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**Do constitutional threads bind the health systems
of the world?**

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Comparative Constitutional Law

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Fall 2012

I. TOPIC OVERVIEW

Health Care has become a hot button issue in America's political arena. With the passing of the Patient Protection and Affordable Care Act ("PPACA") in 2008, political debate ignited regarding the constitutionality and general wisdom of health care reforms in this nation. As one of the only western nations that continues to depend on a private market system for the provision of healthcare to its citizenry, the United States is often seen as being behind the times on a major social reform. While lack of health care reform has created criticism domestically and abroad for the U.S., delays in implementing a universal health care system may provide the U.S. with a unique opportunity. As many western nations have had universal health care systems for the greater part of the 20th century, the U.S. now has the opportunity to learn from the history of other nations.

As the debate regarding the legitimacy of PPACA ignited, constitutional inquiries were engaged, challenging the Legislature's power to enact an individual mandate for the purchase of insurance, as well as other provisions of the law including Medicaid expansion.¹ In *National Federation of Independent Business v. Sebelius*, it was argued that the individual mandate was outside of the scope of the powers enumerated to Congress in the United States Constitution.² Given the number of countries that have undertaken to reform their health care systems and provide health care to their citizenry, the constitutional inquiries raised in *Sebelius* made me question what it was about the constitutions of other nations that permitted the implementation of their health care reforms. More specifically it raised questions regarding the role a constitution truly has in the formation of a health care system within a nation and whether there are any

¹ See generally, *Nat'l Fed'n of Indep. Bus. Et al. v. Sebelius*, 132 S.Ct. 2566 (Nov. 27, 2012).

² *Id.*

characteristics of constitutions that would provide indicators of the type of health care systems that are established within countries.

To engage this analysis I first selected eleven countries, each with different methods of providing health care for their citizens. I then looked at the characteristics of these health care systems and categorized them based on the models they most resemble. Having categorized the health care systems of these countries I then assessed their constitutional frameworks looking at nine variables, to identify any trends between the nations within each health care model category. Finally, I looked to whether there were any trends among the eleven countries generally that would suggest a correlation between a nation's constitutional framework and its capacity to implement universal health reforms.

II. HEALTHCARE MODELS

Three models have emerged in developed nations for the provision of healthcare.³ The first model, the Bismarck Model was named after the German leader who established the first public health insurance system in Germany in 1883.⁴ The second model, the Beveridge Model, was named for Lord Beveridge, who was fundamental in establishing the National Health System in the United Kingdom in 1948.⁵ The final model, the National Health Insurance Model has developed as a hybrid of the Bismarck and Beveridge models.⁶

³ Health Care Systems -- The Four Basic Models, <http://www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/countries/models.html> (last visited Dec. 4, 2012)

⁴ Timothy Stoltzfus Jost, Reading in Comparative Health Law & Bioethics, 29 (2d ed. 2007).

⁵ *Id* at 28.

⁶ Health Care Systems -- The Four Basic Models, *supra* note 3.

The Bismarck model was founded in Germany, arising out of underlying concerns regarding the influence of socialism on German Government.⁷ This model is premised on the idea that members of a society have obligations to each other.⁸ At the foundation of the Bismarck model is an obligation for each citizen to secure health insurance.⁹ In implementing this model in Germany, the government established a system for collecting the revenues necessary to sustain health care.¹⁰ Thus, employees and employers are required to contribute a percentage of wages to health insurance funds, which provide insurance to employees and their families.¹¹ All German citizens with an income below a threshold are required to participate in social health insurance.¹² Those with incomes above the threshold have the option of purchasing private insurance, though most do not.¹³

The Beveridge Model is premised on the principle that health insurance should be provided as a right, not a privilege, to all citizens.¹⁴ Thus this model places a greater burden on the government for sustaining healthcare. Traditional characteristics of this model include government ownership and operation of health care, government responsibility for delivery of health care, and full health access to all citizens regardless of ability to pay or employment status.¹⁵ This model originated in the United Kingdom with the formation of the National Health Service (“NHS”) where, the government determined that access to health care should no longer depend on participation in a social insurance plan, but should

⁷ Jost, *supra* note 4, at 29.

⁸ *Id.* at 30.

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.*

¹³ *Id.*

¹⁴ *Id.* at 28.

¹⁵ Health Care Systems -- The Four Basic Models, *supra* note 3.

be free at the point-of service for every citizen.¹⁶ The establishment of the NHS in England was “the first health system in any western society to offer free medical care to the entire population.”¹⁷ The National Health Service in England is financed through general revenue taxation.¹⁸ Hospitals in England are generally run as public corporations, whereas general practitioners are private businessmen.¹⁹ Thus, a major characteristic of the Beveridge model is greater centralization of the healthcare system .

The National Health Insurance Model has evolved as a combination of the Bismarck and Beveridge Models.²⁰ One major characteristic of this model is a government run insurance plan that all citizens are required to obtain coverage through, embracing the centralization of the Beveridge model.²¹ However, the model utilizes private-sector providers and less direct government funding, thereby incorporating aspects of the Bismarck model.²² As a single insurance provider the government has the ability to use its market power to negotiate lower prices while ensuring uniform coverage.

A. The Beveridge Model

i. Health care in the United Kingdom

The National Health Service in England provides preventative medicine, primary care and hospital services to all residents at no charge at the point of service.²³ The Department of Health is responsible on a national level, for monitoring standards and

¹⁶ Jost, *supra* note 4, at 31.

¹⁷ Seán Boyle, *United Kingdom (England): Health system review*, in *Health Systems in Transition*, vol. 13 no. 1, 44 (2011), available at http://www.euro.who.int/__data/assets/pdf_file/0004/135148/e94836.pdf.

¹⁸ Jost, *supra* note 4, at 31.

¹⁹ *Id.*

²⁰ Health Care Systems -- The Four Basic Models, *supra* note 3.

²¹ *Id.*

²² *Id.*

²³ Boyle, *supra* note 17, at 21.

regulating the system through a number of government and independent bodies.²⁴ At the regional level, the Department of Health operates through Strategic Health Authorities (“SHA”), which are responsible for ensuring the quality and performance of health services within specified regions.²⁵

The first point of contact in the health care system for an English resident is through a general practitioner (“GP”).²⁶ All English residents have the right to be registered with a GP and consult their practice, free of charge.²⁷ GP’s are generally self-employed and responsible for providing primary care within the NHS system.²⁸ GP services include: minor surgery and family planning, care for acute and chronically ill patients, vaccination, immunization and cancer screening, as well as general advice on healthy living or smoking cessation.²⁹ GP’s stand as a gateway to the NHS and to its services.³⁰ Thus, access to non-emergency hospital care and specialist care are dependent on referrals from a GP.³¹ Specialist, or secondary care is provided by salaried specialists working in government owned hospitals in the NHS system.³²

Entitlement to health coverage is based on a person’s status as being ordinarily resident which is defined by the Department of Health as, “someone who is lawfully living in the United Kingdom voluntarily and for a settled purpose as part of the regular order of his or her life for the time being, with an identifiable purpose for his or her residence here

²⁴ *Id* at 22.

²⁵ *Id.*

²⁶ Boyle, *supra* note 17, at 229.

²⁷ *Id* at 231.

²⁸ *Id* at 226.

²⁹ *Id* at 229-230.

³⁰ *Id* at 230.

³¹ *Id.*

³² *Id* at 25.

and that purpose must have a sufficient degree of continuity to be properly described as settled.”³³ Consequently, overseas visitors are not entitled to health coverage under the NHS with the exception of instances of emergent care.³⁴

NHS benefits are funded through general taxation.³⁵ The scope of these benefits are defined by the National Health Service Act of 1977 (“NHS Act”).³⁶ Under the NHS Act the Secretary of State for Health has a duty to provide health services “to such extent as he considers necessary to meet all reasonable requirements.”³⁷ The primary principle governing the scope of coverage under the NHS is that coverage should be comprehensive. Comprehensive has been interpreted to mean, “all health care services that might reasonably be included in the benefits package will be included.”³⁸ There is a small private health care sector in the United Kingdom financed through private medical insurance, direct payments from patients and NHS contracts.³⁹

ii. Health care in Italy

Much like the system implemented in the United Kingdom, Italy’s health system provides universal coverage free of charge at the point of service.⁴⁰ Italy has a regionally based national health service, *Servizio Sanitario Nazionale* (“SSN”).⁴¹ While there are private insurance options in Italy, the Italian health system does not permit members to

³³ *Id* at 78-79.

³⁴ *Id* at 79.

³⁵ Boyle, *supra* note 17 at 21.

³⁶ *Id* at 80.

³⁷ *Id*.

³⁸ *Id*.

³⁹ *Id* at xx.

⁴⁰ Alessandra Lo Scalzo et al., *Italy: Health system review*, Health Systems in Transition, vol. 11 no. 6, 17 (2009), available at http://www.euro.who.int/_data/assets/pdf_file/0006/87225/E93666.pdf

⁴¹ *Id* at xx.

opt out and seek private health care.⁴² The Italian system is organized into three levels, national, regional and local.⁴³ Each level plays a separate role in the overall implementation of the health care system. The national level ensures that the overall objectives and fundamental principles of the system are enforced.⁴⁴ The regional level ensures the delivery of benefits packages through regional health departments.⁴⁵ Local level governments deliver health services through population-based local health enterprises or ASL's and public and private hospitals.⁴⁶

Health care coverage in Italy is primarily financed through a mix of regional and national taxes.⁴⁷ In-patient care and primary care are free at the point of use under the Italian SSN.⁴⁸ These services are covered solely through general taxes, which are allocated to regions based on a weighted capitation rate.⁴⁹ This weighted capitation rate takes into account age, structure and health condition of the population to determine the resources needed to finance the health care needs of the population.⁵⁰ Other services such as pharmaceuticals and specialist care require co-payments.⁵¹ These co-payments are regulated by national legislation.⁵² Additionally, approximately fifteen percent of the population is enrolled in Voluntary Health Insurance ("VHI"). Consequently, only five

⁴² *Id* at 57.

⁴³ *Id* at 17.

⁴⁴ *Id* at 17.

⁴⁵ *Id*.

⁴⁶ *Id* at 29.

⁴⁷ *Id* at 52.

⁴⁸ *Id* at 55.

⁴⁹ *Id* at 58.

⁵⁰ *Id* at 59.

⁵¹ *Id* at 54.

⁵² *Id*.

percent of healthcare spending is for the provision of VHI.⁵³ VHI coverage acts as a supplement or complement to general coverage under the Italian SSN.⁵⁴ VHI is primarily purchased by high-earning and highly educated people in the Italian system.⁵⁵

iii. Health care in Portugal

Health care in Portugal originally developed in the Bismarck tradition. Health care was provided through sickness funds to the employed populations and their dependents.⁵⁶ It was financed through compulsory contributions from employers and employees.⁵⁷ However, after the Portuguese government experienced revolution in 1974 the health system underwent reforms and restructuring.⁵⁸ These reforms resulted in the establishment of the Portuguese National Health Service (“P-NHS”).⁵⁹

Administration and regulation of the P-NHS occurs at the federal level of government, while management for the system occurs at the regional level.⁶⁰ Health planning and resource allocation is highly centralized.⁶¹ Portugal’s health system provides universal coverage financed through general taxation.⁶² While general taxation plays a

⁵³ *Id* at 56.

⁵⁴ *Id* at 57.

⁵⁵ *Id*.

⁵⁶ Pedro Pita Barros et al., *Portugal: Health system review*, Health Systems in Transition; vol. 13 no. 4, xv (2011), available at http://www.euro.who.int/__data/assets/pdf_file/0019/150463/e95712.pdf.

⁵⁷ *Id*.

⁵⁸ *Id* at 15.

⁵⁹ *Id*.

⁶⁰ *Id* at xvi.

⁶¹ *Id* at 32.

⁶² *Id* at xvi.

significant role in the P-NHS system, there is an additional element of cost sharing.⁶³ The P-NHS sets user charges for many P-NHS services.⁶⁴

The P-NHS covers all residents, it is universal, comprehensive and nearly free at the point of use.⁶⁵ The P-NHS provides acute hospital care, general practice, and mother and child care.⁶⁶ The P-NHS does not provide coverage for dental care.⁶⁷ Diagnostic services, renal dialysis and physiotherapy treatments are provided under separate contractual arrangements with the P-NHS.⁶⁸ In addition to the P-NHS there remain a number of health subsystems in Portugal that continue to provide health coverage for specific classes.⁶⁹ These health providers play a supplementary role to the P-NHS.⁷⁰

B. The Bismarck Models

i. Health care in Germany

At the federal level Germany's government is primarily responsible for passing health reforms concerning Statutory Health Insurance ("SHI").⁷¹ Fifty-seven percent of health expenditures are financed through the SHI.⁷² The second level of the health system is the corporatist level, which consists of non-profit, quasi-public sickness funds and associations of SHI-affiliated providers.⁷³

⁶³ *Id* at 60.

⁶⁴ *Id.*

⁶⁵ *Id* at 59.

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ *Id* at 59.

⁶⁹ *Id* at 29.

⁷⁰ *Id* at 30.

⁷¹ Reinhard Busse and Annette Riesberg, *Germany: Health system review*, Health Care Systems in Transition; vol. 6 no. 9, 30-31 (2004), available at http://www.euro.who.int/_data/assets/pdf_file/0018/80703/E85472.pdf.

⁷² *Id* at 57.

⁷³ *Id* at 34.

Germany's health care system is made up of approximately 292 sickness funds.⁷⁴ Sickness funds are responsible for collecting contributions, purchasing benefits and paying providers.⁷⁵ Sickness fund membership is required for those whose income does not meet a minimum threshold.⁷⁶ Contributions to SHI are dependent on income, not risk.⁷⁷ Contributions are generally shared equally between the employer and employee.⁷⁸ Germany's largest source of health care financing is through health insurance. Germany has a mix of public, non-profit and for-profit hospitals.⁷⁹

All members of funds are entitled to the same scope of benefits.⁸⁰ Benefit level is not dependent on contribution paid, duration of insurance or other variables.⁸¹ Statutory health insurance currently provides for the following benefits: prevention of disease, health promotion at the workplace; screening for disease; treatment of disease, care at home, and certain areas of rehabilitative care, emergency and rescue care, patient transport in certain health conditions; certain other benefits like patient information.⁸²

ii. Health care in Japan

Japan has established a health system organized based on the Bismarck health model. Health insurance in Japan covers the entire population through three statutory

⁷⁴ *Id* at 58.

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *Id* at 59.

⁷⁹ *Id* at 55.

⁸⁰ *Id* at 67.

⁸¹ *Id.*

⁸² *Id.*

health insurance schemes.⁸³ Consequently, Japanese citizens may receive insurance coverage through the Society-managed Health Insurance system (“SMHI”), the Government-managed Health Insurance system (“GMHI”), or National Health Insurance (“NHI”).⁸⁴ Eligibility for coverage within an insurance system is dependent on employment status.⁸⁵

The SMHI is a form of insurance provided by large companies.⁸⁶ The Health Insurance Act permits large companies to form societies for the provision of health insurance with the consent of the majority of their employees.⁸⁷ These funds are self-sustaining and are responsible for their own management and maintenance, but are subject to rules and standards set forth by the government.⁸⁸ Health insurers decide the premium rate, subject to limitations set forth by the Health Insurance Act.⁸⁹ Premium rates for these plans range from three percent to ten percent of monthly wages with a ceiling.⁹⁰ The premium is shared equally between the employer and the employee.⁹¹

The GMHI is a government managed insurance provider that covers employees working for small to medium sized corporations and their dependents.⁹² The GMHI is operated by the Japan Health Insurance Association.⁹³ The premium rate for this insurance

⁸³ Kozo Tatara and Etsuji Okamoto; *Japan: Health system review*, Health Systems in Transition; vol. 11 no. 5, 19&37 (2009), http://www.euro.who.int/_data/assets/pdf_file/0011/85466/E92927.pdf.

⁸⁴ *Id* at 37.

⁸⁵ *Id* at 44.

⁸⁶ *Id* at 37.

⁸⁷ *Id*.

⁸⁸ *Id*.

⁸⁹ *Id*.

⁹⁰ *Id*.

⁹¹ *Id*.

⁹² *Id*.

⁹³ *Id*.

pathway is 8.2 percent of wages with a ceiling. As with the SMHI the premium is shared equally between the employer and the employee.⁹⁴

The final health coverage pathway is the NHI, which covers the self-employed.⁹⁵ These health insurance plans are provided through municipal governments for those ineligible for the SMHI and GMHI employment-based plans.⁹⁶ This insurance covers farmers, the self-employed, the retired, and the unemployed.⁹⁷ Each municipal government provides insurance to all eligible individuals within their jurisdiction.⁹⁸

Japan's health care is financed through three main methods, health insurance, general tax and out of pocket payments.⁹⁹ Health care is financed through three main sources.¹⁰⁰ Health insurance constitutes 49.2 percent of total spending on health care and is funded through compulsory premiums, with subsidies from the government.¹⁰¹ Additionally, general taxation constitutes 36.4 percent of spending while 15.4 percent of spending comes from out-of-pocket payments.¹⁰²

The Japanese health insurance system has a uniform benefits package covering almost all drugs and treatment except experimental treatment.¹⁰³ Benefits packages cover the costs of prescription drugs, dental care and unlimited hospital stay.¹⁰⁴ Services covered by health insurance are set forth in the national fee schedule, thus determining the scope of

⁹⁴ *Id.*

⁹⁵ *Id.* at 38.

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ *Id.* at 51.

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ *Id.* at 44.

¹⁰⁴ *Id.* at 56.

coverage through a positive list of services.¹⁰⁵ While scope of benefits is uniform, health insurance funds with optimal financial conditions may provide additional benefits.¹⁰⁶ Furthermore, the health insurance system in Japan entitles patients to an unlimited choice of providers.¹⁰⁷ Free access to health care is a key ideal in the Japanese health system.¹⁰⁸ Thus, there is no registration mechanism for primary care physicians, nor gatekeeping by general practitioners.¹⁰⁹ Consequently, the health care system relies on financial disincentives to deter patients who utilize specialized care before consulting a primary care physician.¹¹⁰

iii. Health care in the Netherlands

The Netherlands' health care system originated during the German occupation and was structured under the German Bismarck tradition.¹¹¹ This original health system covered those with lower incomes.¹¹² The government had direct control of volumes, prices and productive capacity and general practitioners acted in gatekeeper positions.¹¹³ This system was in place from 1941 until 2006.¹¹⁴

In 2006 the Dutch government instituted reforms that created a single compulsory insurance scheme.¹¹⁵ Under this new health care scheme, multiple private health insurers

¹⁰⁵ *Id*

¹⁰⁶ *Id* at 57.

¹⁰⁷ *Id* at 44.

¹⁰⁸ *Id*.

¹⁰⁹ *Id*.

¹¹⁰ *Id*.

¹¹¹ Willemijn Schäfer et. al., *The Netherlands: Health system review*, Health Systems in Transition; vol. 12 no. 1, 13 (2010), available at http://www.euro.who.int/__data/assets/pdf_file/0008/85391/E93667.pdf.

¹¹² *Id* at 13.

¹¹³ *Id* at 13 and 21.

¹¹⁴ *Id* at 13.

¹¹⁵ *Id* at xxiv.

compete for insured persons.¹¹⁶ This reform abolished the distinction between sickness fund insurance and voluntary private insurance.¹¹⁷ Consequently, the government no longer has direct control over the administration of the health care system and instead safeguards the system from a distance.¹¹⁸ Health care insurers, the insured and patients are direct market participants while the government plays a less direct role of setting policy and controlling the quality, accessibility and affordability of health care.¹¹⁹ Thus, supervision and management of the new system has been delegated to independent entities.¹²⁰

The Dutch health system consists of three main compartments or coverage types, the social health insurance scheme for long-term care (“SHI-long-term”), the SHI scheme for basic health insurance (“SHI-Basic”) and voluntary health insurance (VHI).¹²¹ SHI-long term provides chronic and continuous care, for the disabled and those with congenital mental or physical disorders.¹²² Care is provided after a needs assessment and is financed through an income-dependent cost-sharing system.¹²³ SHI-Basic covers the entire population and covers essential curative care.¹²⁴ All insureds contribute to this scheme through flat-rate premiums and income-dependent employer contributions, deducted

¹¹⁶ *Id* at 13.

¹¹⁷ *Id* at 21.

¹¹⁸ *Id* at xxiv.

¹¹⁹ *Id* at xxiv and 22.

¹²⁰ *Id* at 13.

¹²¹ *Id* at 53.

¹²² *Id*.

¹²³ *Id*.

¹²⁴ *Id*.

through payroll.¹²⁵ The final compartment of the health care system is the VHI, which provides health services that are not covered under the other compartments.¹²⁶

The free market system is the main regulatory mechanism utilized for regulation of the SHI-basic.¹²⁷ Patients have a choice of health insurer and health provider and the government provides patients with necessary information to help them make purchasing decisions.¹²⁸ All insurers are required to provide care at the level defined by the basic health insurance package, but may compete with patients regarding price of insurance and quality of care.¹²⁹ Additionally, health insurers are free to refuse to contract with providers and are expected to make this decision based on quality and cost of care.¹³⁰

Basic health insurance is obligatory for all Dutch residents.¹³¹ Benefits packages are defined by the government with the advice of the Health Insurance Board.¹³² Health insurers are required to offer this basic health package and may only otherwise compete on service, price and quality of care. Similar to the Canadian and UK systems, under the Dutch system, general practitioners play a significant gatekeeping role.¹³³ Thus, Dutch citizens experiencing health concerns will consult with a GP and must receive a referral if specialist care is necessary.¹³⁴

¹²⁵ *Id* at 54.

¹²⁶ *Id.*

¹²⁷ *Id* at 22.

¹²⁸ *Id.*

¹²⁹ *Id.*

¹³⁰ *Id* at 23.

¹³¹ *Id* at 64.

¹³² *Id* at 65.

¹³³ *Id* at 23.

¹³⁴ *Id.*

The health care sector is primarily financed through compulsory contributions and premiums.¹³⁵ The average premium in 2008 was approximately 6% of a net modal income.¹³⁶ Health insurers are free to set their premium levels and the premiums are paid directly to the health insurer.¹³⁷ While insurers may set the premiums they may not establish separate premiums for different groups of people.¹³⁸ In addition to premiums Dutch health insurance imposes a compulsory deductible.¹³⁹ The deductible is levied against everyone eighteen and older for all health expenditures except general practice care, maternity care and dental care for those under the age of twenty-two.¹⁴⁰

iv. Health care in Russia

During the period of Soviet Union control, Russia's health care system was highly centralized and socialist in nature.¹⁴¹ The federal government acted as both financier and provider of all medical services which were provided free of charge to all citizens.¹⁴² Ultimately, this model proved to be financially unsustainable as it was determined through world surveys that hospitals lacked adequate financing. In fact these surveys discovered that 20 percent of Russian hospitals in 1989 lacked basic amenities such as piped hot water.¹⁴³

¹³⁵ *Id* at 72.

¹³⁶ *Id* at 74.

¹³⁷ *Id*.

¹³⁸ *Id*.

¹³⁹ *Id* at 77.

¹⁴⁰ *Id*.

¹⁴¹ Larisa Popovich et. al., *Russian Federation: health system review*, Health Systems in Transition; vol. 13 no. 7, xvi (2011), available at http://www.euro.who.int/__data/assets/pdf_file/0006/157092/HiT-Russia_EN_web-with-links.pdf.

¹⁴² Popovich, *supra* note 141, at 14-15.

¹⁴³ *Id*.

Upon the collapse of the Soviet government, Russia's health system underwent reforms focused on the decentralization of the federal government.¹⁴⁴ Health care in Russia is now characterized by less federal control and greater privatization.¹⁴⁵ The federal government sets standards for the health system that are then enforced by local and regional levels of government.¹⁴⁶ Local and regional authorities are responsible for maintaining policy clinics and hospitals, including covering costs of general repairs, equipment and drugs.¹⁴⁷

The scope of medical care in Russia is determined by the Programme of State Guarantees for Medical Care Provision Free of Charge ("PGG").¹⁴⁸ The PGG has two parts, the basic MHI package and the budgetary funded package.¹⁴⁹ The basic MHI package covers everyday health needs while the budget package covers specialized and high-technology medical care, certain outpatient pharmaceutical costs and emergency care.¹⁵⁰

The budgetary system consists of federal health financing from the federal government to local governments to cover specialized care.¹⁵¹ The federal financing is distributed to regions by calculating the index of taxable capacity and index of budget expenditures.¹⁵² Budget transfers from the federal government are not earmarked and as such the transfers may be used for any purpose. Similarly regional budget transfers to

¹⁴⁴ *Id* at 40.

¹⁴⁵ *Id* at vxii.

¹⁴⁶ *Id*.

¹⁴⁷ *Id*.

¹⁴⁸ *Id*.

¹⁴⁹ *Id* at 75.

¹⁵⁰ *Id*.

¹⁵¹ *Id* at 82.

¹⁵² *Id*.

municipalities are not earmarked and municipalities can decide how to allocate the funds to each activity.¹⁵³

Under the MHI system individuals can obtain insurance for basic health needs from insurers competing within MHI funds.¹⁵⁴ MHI funds are financed through a combination of government subsidy and payroll contributions.¹⁵⁵ Government funding and payroll contributions are allocated to MHI funds, which contract with insurers.¹⁵⁶ The Insurers then pay for the medical care provided to the insured.¹⁵⁷ MHI funds pool contributions and distribute them to insurance companies based on a weighted capitation formula.¹⁵⁸ There are over 100 health insurance companies in the MHI system.¹⁵⁹

v. Health care in Israel

The Ministry of Health (“MoH”) has primary responsibility for the health of Israeli citizens and for the functioning of the health system.¹⁶⁰ The MoH is responsible for planning and regulation and owns half of the nation’s hospital beds, two thirds of the psychiatric beds and one tenth of the chronic disease beds.¹⁶¹ The Ministry of Finance (“MoF”) is responsible for preparing and implementing the budget.¹⁶²

The NHI consists of four health plans that are voluntary, non-profit organizations. These plans provide benefits packages specified by NHI law.¹⁶³ The government provides

¹⁵³ *Id* at 83.

¹⁵⁴ *Id* at 78.

¹⁵⁵ *Id* at 72.

¹⁵⁶ *Id* at 78.

¹⁵⁷ *Id* at 152.

¹⁵⁸ *Id* at 84.

¹⁵⁹ *Id* at 38.

¹⁶⁰ *Id* at xx.

¹⁶¹ *Id* at 19.

¹⁶² *Id* at 18-19.

¹⁶³ *Id* at 18.

funding for the plans with an annual capitation fee per insured.¹⁶⁴ The Israeli health system is financed primarily from public sources including payroll tax and general revenue tax.¹⁶⁵ The payroll tax earmarked for health consists of 26% of health care financing in the Israeli system.¹⁶⁶ The NHI system covers all citizens and permanent residents.¹⁶⁷ The NHI Law provides for broad coverage universally. However, services not covered by the NHI benefits package include long-term care, psychiatric care, preventive health care, public health services and dental care.¹⁶⁸

C. National Health Insurance Model

i. Healthcare in Canada

In the minds of Canadians, insured services are thought of as entitlements or rights of citizenship.¹⁶⁹ Canada's Medicare system was founded on the ideal of providing universal coverage for the populous based on need and not ability to pay. However, the Canadian health care system is distinct in its overall organizational structure and method of delivery. Canada's health system is implemented through a decentralized government structure.¹⁷⁰ Canada's health system is governed and administered by its provinces.¹⁷¹ Thus, the public health care system is made up of thirteen single-payer universal schemes loosely contained by standards set out in the Canada Health Act ("CHA").¹⁷²

¹⁶⁴ *Id* at 11.

¹⁶⁵ *Id* at xxi.

¹⁶⁶ *Id* at 42.

¹⁶⁷ *Id* at 41.

¹⁶⁸ *Id* at xxi

¹⁶⁹ Gregory P. Marchildon, *Canada: Health system review*, *Health Systems in Transition*, vol. 7 no. 3, 50 (2005), available at http://www.euro.who.int/__data/assets/pdf_file/0009/80568/E87954.pdf.

¹⁷⁰ *Id* at 19.

¹⁷¹ *Id*.

¹⁷² *Id* at 118.

The provinces each have legislation governing the administration of a single payer system for universal services.¹⁷³ Additionally, provinces fund hospitals and set rates of remuneration for physicians.¹⁷⁴ Payment of physicians is organized through fee schedules that are negotiated with provincial medical associations.¹⁷⁵ Allocation of resources based on health needs is facilitated by Regional Health Authorities (“RHA”).¹⁷⁶ RHA’s are primarily responsible for financial resource allocation.¹⁷⁷ Each RHA is responsible for organizing health and health care services and allocating a budget for a population contained within a specified geographic area.¹⁷⁸

Under the CHA all residents of a province are eligible to receive medically necessary services, without payment.¹⁷⁹ Medically necessary services or “insured services”, under the CHA include virtually all hospital, physician and diagnostic services.¹⁸⁰ Private insurance coverage for services covered by the CHA is discouraged via legislation in six provinces and discouraged by prohibiting the subsidy of private practice by public plans in the other four provinces.¹⁸¹

The primary source of health care finance in Canada is multi-government taxation via the provincial, territorial and federal governments.¹⁸² The principle source of funding is the general revenue funds, which are financed through individual income taxes,

¹⁷³ *Id* at 26.

¹⁷⁴ *Id.*

¹⁷⁵ *Id* at 27.

¹⁷⁶ *Id* at 28.

¹⁷⁷ *Id* at 50.

¹⁷⁸ *Id.*

¹⁷⁹ *Id* at 49.

¹⁸⁰ *Id.*

¹⁸¹ *Id.*

¹⁸² *Id* at 39.

consumption taxes and corporate taxes.¹⁸³ Additionally, some provinces raise supplementary revenues through earmarked taxes known as premiums.¹⁸⁴ Out of pocket payments make up 15% of funds for health care.¹⁸⁵ Out of pocket payments are the primary means of funding, vision care, over the counter medication and complementary and alternative medicines and therapies.¹⁸⁶ The third most prominent source of health care financing in Canada is private health insurance.¹⁸⁷ As, Canada's Medicare system provides citizens with universal medical coverage, private health insurance is primarily employed for the provision of health goods and services not covered by Medicare.¹⁸⁸

ii. Health care in the Republic of Korea

When the Republic of Korea ("South Korea" or "Korea") instituted compulsory health insurance in 1977 the system consisted of a multiple insurer structure.¹⁸⁹ At the time the government was not willing to shoulder the financial burden of a unified government provided insurance system.¹⁹⁰ Thus the government established the Korean Medical Insurance Corporation ("KMIC") for the limited purpose of insuring government and private school employees.¹⁹¹ Consequently, the Korean healthcare system provided for dual pathways for health coverage, one through KMIC and the other through multiple

¹⁸³ *Id* at 41.

¹⁸⁴ *Id.*

¹⁸⁵ *Id* at 47.

¹⁸⁶ *Id* at 47.

¹⁸⁷ *Id.*

¹⁸⁸ *Id.*

¹⁸⁹ Chang Bae Chun et. al., *Republic of Korea: Health system review*, Health Systems in Transition, vol. 11 no. 7, 140 (2009), available at http://www.euro.who.int/_data/assets/pdf_file/0019/101476/E93762.pdf.

¹⁹⁰ *Id.*

¹⁹¹ *Id.*

insurer options provided for employees and the self-employed.¹⁹² However it became clear that this system of health coverage created inequity for policyholders across different socioeconomic groups, thus resulting in the reforms, which define Korea's health system as it exists today.¹⁹³

Currently, the health system in Korea is provided through a National Health Insurance system with a single insurer, the National Health Insurance Corporation ("NHIC").¹⁹⁴ Thus, no individuals have a choice of insurer.¹⁹⁵ Membership in the NHI scheme is compulsory, there is no opting in or opting out.¹⁹⁶ NHI provides universal coverage and is funded through a mix of public and private financing.¹⁹⁷ The NHI benefit package is nationally uniform, though contributions are calculated distinctly for employed workers and the self-employed.¹⁹⁸ Those who cannot afford to contribute to the NHI scheme, may receive coverage through MAP.¹⁹⁹ The MAP program provides individuals whose income does not reach the minimum standard of living with free medical services and the same benefits provided by the NHI.²⁰⁰

Financing for the NHI is dominated by contributions and general taxation.²⁰¹ Tax revenues partially finance the NHI, but finance MAP and the Public Health Service in full.²⁰²

¹⁹² *Id* at 140-141.

¹⁹³ *Id* at 140.

¹⁹⁴ *Id* at 43.

¹⁹⁵ *Id* at 48.

¹⁹⁶ *Id*.

¹⁹⁷ *Id* at 43.

¹⁹⁸ *Id* at 48.

¹⁹⁹ *Id* at 47.

²⁰⁰ *Id* at 49.

²⁰¹ *Id* at 52.

²⁰² *Id*.

Tax revenues account for 20 percent of total financing for the NHI.²⁰³ Taxes are levied from various means including liquor tax and property taxes through both the federal and local levels of government.²⁰⁴ In addition to taxes, the NHI is financed via contributions, which are levied on the basis of ability to pay.²⁰⁵ Employee contributions are levied against gross salary and are shared equally between employer and employee.²⁰⁶ Self-employed contributions are levied on the basis of income, assets, living standards and rate of participation.²⁰⁷ NHI contributions are tax deductible.²⁰⁸

The scope of medical benefits is set forth in the National Health Insurance Act. A patients' first contact with the NHI system is through a primary care physician. Patients obtain referrals to secondary care, which takes the form of specialized general hospitals.²⁰⁹ Specialized hospitals are required to meet specified standards and are then entitled to higher fee schedules and special consultation fees.²¹⁰ While referrals are necessary from primary care physicians to receive specialist care, primary care physicians do not serve the same gatekeeping role that physicians do in other healthcare systems.²¹¹ Consequently physician services in Korea do not focus on outpatient care.²¹²

iii. Health care in Taiwan

²⁰³ *Id* at 53.

²⁰⁴ *Id.*

²⁰⁵ *Id.*

²⁰⁶ *Id* at 53-54.

²⁰⁷ *Id* at 54.

²⁰⁸ *Id.*

²⁰⁹ Bruce Rosen and Hadar Samuel, *Israel: Health system review*, Health Systems in Transition, vol. 11 no. 2, 113 (2009), available at http://www.euro.who.int/__data/assets/pdf_file/0007/85435/E92608.pdf.

²¹⁰ *Id* at 113.

²¹¹ *Id* at 114.

²¹² *Id.*

Taiwan instituted a universal health system in 1995.²¹³ Prior to these health reforms, approximately 45 percent of the Taiwanese population did not have health insurance and faced financial barriers to accessing health care.²¹⁴ Ultimately, after reviewing health systems internationally, the government of Taiwan adopted a single-payer health insurance system modeled after Canada's health system.²¹⁵

Citizens of Taiwan are given a choice of health care providers.²¹⁶ All citizens are provided universal and comprehensive coverage, which includes preventative care, primary care and hospitalization.²¹⁷ Providers in the Taiwanese system are compensated on a fee for service basis.²¹⁸

For the employed, insurance is financed through contributions.²¹⁹ The total insurance premium for employed workers is 4.6 percent of income.²²⁰ The premium is then divided between the employer and employee, with the employer paying 60 percent of the premium and the employee paying 30 percent of the premium.²²¹ The remaining 10 percent of the premium is subsidized by the government.²²² Additionally, the insured is responsible for minor co-pays at the point of service.²²³

III. GOVERNMENT STRUCTURES AND CONSTITUTIONAL FRAMEWORKS

A. Political and Constitutional Frameworks of Beveridge Model Countries

²¹³ Anne Underwood, *Health Care Abroad: Taiwan*; The New York Times; (Nov. 3, 2009) <http://prescriptions.blogs.nytimes.com/2009/11/03/health-care-abroad-taiwan/>.

²¹⁴ *Id.*

²¹⁵ *Id.*

²¹⁶ *Id.*

²¹⁷ *Id.*

²¹⁸ *Id.*

²¹⁹ *Id.*

²²⁰ *Id.*

²²¹ *Id.*

²²² *Id.*

²²³ *Id.*

i. United Kingdom

The United Kingdom is a constitutional monarchy governed by parliament.²²⁴ There are three institutions that make up parliament, the Queen, the House of Lords and the House of Commons.²²⁵ The House of Commons is directly accountable to the electorate and is recognized by the House of Lords as the more supreme authority.²²⁶ Parliament has the power to enact any law and change any previous law.²²⁷ Thus, Parliamentary power is supreme and the validity of an act of Parliament cannot be disputed in the courts.

Additionally, as a member of the European Community, Community Law is a part of British law and where there is conflict between the two, Community Law takes precedence.²²⁸

The British constitution consists of statutory law, common law, and conventions.²²⁹ Conventions are rules and practices, which are not legally enforceable but are derived from the historical events through which the British system of government has evolved.²³⁰

iii. Italy

Italy's current political system is based on the 1948 Constitution.²³¹ A popular referendum abolished the monarchy in 1946.²³² Italy is a parliamentary government with a multi-party system.²³³ The executive power is vested in the Council of Ministers, which is

²²⁴ Boyle, *supra* note 17, at xxi.

²²⁵ *Id.* at 6.

²²⁶ *Id.*

²²⁷ *Id.*

²²⁸ *Id.*

²²⁹ *Id.*

²³⁰ *Id.*

²³¹ Scalzo, *supra* note 41, at xix.

²³² *Id.* at 8.

²³³ *Id.*

headed by the Prime Minister.²³⁴ The legislative branch of government is composed of two houses of parliament.²³⁵

The current constitution of Italy was enacted on December 22, 1947.²³⁶ Amendments to the constitution must undergo double reading.²³⁷ “Laws amending the Constitution . . . shall be adopted by each House after two successive debates at intervals of not less than three months. . . .”²³⁸ Thus, the amendment must be approved by each house, twice within a three month period, and the amendment must carry with simple majority in each house.²³⁹ Once the Amendment is approved through the second reading, a request must be made by one-fifth of the members of a house to submit the Amendment to referendum.²⁴⁰ The Amendment must then be approved by a majority of all valid votes.²⁴¹ The Italian constitution places a limit on the types of amendments that may be proposed. Amendments may not be enacted to change the republican form of the state.²⁴² The Constitution has been amended fourteen times since its enactment.²⁴³

The Italian constitution sets forth the Judiciary as a separate and autonomous branch of government.²⁴⁴ Thus, Article 101 provides that “Justice is administered in the name of the people. Judges are subject only to the law.”²⁴⁵ The legal system in Italy has a

²³⁴ Italy, <http://en.wikipedia.org/wiki/Italy#Government> (last visited Dec. 4, 2012).

²³⁵ *Id.*

²³⁶ Costituzione [Constitution] Dec. 22, 1947.

²³⁷ *Id.* at Title II Art. 138(1).

²³⁸ *Id.*

²³⁹ *Id.*

²⁴⁰ *Id.* at Sec. II Art. 138(2).

²⁴¹ *Id.*

²⁴² *Id.* at Sec. II Art. 139.

²⁴³ Constitution of Italy, http://en.wikipedia.org/wiki/Constitution_of_Italy#Amendments (last visited Dec. 4 2012).

²⁴⁴ Costituzione [Constitution] Dec. 22, 1947, Sec. I Art. 104.

²⁴⁵ *Id.* at Title IV Art 101(2).

civil law tradition and as such judges do not form or shape the law, but simply apply the law.

Article 32 of the Italian Constitution provides that, “the Republic safeguards health as a fundamental right of the individual and as a collective interest, and guarantees free medical care to the poor.”²⁴⁶ Thus, the Italian Constitution recognizes health as an enumerated right and places duties on the government to secure the right for all of its citizens.

iii. Portugal

Portugal is a constitutional democratic republic.²⁴⁷ The branches of the Portuguese government consist of the President, the Parliament, the government and the courts.²⁴⁸ Both the president and the Parliament are selected through national elections.²⁴⁹

The current Portuguese constitution was enacted in 1976.²⁵⁰ The constitution is eligible for revision after five years has passed since any revised law.²⁵¹ However, if four-fifths of the members of the Republic entitled to, vote to undertake a constitutional reform, it may assume the reform powers.²⁵² Once the power of constitutional reform has been undertaken an amendment can be approved by a two-thirds majority of the members of the Assembly entitled to vote.²⁵³

²⁴⁶ *Id* at Title II Art. 32(1).

²⁴⁷ Barros, *supra* note 56, at xv.

²⁴⁸ *Id* at 6.

²⁴⁹ *Id*.

²⁵⁰ Constitution of the Portuguese Republic April 2, 1976.

²⁵¹ *Id* at Part IV Art. 284.

²⁵² *Id*.

²⁵³ *Id* at Part IV Art. 286.

The Judicial branch of government is one of three organs of supreme authority under the Portuguese Constitutions.²⁵⁴ The Judicial system in Portugal provides for a Constitutional Court charged with reviewing questions of constitutionality.²⁵⁵

Article 64 of the Portuguese Constitution provides, “everyone has the right to protection of his or her health and the duty to defend and foster it.”²⁵⁶ The Article continues on to delineate the obligations of the government in securing this right for its citizens. Thus, the Article provides for a constitutional right to universal coverage and general national health services.²⁵⁷

B. Political and Constitutional Frameworks of Bismarck Model Countries

i. Germany

Germany is a federal republic made up of sixteen states.²⁵⁸ The government consists of the President, the courts, the Cabinet and the Legislature. The Legislature consists of the Federal Assembly and the Federal council.²⁵⁹ The Cabinet consists of the Chancellor and the federal ministers.²⁶⁰

The German Constitution was passed May 23, 1949 and is referred to as the Basic Law.²⁶¹ The Constitution can be amended by a statute that directly amends or supplements the text of the Constitution.²⁶² To approve the amendment it must receive the consent of

²⁵⁴ *Id* at Part III Art. 113.

²⁵⁵ *Id* at Sec. IV Art. 223.

²⁵⁶ *Id* Sec. III Art. 64.

²⁵⁷ *Id* Sec. Art. 64(2)(a).

²⁵⁸ Busse and Riesberg, *supra* note 71, at 1.

²⁵⁹ *Id* at 1-3.

²⁶⁰ *Id* at 4.

²⁶¹ Grundgesetz für die Bundesrepublik Deutschland (Basic Law) May 23, 1949.

²⁶² *Id* at Ch. VII Art. 79.

two thirds of the members of the House of Representatives and two thirds of the votes of the Senate.²⁶³

The German Judiciary consists of the Federal Constitutional Court, the federal courts established under the Constitution and the courts of the states.²⁶⁴ The Federal Constitutional Court is vested with the authority to interpret the constitution.²⁶⁵ The German Constitution does not specifically enumerate health as a right.

ii. Japan

Japan has a constitutional monarchy with a parliamentary government.²⁶⁶ Parliament consists of two houses, the Upper House and the Lower House.²⁶⁷ Following elections, the leader of the majority party, controlling the Lower House becomes the prime minister.

The current Japanese constitution was enacted May 3, 1947.²⁶⁸ Amending the Japanese Constitution requires initiation by the Diet.²⁶⁹ The amendment must receive a concurring vote of two-thirds or more of all the members of each House.²⁷⁰ The amendment must then be submitted to the people for ratification.²⁷¹ Promulgation of the

²⁶³ *Id.*

²⁶⁴ *Id.* at Ch. IX Art. 92.

²⁶⁵ *Id.* at Ch. IX Art. 93.

²⁶⁶ Tatara and Okamoto, *supra* note 83, at 7

²⁶⁷ *Id.*

²⁶⁸ *Id.*

²⁶⁹ Nihonkoku Kenpo [Constitution] Nov. 3, 1946, ch. IX art. 96, para 2.

²⁷⁰ *Id.*

²⁷¹ *Id.*

amendment requires the affirmative vote of a majority of all votes cast.²⁷² The Constitution has not been amended since its enactment.²⁷³

The Japanese judicial system arose out of a civil law tradition. “The Supreme Court is the court of last resort with power to determine the constitutionality of any law, order, regulation, or official act.”²⁷⁴

Article 25 sec. (2) of the Japanese constitution provides, “In all spheres of life, the State shall use its endeavors for the promotion and extension of social welfare and security, and of public health.”²⁷⁵ Thus the constitution neither enumerates a right to health nor places a specific duty on the government in the provision of health care. Rather, the Japanese Constitution is more a statement of aspiration.

iii. Netherlands

The Dutch government is a parliamentary democracy.²⁷⁶ The parliament is a bicameral system consisting of the First Chamber and the Second Chamber.²⁷⁷

To amend the Dutch Constitution an act must be passed with a simple majority, by both the House of Representatives and the Senate of the States General.²⁷⁸ After this act is passed the House of Representatives must be dissolved and general elections held.²⁷⁹ The

²⁷² *Id.*

²⁷³ Constitution of Japan, http://en.wikipedia.org/wiki/Constitution_of_Japan#Amendments_and_revisions (last visited Dec. 4, 2012)

²⁷⁴ Nihonkoku Kenpo [Constitution] Nov. 3, 1946, ch. VI art. 81.

²⁷⁵ *Id.* at ch. III art. 25, para 2.

²⁷⁶ Schäfer, *supra* note 111, at 4.

²⁷⁷ *Id.*

²⁷⁸ Grondwet voor het Koninkrijk der Nederlanden [Constitution], Feb. 17, 1983, ch. 8 art.

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²⁷⁹ *Id.*

proposed amendments are then considered again by the newly elected House and Senate and must be approved with a two-thirds majority by both.²⁸⁰

Article 22 of the Dutch Constitution provides that, “the authorities shall take steps to promote the health of the population.”²⁸¹ Thus, similar to the Japanese Constitution the Dutch Constitution does not enumerate health as a right, or establish a duty for the government, but instead sets forth an objective of the government.

iv. Russia

The Russian federation separated from the Soviet Union in 1991.²⁸² The Russian Federation is a presidential federal political system.²⁸³ The bicameral Federal Assembly consists of two branches, the legislative branch and the State Duma.²⁸⁴ In addition the judicial branch consists of the Constitutional Court, the Supreme Court and the Supreme Arbitration Court.²⁸⁵ The Russian government emphasizes executive control.²⁸⁶ In recent years the political system has undergone a number of reforms intended to recentralize control of the government and strengthen the power of the executive.²⁸⁷ The current Russian constitution came into effect on December 12, 1993 after a national referendum.²⁸⁸

The process of amending the Russian constitution begins with a proposal for a constitutional assembly.²⁸⁹ If review of the provisions of Chapters 1, 2 or 9 of the constitution is supported by three fifths of the members of the Council of the Federation

²⁸⁰ *Id.*

²⁸¹ *Id.* at ch 1 art. 22.

²⁸² Schäfer, *supra* note 111, at 6.

²⁸³ *Id.* at 6.

²⁸⁴ *Id.* at 6.

²⁸⁵ *Id.*

²⁸⁶ *Id.*

²⁸⁷ *Id.* at 8.

²⁸⁸ *Id.*

²⁸⁹ Konstitutsiia Rossiikoi Federatsii [Constitution] Dec. 12, 1993, art. 134.

and the deputies of the State Duma then a Constitutional Assembly will be convened.²⁹⁰ The assembly may then draft a new constitution, which can be adopted by two thirds of its members or submitted to a referendum.²⁹¹ Upon referendum the revised constitution shall be adopted where half of the voters who came to the poles approved the adoption, so long as over half of eligible voters participated in the vote.²⁹² Amendments to Chapters 3-8 of the Constitution shall be adopted “according to the rules fixed for adoption of federal constitutional laws and come into force after they are approved by the bodies of legislative power of not less than two thirds of the subjects of the Russian Federation.”²⁹³

The Constitutional Court is responsible for ruling on the constitutionality of laws and government acts.²⁹⁴ Due to Russia’s civil law system and emphasis on the executive, rulings of the Constitutional Court have had a limited and tenuous impact. However, executive reforms put in place by Vladimir Putin in 2001, attempted to give teeth to judicial decisions. The reforms obliged regional authorities to repeal legislation found to be unconstitutional and set sanctions for the failure to implement Russian Constitutional Court decisions.²⁹⁵

Article 41 of the Russian constitution provides that, “everyone shall have the right to health care and medical assistance.²⁹⁶ Medical assistance shall be made available by state and municipal health care institutions to citizens free of charge, with the money from the

²⁹⁰ *Id* at art. 135.

²⁹¹ *Id* at art. 136.

²⁹² *Id* at art. 135.

²⁹³ *Id* at art. 136.

²⁹⁴ Konstitutsiia Rossiikoi Federatsii [Constitution] Dec. 12, 1993, art. 125.

²⁹⁵ 11 E. Eur. Const. Rev. 95 (2002).

²⁹⁶ Konstitutsiia Rossiikoi Federatsii [Constitution] Dec. 12, 1993, art 41.

relevant budget, insurance payments and other revenues.”²⁹⁷ It further provides that “the Russian Federation shall finance federal health care and health-building programs, take measures to develop state, municipal and private health care systems, encourage activities contributing to the strengthening of the man's health, to the development of physical culture and sport, and to ecological, sanitary and epidemiologic welfare.”²⁹⁸

v. Israel

Israel is a democratic state with a parliamentary, multi-party system.²⁹⁹ The President acts as the head of state. The legislative branch is governed by Parliament, or the *Knesset*.³⁰⁰ The Prime Minister is the head of the elected branch and is elected as the head of the largest party.³⁰¹

Israel does not have a constitution codified in a singular document, rather constitutional principles have been codified in a series of Basic Laws.³⁰² Basic Law: Human Dignity and Liberty, passed in 1994 was the first of the Basic Laws to enumerate specific rights to Israeli citizens.³⁰³ As the Israeli Constitution is not a single codified document there is no provision regarding amendment. The document continues to grow and develop, thereby removing any need for a revision process. The Israeli Basic Law does not enumerate Health as a private right.

C. Political and Constitutional Frameworks of NHI-Model Countries

i. Canada

²⁹⁷ *Id.*

²⁹⁸ *Id.*

²⁹⁹ Rosen and Samuel, *supra* note 209, at 6.

³⁰⁰ *Id.* at 6.

³⁰¹ *Id.*

³⁰² Daniel J. Elazar, The Constitution of the State of Israel, <http://jcpa.org/dje/articles/const-intro-93.htm> (last visited Dec. 4, 2012).

³⁰³ *Id.*

“Canada is a constitutional monarchy based upon a Westminster-style parliamentary democracy. It is also a federation with two constitutionally recognized orders of government.”³⁰⁴ The Canadian government has two levels, the federal government and provincial governments.³⁰⁵ Canada’s government structure has become increasingly decentralized as provinces have taken a more significant control over social policy including health.

The current Canadian constitution did not come into existence until 1982, effectuating the final dissolution of United Kingdom control over Canada.³⁰⁶ One impact of the adoption of the current Canadian constitution was that it made amendment of the constitution more difficult and set it as the supreme law.³⁰⁷

The Canadian constitution provides for five formulae for constitutional amendments. The first method of amendment requires utilization of the formal amendment process delineated at section 38(1) of the constitution.³⁰⁸ This method is necessary for any constitutional amendments relating to the powers of the senate, methods of selecting senators, and the extension of existing provinces into territories.³⁰⁹ This amendment process requires resolutions from the House of Commons, the Senate, and the legislative assemblies of at least two thirds of the provinces, amounting to 50% of the population of Canada.³¹⁰ Thus the process requires resolutions by seven of the provinces

³⁰⁴ Marchildon , *supra* note 169, at 8.

³⁰⁵ *Id.*

³⁰⁶ Constitution of Canada, http://en.wikipedia.org/wiki/Constitution_of_Canada (last visited Dec. 4 2012).

³⁰⁷ *Id.*

³⁰⁸ Constitution Act, 1982, being schedule B to the Canada Act, 1982, c. 11, sec. 38(1) (U.K.).

³⁰⁹ *Id.*

³¹⁰ *Id.*

containing a minimum of 50% of the nations population and is thus referred to as the 7/50 formula.³¹¹

The second amendment method requires unanimous consent of all provinces. Thus, these amendments require resolutions of the Senate, the House of commons and the legislative assembly of each province.³¹² Matters that require utilization of this method include, amendments relating to; the office of the Queen, the Governor General, and the Lieutenant Governor of a province; the right of a province to a number of members in the House of Commons not less than the number of Senators by which the province is entitled to be represented at the time this part comes into force; the use of the English or the French language; and the composition of the Supreme Court of Canada.³¹³

Section 43 of the Canadian constitution permits for constitutional amendments that apply to some but not all of the provinces.³¹⁴ In these circumstances, resolutions must be passed by the Senate, the House of Commons and the legislative assemblies of the provinces to which the amendment applies.³¹⁵ Section 44 of the Canadian constitution permits the Parliament of Canada to exclusively make laws amending the constitution relating to the Senate and the House of Commons³¹⁶. Finally, the legislative assembly of each province may make laws that amend the constitution of that province.³¹⁷ There have been ten amendments to the Canadian constitution since 1982.³¹⁸

Canada has a common law legal system. The Supreme Court is the highest court

³¹¹ *Id.*

³¹² *Id* at sec. 41.

³¹³ *Id.*

³¹⁴ *Id* at sec. 43.

³¹⁵ *Id.*

³¹⁶ *Id* at sec. 44.

³¹⁷ *Id* at sec. 45.

³¹⁸ Constitution of Canada, *supra* note 297.

within the judicial system.³¹⁹ The Supreme Court hears final appeals of lower court decisions that have been granted leave to be heard.³²⁰ Additionally, the Supreme Court may hear referrals from the cabinet.³²¹ When referrals are sent, the Supreme Court is asked constitutional questions regarding issues of constitutional significance.³²²

ii. The Republic of Korea

The government of Korea is a democratic republic, consisting of an executive branch run by a president, a unicameral legislature called the National Assembly and a judiciary branch.³²³ The constitution of Korea was enacted on October 12, 1987.³²⁴

Proposals to amend the constitution may be presented by the president or by a simple majority of the National assembly.³²⁵ The proposal must then be approved by the National Assembly with a two-thirds majority. After passing the National Assembly the amendment may then be presented for a national referendum where it must receive a majority vote to be officially enacted.³²⁶ The Constitution has been amended nine times since its enactment.

South Korea is a Civil Law system. The Judicial branch has a Supreme Court and a Constitutional Court.³²⁷ The Supreme Court is a court of last resort responsible for hearing appellate cases.³²⁸ The Constitutional Court is a specialized court reviewing questions of

³¹⁹ *Id.*

³²⁰ *Id.*

³²¹ *Id.*

³²² *Id.*

³²³ Chun, *supra* note 189, at 8.

³²⁴ Daehanminkuk Hunbeob [Constitution] July 17, 1948.

³²⁵ *Id.* at ch. X art. 128.

³²⁶ *Id.* at art. 130.

³²⁷ *Id.* at arts. 102 and 107.

³²⁸ *Id.* at art. 107.

constitutional relevance.³²⁹ Thus it is the Constitutional Court and not the Supreme Court that is charged with interpreting the constitution.

Article 36 of the South Korean Constitution provides that, “the health of all citizens is protected by the state.”³³⁰ Thus, the Constitution does not enumerate health as a right but establishes a duty for the government.

iii. Taiwan

The government of Taiwan is a democratic republic, consisting of five administrative branches of government.³³¹ The branches are, the Executive Yuan, the Legislative Yuan, the Judicial Yuan, the Control Yuan, and the Examination Yuan.³³² The president is the head of the executive branch and is responsible for appointing a cabinet.³³³ The president is elected by popular vote for a maximum of two, four-year terms.³³⁴

The legislative branch of government consists of a unicameral body.³³⁵ Representative may be elected to the seats by popular vote or by proportion.³³⁶ The legislature may pass laws without approval from the executive, as there is no executive veto.³³⁷

The Taiwanese constitution provides for two methods of amendment.³³⁸ First, requires a proposal presented by one fifth of the National Assembly.³³⁹ A resolution on the

³²⁹ *Id.*

³³⁰ *Id.* at art. 36.

³³¹ Taiwan, <http://en.wikipedia.org/wiki/Taiwan#Government>, (last viewed Dec. 4 2012).

³³² *Id.*

³³³ *Id.*

³³⁴ *Id.*

³³⁵ *Id.*

³³⁶ *Id.*

³³⁷ *Id.*

³³⁸ *Minguo Xianfa* art. 1 (Taiwan) [Constitution] Dec. 25, 1946, art. 174.

³³⁹ *Id.*

amendment then requires approval by “three fourths of the Delegates present at a meeting with a quorum of two thirds of all Delegates to the National Assembly.”³⁴⁰ The second method permits the Legislative Yuan to submit a proposed amendment to the National Assembly if the Legislative Yuan garners one-fourth approval.³⁴¹ Resolution of the amendment then requires approval by “three fourths of the Members present at a meeting with a quorum of three fourths of all Members of the Yuan.”³⁴² The Judicial branch in Taiwan includes the Judicial Yuan which is the highest judicial court and has the power to interpret the constitution.³⁴³

The Taiwanese constitution provides for the positive enumeration of various rights.³⁴⁴ However, the constitution of Taiwan does not provide for a positive right to health or health care. Rather, it sets forth a duty on the state to “improve national health”, protect health and establish “a system of public medical care.”³⁴⁵

III. TRENDS IN CONSTITUTIONAL FRAMEWORKS

To determine if there is any correlation between a nation’s constitution and its form of health care system I engaged in an assessment of constitutional trends within health care models. I first selected eleven nations and evaluated their health systems to determine whether they exhibit characteristics of the Bismarck Model, Beveridge Model or National Health Insurance Model. The countries within the Beveridge model category are the United Kingdom, Italy and Portugal. The countries in the Bismarck model category include,

³⁴⁰ *Id.*

³⁴¹ *Id.*

³⁴² *Id.*

³⁴³ Taiwan, *supra* note 332.

³⁴⁴ *See generally* Minguo Xianfa art. 1 (Taiwan) [Constitution] Dec. 25, 1946.

³⁴⁵ *Id.* at 157.

Germany, the Netherlands, Japan, Russia and Israel. Countries in the National Health Insurance Model category are Canada, the Republic of Korea and Taiwan.

To identify constitutional trends within each health model category, I established nine characteristics/variables. These nine characteristics are: 1) the amendability of the constitution; 2) the length of time the constitution has been in place; 3) whether the constitution was in place before the establishment of the health care system; 4) if the constitution sets forth positive rights; 5) whether the constitution provides for a positive right to health or health care; 6) the influence of the Judiciary over the law and constitutional interpretation; 7) the power of the executive; 8) deference of references to international law within the constitution; and 9) the supremacy of the constitution over other laws and the branches of government. Ultimately, I reviewed each nation independently to assess these characteristics within the individual nation, and then grouped the nations based on the model category and looked for similarities in these variables between these nations within the group. I then looked for distinctions in these variables between the model categories, to determine if one group exhibited characteristics that did not arise in the other categories.

A. Beveridge Model Findings

The Beveridge Model category contains three nations that have each adopted one of two forms of government. The government types found in this category are democratic republic and constitutional monarchy. Two of the three Beveridge nations have documented constitutions. Ranking the difficulty in procedures for the amendment of a nation's constitution on a 1-10 scale, 10 being the American amendment process, the countries within the Beveridge category were ranked with a 1, 6 and 9. The United

Kingdom was ranked with a 1 because the U.K. does not have a documented constitution; rather, common law and Parliamentary Acts serve as the supreme law of the land. Thus, any changes to constitutional law in the United Kingdom would only require a legislative enactment. Conversely, Italy was ranked with a 9 because amending the constitution requires two approvals by both chambers after a three-month waiting period, and a referendum when the final reading does not receive two-thirds approval in both houses.³⁴⁶

All of the countries in the Beveridge category had constitutions in place before the implementation of their health systems. Additionally, in all three governments the judiciary plays a significant role. Furthermore, in Italy and Portugal, the judiciary is an entirely independent branch of government that answers only to the law, and acts as arbiter of constitutional disputes.³⁴⁷ Moreover, both Italy and Portugal's constitutions set forth positive enumerated rights including a right to health.³⁴⁸ However, Portugal expressed this right in a more specific manner.

B. Bismarck Model Findings

The five countries within the Bismarck category have distinct forms of governance. The four government systems observed within the Bismarck category include, federal republic, constitutional monarchy, parliamentary democracy and presidential federal government. Amendability of the Bismarck constitutions are ranked at, 2, 6, 8, 8 and 9. The Israeli constitution is ranked at 2, because much like the U.K., Israel does not have a documented constitution and relies on Parliament for the establishment of the supreme

³⁴⁶ Costituzione [Constitution] Dec. 22, 1947, Title VI Art. 138.

³⁴⁷ *Id* at Title IV Arts. 101 & 104 and Title VI Art. 134; Constitution of the Portuguese Republic April 2, 1976, Part III Art. 205, 206 & 225;

³⁴⁸ Constitution of the Portuguese Republic April 2, 1976, Part I Art. 64; Costituzione [Constitution] Dec. 22, 1947, Title II Art. 32.

law. However, unlike the U.K. Israel is in an ongoing process of promulgating a constitution through the enactment of its Basic Law. The German Constitution, ranked at 6, allows for the amendment of its constitution with two-thirds approval from both the House and the Senate.³⁴⁹ The Japanese constitution was ranked at 9, as it requires a two-thirds majority from both houses as well as ratification by a simple majority of the electorate.³⁵⁰

Three of the five countries' health systems were instituted before their current constitutions were formed. The judiciary in each of these states plays slightly distinct roles. In the Netherlands, the judiciary is the most limited as the constitutionality of acts of Parliament are not reviewable by the courts.³⁵¹ Russia, Japan and Germany provide for the separation of powers and the independence of the Judiciary.³⁵² Additionally, in these three nations the judiciary has power to review constitutional issues.³⁵³ Uniquely, in Israel, the judiciary is seen as independent under the Basic Law, however they are vested with the power to review legality and not constitutionality as there is no constitution. The four countries with documented constitutions in the Bismarck model category, set forth positive

³⁴⁹ Grundgesetz für die Bundesrepublik Deutschland (Basic Law) May 23, 1949, Ch. VII Art. 79.

³⁵⁰ Nihonkoku Kenpo [Constitution] Nov. 3, 1946, art. 96.

³⁵¹ Grondwet voor het Koninkrijk der Nederlanden [Constitution], Feb. 17, 1983, ch. 8 art. 120.

³⁵² Konstitutsiia Rossiikoi Federatsii [Constitution] Dec. 12, 1993, art. 118; Grundgesetz für die Bundesrepublik Deutschland (Basic Law) May 23, 1949, Ch. VII Art. 97; Nihonkoku Kenpo [Constitution] Nov. 3, 1946, ch. VI art. 76.

³⁵³ Konstitutsiia Rossiikoi Federatsii [Constitution] Dec. 12, 1993, art. 125; Grundgesetz für die Bundesrepublik Deutschland (Basic Law) May 23, 1949, Ch. VII Art. 100; Nihonkoku Kenpo [Constitution] Nov. 3, 1946, ch. VI art 81.

rights in their constitutions. Additionally, Japan, Russia and the Netherlands recognize a positive right to health.³⁵⁴

C. National Health Insurance Model Findings

The National Health Insurance countries each have a distinct form of government. The government forms within this category are, constitutional monarchy and democratic republic. Amendability of the NHI constitutions were ranked at 7, 8, and 8. Of the countries within this category Taiwan's constitution is the easiest to amend and was ranked at 7. Taiwan's constitution provides for two modes of amending the constitution and neither method requires input from the electorate.

Each of the constitutions within the NHI category provide for the positive enumeration of rights to the citizenry. The Constitution of Canada focuses on the enumeration of rights, and is not as concerned with structure, function, or limits on government.³⁵⁵ The Republic of Korea sets forth the positive rights of citizens at Chapter II, "Rights and Duties of the Citizens".³⁵⁶ Within the NHI countries, both Taiwan and the Republic of Korea set forth a positive right to health within their constitutions.

V. CONCLUSIONS FROM THE CONSTITUTIONAL SURVEY AND ANALYSIS

A. The Positive Enumeration of a Right to Health or Health Care

Many countries have addressed health or healthcare in their constitutions.³⁵⁷ In fact approximately 67 percent of the constitutions of the world have a provision regarding

³⁵⁴ Konstitutsiia Rossiikoi Federatsii [Constitution] Dec. 12, 1993, art. 41; Grondwet voor het Koninkrijk der Nederlanden [Constitution], Feb. 17, 1983, ch. 8 art. 22; Nihonkoku Kenpo [Constitution] Nov. 3, 1946, ch. VI art. 25.

³⁵⁵ Constitution Act, 1982, being schedule B to the Canada Act, 1982 (U.K.).

³⁵⁶ Daehanminkuk Hunbeob [Constitution] July 17, 1948, ch. 2.

³⁵⁷ Jost, *supra* note 4, at 14.

health or health care.³⁵⁸ In most of these constitutions, the provisions are universal, rather than limited to particular groups.³⁵⁹ The recognition of health within constitutions has taken on a number of forms. Thus, a constitution may not specifically articulate a right to health care but may address health in a less direct way. Constitutional consideration of healthcare has taken on five forms: 1) a statement of aspiration; 2) a statement of entitlement; 3) a statement of duty; 4) a programmatic statement; and 5) a referential statement of international law.³⁶⁰

Of the ten countries I surveyed, six have articulated provisions addressing health or health care. Of the four countries without provisions relating to health or health care, two do not have documented constitutions, and instead address health and health care rights through legislative enactments.

The Russian and Portuguese constitutions take the most specific approach to addressing health.³⁶¹ In both constitutions, health is delineated as a positive right.³⁶² Additionally, these constitutions contain a programmatic statement specifying methods for financing, delivering and regulating health services.³⁶³ These constitutions provide in relevant part:

(1) Everyone has the right to health care and medical assistance. Medical assistance is made available by state and municipal health care institutions to citizens free of charge, with the money from the relevant budget, insurance payments another revenues.

³⁵⁸ *Id* at 16.

³⁵⁹ *Id*.

³⁶⁰ *Id*.

³⁶¹ Konstitutsiia Rossiikoi Federatsii [Constitution] Dec. 12, 1993, art. 41; Constitution of the Portuguese Republic April 2, 1976, art. 64.

³⁶² Konstitutsiia Rossiikoi Federatsii [Constitution] Dec. 12, 1993, art. 41; Constitution of the Portuguese Republic April 2, 1976, art. 64.

³⁶³ Konstitutsiia Rossiikoi Federatsii [Constitution] Dec. 12, 1993, art. 41; Constitution of the Portuguese Republic April 2, 1976, art. 64.

(2) The Russian Federation finances federal health care and health-building programs, take measures to develop state, municipal and private health care systems, encourage activities contributing to the strengthening of the man's health, to the development of physical culture and sport, and to ecological, sanitary and epidemiologic welfare.³⁶⁴

(1) Everyone has the right to protection of his or her health and the duty to defend and foster it.

(2) The right to health protection is to be met by:

- a) A universal and general national health service that, taking into account the economic and social conditions of the citizens, tending to be free of charge;
- b) The creation of economic, social, and cultural conditions securing the protection of children, the young, and the old; the systematic improvement of living and working conditions; the promotion of physical fitness and sports in school and among the people; the development of the people's sanitary education.

(3) In order to secure the right to health protection, the State has prime duty to:

- a) Secure the access of all citizens, regardless of their economic condition, to preventive as well as curative and rehabilitation medical care;
- b) Secure a rational and efficient medical and hospital coverage of the whole country;
- c) Direct its action towards the socialization of the costs of medical and medico-pharmaceutical care;
- d) Control and supervise medicine practiced in partnership and privately, coordinating it with the national health service;
- e) Control and supervise the production, marketing and use of chemical, biological and pharmaceutical products and other means of treatment and diagnosis.

(4) The national health service has a decentralized management in which the beneficiaries take part.³⁶⁵

The Italian constitution takes a hybrid form to addressing health and health care.

The constitution acknowledges health as a “basic right”, thus establishing a positive right to health.³⁶⁶ However, this provision does not place a duty on the state to provide health to all

³⁶⁴ Konstitutsiia Rossiikoi Federatsii [Constitution] Dec. 12, 1993, art. 41.

³⁶⁵ Constitution of the Portuguese Republic April 2, 1976, art. 64.

³⁶⁶ Costituzione [Constitution] Dec. 22, 1947, art. 32.

of its citizens. Rather, the constitution limits the state's obligation to a specific group.³⁶⁷

Consequently, under the Italian constitution, while all citizens may have a basic right to health, the state need only provide medical care to the poor. For the remaining citizenry the state is simply obligated to protect individual health.³⁶⁸ The Italian constitution provides in relevant part:

(1) The republic protects individual health as a basic right and in the public interest; it provides free medical care to the poor.³⁶⁹

The Constitution of Taiwan, addresses health with a statement of duty.³⁷⁰ The constitution does not articulate a positive right to health care or health services.³⁷¹ Rather, the constitution places an obligation on the state to establish a system of public medical care.³⁷² The Taiwan constitution provides in relevant part:

The State, in order to improve national health, shall establish extensive services for sanitation and health protection and a system of public medical care.³⁷³

The remaining constitutions addressing health, from the countries I surveyed set forth, mere objectives or goals, protecting an interest in health or health care. These constitutions include the constitutions of The Netherlands, Japan and the Republic of Korea. Thus these constitutions take on the form of a statement of aspiration.³⁷⁴ In these countries the government is not assigned specific constitutional duties in the provision of

³⁶⁷ *Id.*

³⁶⁸ *Id.*

³⁶⁹ *Id.*

³⁷⁰ *Minguo Xianfa* art. 1 (Taiwan) [Constitution] Dec. 25, 1946, art. 157.

³⁷¹ *Id.*

³⁷² *Id.*

³⁷³ *Id.*

³⁷⁴ *Grondwet voor het Koninkrijk der Nederlanden* [Constitution], Feb. 17, 1983, art. 22; *Nihonkoku Kenpo* [Constitution] Nov. 3, 1946, art. 25; *Daehanminkuk Hunbeob* [Constitution] July 17, 1948, art. 36.

health or medical services, and the constitutions do not specifically recognize health as a positive right.³⁷⁵ These constitutions set forth in relevant part:

(1) The authorities shall take steps to promote the health of the population.³⁷⁶

(1) All people shall have the right to maintain the minimum standards of wholesome and cultured living.

(2) In all spheres of life, the State shall use its endeavors for the promotion and extension of social welfare and security, and of public health.³⁷⁷

Article 36

...

(3) The health of all citizens is protected by the State.³⁷⁸

The diversity in the methods of addressing health within various constitutions demonstrates a lack of correlation between a positive right to health care and the type of health systems that a country ultimately develops. While the Netherlands, Japan and the Republic of Korea have adopted similar statements of aspiration in addressing health concerns, these countries have taken different paths in the development of health systems. While The Netherlands and Japan have adopted Bismarck models of health care, the Republic of Korea has adopted a National Health Insurance Model. Furthermore, Israel and the United Kingdom provide for a positive right to health care through acts of parliament. While these two nations have similarly relied on legislation to address health needs, they have adopted distinct mechanisms for the provision of health to their citizenry. In providing health to its citizenry, Israel relies on the Bismarck tradition whereas the UK relies on the

³⁷⁵ Grondwet voor het Koninkrijk der Nederlanden [Constitution], Feb. 17, 1983, art. 22; Nihonkoku Kenpo [Constitution] Nov. 3, 1946, art. 25; Daehanminkuk Hunbeob [Constitution] July 17, 1948, art. 36.

³⁷⁶ Grondwet voor het Koninkrijk der Nederlanden [Constitution], Feb. 17, 1983, art. 22.

³⁷⁷ Nihonkoku Kenpo [Constitution] Nov. 3, 1946, art. 25.

³⁷⁸ Daehanminkuk Hunbeob [Constitution] July 17, 1948, art. 36.

Beveridge tradition. Thus, how a constitution addresses health is not demonstrative of the health system ultimately implemented by the nation.

B. The Constitutional framework of a nation may not dictate the health system it ultimately implements.

This international survey of constitutional characteristics of nations with universal health systems did not reveal any notable trends among national health systems, relating to constitutional frameworks. Examining, the nine variables used as constitutional indicators in this study, there were no correlations or similarities within model categories that would demonstrate a connection between constitutional characteristics and the health care model a nation establishes. Thus, the health model a country implements or implemented does not appear to have any relation to the constitutional framework within a country.

Having found no similarities between the nations within each model category, I looked for cross-model similarities. Ultimately this analysis was intended to decipher whether constitutional characteristics have some impact on whether a country adopts any form of universal health coverage. Thus, this aspect of the analysis was intended to determine whether there is any correlation between the constitutional frameworks of universal health care nations generally.

Among the eleven nations surveyed, seven have doctrinal constitutions that set forth positive rights for citizens. Additionally, only four of the nations studied have constitutions that set forth a positive right to health care. The remaining nations either do not address health within their constitutions or address health in a less direct manner.

In all of the countries studied, the judiciary is set forth as a separate and independent branch of government, beholden to the people and the law. Furthermore, all of

the nations provide for constitutional review by the judiciary, though the Netherlands does not permit the judiciary to review acts of Parliament. Each of the doctrinal constitutions reviewed, reference international law and acknowledge an interest in comports with international norms to some degree.

While these findings do indicate some cross model similarities between the nations, there were no unanimous findings among the eleven nations for any one of the nine variables used as constitutional characteristics. These findings indicate that the constitutional framework of a nation do not dictate or necessarily impact the type of health system that is ultimately implemented, or even dictate whether a universal health system is implemented at all.

VI. LESSONS THE UNITED STATES CAN LEARN FROM THESE FINDINGS

In discovering that no singular factor or number of factors will dictate or preclude the types of health systems implemented in a nation I was able to draw two conclusions. First, the lack of correlation between constitutional variables and specific health systems, serves to demonstrate that any of the three health care models can be implemented within nations with diverse constitutional frameworks. Additionally, these findings reveal that a nation must look to the specific characteristics of its particular constitution to determine its capacity to institute particular health care reforms. Thus, there is no singular characteristic of the U.S. constitutional framework, which would preclude the implementation of any of the three universal health systems. Given these findings, any meaningful discussion regarding health care reform in the United States must assess the specific constitutional provisions that are seen as barriers to the implementation of a universal health system within the host country. Once the focus is narrowed to specific barriers within the U.S.

constitution a proper assessment must be made regarding whether any nations that have adopted universal health systems have overcome similar obstacles in the process of reforming their health systems.

A. Current structure of the U.S. health care system

The current structure of the U.S. health system is unique when compared to other western societies. Within the U.S. health system, method of health care delivery is dependent on the class of an individual. In essence the United States has adopted each of the three health care models implemented throughout the world, but has done so for specific populations.

Veterans in the United States are provided medical services and benefits through a Beveridge styled health system, whereby the federal government acts as both provider and financier of health services.³⁷⁹ Citizens over the age of 65 are provided medical care through a NHI Model, by way of Federal Medicare.³⁸⁰ Finally, employed individuals receive health care through a Bismarck model by way of employment benefits.³⁸¹ Thus, aspects of each model have been implemented in the U.S. However, what distinguishes the U.S. from other western nations is a failure to implement a universal health system for the entire population.

B. Constitutional comparison between the US and other similarly situated nations

The Canadian constitutional framework establishes a federal-provincial form of federalism, whereby the federal government's powers are limited by those powers

³⁷⁹ Health Care Systems -- The Four Basic Models, *supra* note 3.

³⁸⁰ *Id.*

³⁸¹ *Id.*

enumerated to the provincial governments.³⁸² Thus there are two constitutionally recognized orders of government in Canada.³⁸³ Under this system, both orders of government have specific authorities and responsibilities in the organization of government.³⁸⁴

In the area of health care reform this division of government control created a unique dynamic in Canada, as its original constitution did not specifically enumerate a power to regulate health care to the federal government.³⁸⁵ In fact, “with the exception of jurisdiction over hospitals and psychiatric institutions which the constitution assigns exclusively to the provinces, the authority over health or health care was never explicitly addressed in the original document that assigned powers to the central and provincial governments in the 1860s.”³⁸⁶

This dynamic is similar to the federalism that exists within the U.S. political system. Under the United States Constitution, the powers of the federal government are limited to those powers specifically enumerated in the constitution and all other powers are reserved for the States.³⁸⁷ These similarities between the Canadian and the U.S. constitutional frameworks indicate that federalism should not preclude the United States from implementing a universal health care system. More specifically, given Canada’s success in implementing a universal health system in light of its federal-provincial division of powers, the U.S. would have no reason to conclude that U.S. federalism would in any way preclude the implementation of a universal health system.

³⁸² Marchildon, *supra* note 169, at 8.

³⁸³ *Id.* at 8.

³⁸⁴ *Id.*

³⁸⁵ *Id.* at 25.

³⁸⁶ *Id.*

³⁸⁷ U.S. Const. amend X.

Another country worth review when determining the propriety of health reforms in the U.S., is the Netherlands. While political institutions of the Netherlands are distinct from the United States, the health reforms the Netherlands has recently undertaken are similar to the reforms the U.S. has attempted to implement with PPACA.

In 2006 the Netherlands began the implementation of reforms that altered the Dutch health system from its traditional Bismarck model to a modified Bismarck Model.³⁸⁸ The 2006 reforms introduced a single compulsory insurance scheme, where private health insurers compete for insured persons.³⁸⁹ The federal government's role in this new system is less direct, and has transitioned to a regulatory and oversight function.³⁹⁰ "The government controls the quality, accessibility and affordability of health care," but the health system is otherwise privatized and realized significantly on market participation for regulation.³⁹¹

The current health system in the Netherlands greatly resembles the health care exchange model that is being implemented with PPACA. Under PPACA states will be required to create exchanges where consumers may browse their insurance options and pick the plan that meets their needs.³⁹² The exchanges serve a self-regulatory and direct regulatory function much like the market system currently in place in the Netherlands.³⁹³ The exchanges serve a self-regulatory function, as competition through the market will encourage better service to insured persons.³⁹⁴ Additionally, the exchange market permits

³⁸⁸ Schäfer, *supra* note 111, at 97-98.

³⁸⁹ *Id.*

³⁹⁰ *Id.*

³⁹¹ *Id.*

³⁹² Barry R. Furrow et al., *Health Law: Cases Materials and Problems*, 115 (6th ed. 2010).

³⁹³ *Id.* at 115-116.

³⁹⁴ *Id.* at 115.

a more direct form of oversight as only Qualified Health Plans (“QHP”) will be permitted to participate in the exchanges.³⁹⁵ To be a QHP health insurers will have to meet specified requirements.³⁹⁶

Given these similarities the U.S. can use the Netherlands as a case study for the effectiveness of this modified Bismarck model. Thus, the U.S. will be able to consider the problems faced by the Netherlands in implementing purchasing markets, including a lack of patient mobility between insurers and financial losses for insurers due to the competitiveness of the premium market.³⁹⁷

V. CONCLUSION

Having found no correlation or trends between constitutional frameworks and health care systems it is clear that any barriers to the implementation of health reforms and universal health systems are individualized to each nation. There is no singular factor or set of factors that act as indicators of the type of health care system a nation will implement or has implemented. An examination of the United States Constitutional framework indicates that there should be no constitutional barrier to the implementation of universal coverage. Arguments are made that the U.S. constitution’s failure to set forth positive rights, lack of a positive right to health care, or limited enumeration of powers to the federal government would act to preclude the adoption of a universal health care system. However, as has been exhibited from this study there are countries that have faced similar constitutional constraints but have adopted universal health systems. More significantly, there is a diversity of nations, facing various political climates and

³⁹⁵ *Id.*

³⁹⁶ *Id.*

³⁹⁷ Schäfer, *supra* note 111, at 172-175.

constitutional constraints that have managed to implement universal health systems. Thus, demonstrating the ability to adopt universal health reforms regardless of constitutional characteristics.