a single-payer system (ex: Canada and U.K.). At the other end of the continuum is complete atomization of payers where individuals directly pay for their health care (ex: Switzerland). In the middle is the competitive model where many private insurers play the payer role competitively (ex: USA).

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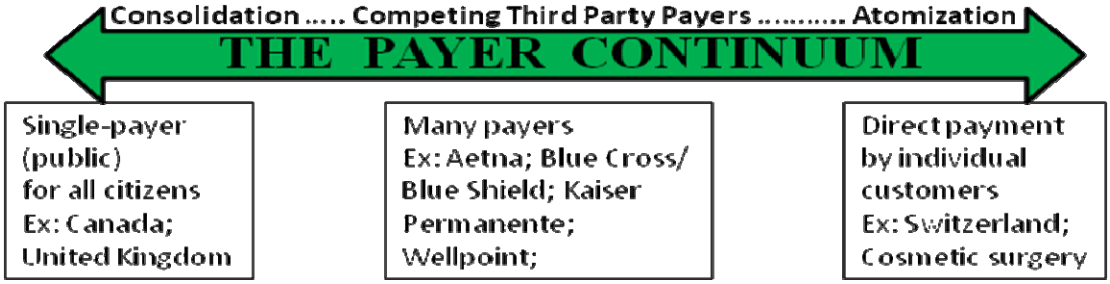
FIGURE 1



Envisioning the three health care systems is just a starting point. Given the increasing global nature of health and health care, one immediately posits a question if non-US health care systems are more effective, and if US should learn from them. Fuchs and Emmanuel (2005) suggest that all ideas for health care reform in US must be subjected to harsh analysis along several dimensions that include among others, access, financing, quality. They must be compared and contrasted along several analytical dimensions to better understand their relative merits and demerits. Table 1 below provides a detailed comparative analysis of the three health care systems along 10 dimensions. First, examples are identified that illustrate each of the three models. A brief description of how each health care system works is given. Then the strengths and weaknesses of are outlined at an aggregate level. Industry consolidation is discussed to note structural changes in the health care systems. Several outcome variables such as access to care, preventive care, quality of care, waiting times, efficiency and effectiveness are used to compare and contrast the three systems.

III. Three Competing Health Care Systems

Health care systems in every nation need improvement, and can learn from one another (Ross, 2009). Following the detailed comparative analysis is a discussion on key issues that call for policy decisions on trade-offs in each of three systems. For example, the tension between containing costs and providing universal coverage is a perennial issue that calls for a policy decision. Likewise, the tension between innovation and efficiency will be addressed in the three systems. After discussion the key issues and trade-offs, several tendencies for reform in the US health care system are discussed with a particular focus on state level health care reforms (ex: States of Massachusetts, Oregon, Arizona). Such mini-reforms at state level may portend future scenarios and hence must be seen as harbingers for the future state of US health care system.

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TABLE 1: COMPARATIVE ANALYSIS OF THE THREE COMPETING HEALTHCARE SYSTEMS

	Single-payer System	Many-private-insurers System	Customer-is-the-payer System
EXAMPLES	**Canada; United Kingdom**	**USA**; Aetna; Blue Cross/Blue Shield; Wellpoint; Kaiser Permanente; Health South; etc.	**Switzerland**; Cosmetic surgery;
HOW IT WORKS	Government mandates all citizens to have health insurance in the single-payer system. **Bureaucratic forces**.	Employers pay for employee and their families; employees pay a small part as copayment. **Competitive forces**.	In the Swiss system, individuals are required to purchase their own health insurance. All prices are transparent. **Market forces**.
STRENGTHS	Universal health coverage, free or inexpensive medical services and prescription drugs, unrestricted access to care, doctors with complete clinical freedom	Largely employer-based system; Full health coverage for insured, competition forces efficient delivery of medical services, quality of care becomes a source of competitive advantage;	Switzerland's consumer-driven health care system achieves universal insurance and high quality of care due to consumer control, price transparency of the insurance plans, risk adjustment of insurers, and solidarity
WEAKNESSES	Long lines for treatment, substandard technology, frustrated doctors and patients, and -- most important -- government rationing of care. Top-down approach.	Increasing employee copayments; Clinical discretion of doctors frustrated by insurers' procedures; rising costs; unequal access to care; fragmented structures; productivity losses	Price transparency takes time to become widely dispersed; Tiers based on income levels; Lax regulation; unequal access; underserved segments of population. Bottom-up approach.
INDUSTRY CONSOLIDATION	Consolidation of all payers into one results in significant economies of scale. However, value chain of providers remains fragmented.	To gain market power, payers tend to vertically integrate thus becoming larger firms. Increasing industry consolidation	Health care value chain remains disaggregated across providers. Focused factories and centers of excellence dominate.
ACCESS TO CARE	All customers are mandated to be part of this system. No segments within the citizenry	Employed are insured, but unemployed are not; uninsured and underinsured segments emerge	Poorer (low income) segments in the population are underserved or not served..
PREVENTIVE CARE	Customers tend **not** to stress preventive care.	Customers tend to stress preventive care.	Customers stress more preventive care. Promoting consumerism in health care.
QUALITY OF CARE	Customers perceive lower quality of healthcare service; longer waiting; substandard technology; less innovation.	Customers have more choices; and perceive higher quality of service; but insurers become gate keepers.	Customers expect highest levels of quality of healthcare service
WAITING TIME	Customers fear long waiting times.	Customers do not feel they have to wait long for service	Customers do not feel they have to wait long for service
EFFICIENCY	Economies of scale make the healthcare system most efficient on payers side; However, low innovation.	Less efficient than the single-payer system; Customers endure slightly higher administrative costs.	Least efficient due to low economies of scale. However, greatest innovation.
EFFECTIVENESS	The healthcare system is least effective due to delays, waiting times and providers' noncooperation.	The healthcare system is slightly more effective than the single payer system.	The healthcare system is most effective. Served customers who can afford love this system.

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IV. Insights From Comparisons

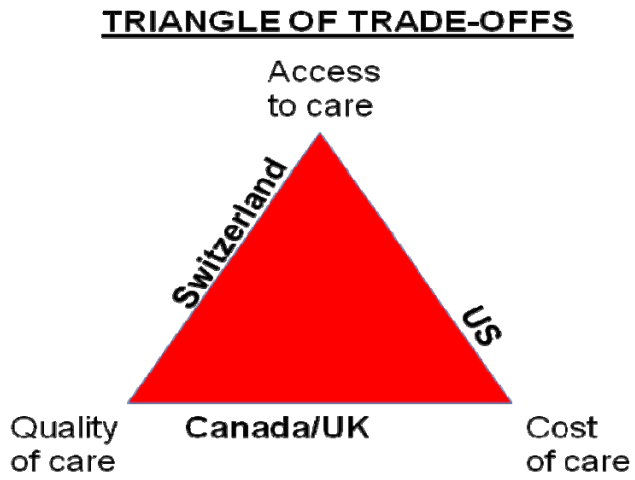
Even a cursory reading of Table 1 reveals that Canada/UK, US and Switzerland have significantly different health care systems. In the Canada/UK system, the government is the sole payer; all the citizens are mandated to be part of that single-payer system; providers get paid by the government at predetermined rates. Bureaucratic forces are dominant in the Canada/UK heath care system (prices are fixed; capital outlays for new technology are also fixed). Access to care and cost of care are effectively managed to the detriment of quality of care as manifested in longer waiting times, substandard technology, etc. Quality of care in Canada has become such a big problem that health care tourism to US has increased dramatically in the past ten years.

In contrast, in the US health care system, competitive forces play a dominant role. Multiple payers compete with one another and in order to gain relative competitive advantages, consolidation of payers and providers occurs resulting in growth of huge health care corporations. Access to care and quality of care are effectively managed to the detriment of cost of care. New technology acquisition has become common place in order to compete. If one hospital acquires an MRI machine, the next-door neighbor hospital also acquires the MRI machine or even a more superior and expensive machine. Such bulking of cost structure has led to an overcapacity of imaging equipment in several urban areas in the US. Cost of care has become so problematic in the US that health care cost inflation has been two to three times the annual inflation in the US. One consequence of this cost trend is the increase in number of uninsured and also in the copayment of employee insurance premiums. Many experts note that any health care reform in the US without a concomitant cost-containment effort will be futile.

Most interesting is the Switzerland health care system where it is customer-driven. Health care is seen as any other product or service that customers purchase. Market forces dominate. Lee (2006) notes that promoting market forces through "consumerism" is a bottom-up market oriented system that ensures the right balance between cost of care and quality of care. If the prices are high at one hospital, the demand will go down forcing the hospital to adjust its pricing. Transparency will be the most immediate benefit realized in this system. While cost of care and quality of care are effectively managed, access to care deteriorates, especially for the very sick or chronically ill or older populations whose health care expenditures tend to be above average. Heath care is about treating whole people, not merely individuals or specific ailments. Limiting access only to those who can afford to pay would automatically raise several social equity issues.

V. Triangle of Trade-offs

In the diagram below, we summarize, at the risk of simplification, the quintessential dilemmas in each of the three heath care systems (Canada/UK, USA and Switzerland). The corner closest to the country indicates the most significant problem and the side of the triangle on which the nation rests indicates the current struggle for that nation.



For example, US has a dramatic "cost of care" problem and is facing a significant trade-off between cost of care and access to care that is precipitated by the burgeoning numbers of uninsured in the US. US has no real/key issues with quality of care. Likewise, Canada/UK has a severe "quality of care" problem and is facing a significant trade-off between quality of care and cost of care that is manifested by increasing health care tourism to the south (Brooke, 2000). Finally, Switzerland faces the trade-off between access to care and quality of care as market forces determine what to provide and what not to provide. Clinical decisions are made at an aggregate level using non-clinical decision criteria (ex: profit motive).

VI. Application to Health Care Reform in US

As noted before, the above three systems must be viewed as three distinct points in the payer continuum depicted in Figure 1 above. With that in mind, it would be instructive to discuss some

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examples of state-level health care reforms in the US. Such examples provide us early signals regarding the direction of reform movement for the US health care system.

Massachusetts: Officially passed in April 2006, Massachusetts' health care reform relies on all parties--residents, employers, insurance providers, policy-makers--to join the state-managed insurance plan. Not joining the plan entails a penalty of pay up to $295 per employee per year into a state fund (Krisberg, 2008). Overall, this is a movement towards the Canada/UK system. Think of consolidation; bureaucratic forces; and all the other perils discussed in Table 1.

Oregon: Approve in 1994, Oregon Health Plan rations health care to its citizens, and this came into limelight when the state refused to pay for a bone marrow transplant to a seven-year boy with leukemia. Clearly you see the play of bureaucratic forces here, and this is a movement towards the Canada/UK system. Floyd (2003) notes that, about 40 years ago, more than half of all health care expenditures in the US were directly paid by patients. The price-based self-rationing system gradually evolved into the current system in the US – one in which third party insurers, pay for and ration medical expenses.

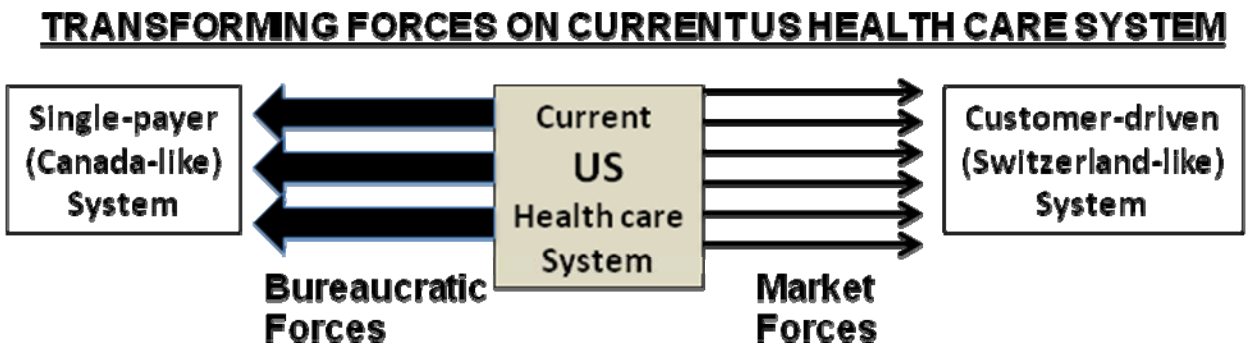
Arizona: The Arizona Health Care Cost Containment System (AHCCS) requires all participating insurers compete through bidding process for capitated pre-paid contracts to provide health care. This juxtaposes competitive forces and bureaucratic forces in Table 1. Bidding ensures competition, but bureaucracy come through the capitation of prices. This too is a movement towards the Canada/UK system. Arizona is just one example of several other states that cap insureers' rates for MediaAid programs.

MediCare System: The MediCare system in the US is perhaps the world's largest single-payer system dwarfing even the Canada/UK health care systems. US citizens over 65 years, called senior citizens, are covered by MediCare. However, many of the senior citizens find MediCare coverage inadequate and pay, on their own, for supplemental insurance. This is a movement from the Canada/UK system toward the US system. Interestingly, Mason (2006) also notes that several Canadian doctors are advocating a larger role for private medicine in Canada. That is, not all is perfect with the Canada/UK system and to many in those countries the grass is greener in the US health care system.

Given the above listed mini-reforms at the state level and also the experiential learning from the MediCare and the Veterans Administration systems, one may infer that there are several forces, though small at present, that are slowly but surely impelling the US health care system toward a single-payer system. However, one cannot discount the pull of market forces in a capitalistic society such as US. Many market solutions such as health savings accounts, healthcare expense reimbursement accounts, tax credits and subsidies for individual insurance policies continue to be introduced (Berenson and Cassel, 2009). The difficulty is that these market forces are manifesting in disparate and highly varied formats and dispersed thinly across the large US landscape. Thus, they are hard to discern at the aggregate level but their existence is perceptible.

VII. Conclusion

We conclude by noting that bureaucratic forces pulling the US system to become a single-payer Canada-like system are big but few in numbers. At the same time, market forces pulling the US system to become a more customer-driven Switzerland-like system are small but many in numbers. We show below these forces impinging on the current US health care system.



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