The Global Experience

Healthcare Models in various countries

Beveridge	Bismark	National Health Insurance	Out-of-Pocket	Free-Market
Great Britain, Spain, Scandinavia, New Zealand, Hong Kong	Germany, France Belgium, Netherlands, Japan, Switzerland, Latin America	Canada, Taiwan and South Korea	Africa, India, China and South America	United States of America

BROAD FEATURES

- Healthcare is provided and financed by the govt through tax payments
- There are no medical bills
- Medical treatment is a public service
- Providers can be govt employees
- Lows costs b/c the govt controls costs as the sole payer

- This model uses a health insurance system which is usually financed by both employers and employees through payroll deduction.
- Health insurers are required to insure everybody and they are not profit-making ventures.
- Provides insurance through competing social funds
- Offers multiple sources of provision

- Providers are private
- Payer is a government-run insurance program that every citizen pays into;
- Has considerable market power to negotiate lower prices
- National insurance collects monthly premiums and pays medical bills
- Plans tend to be cheaper and much simpler administratively than American-style insurance

- Most medical care is paid for by the patient, out-of-pocket
- No Universal Health Coverage
- Only the rich get medical care; the poor stay sick or die

- Maintains safety net through public payment of premiums
- Offers services and insurance through private sector

The United States has a fragmented system, with different plans for different populations (i.e., government-sponsored Medicare for those over 65, free care for military veterans, employer-funded insurance for those who are working, private medical insurance for those who can afford it, and out-of-pocket care or medical assistance for those who have no insurance).

United Kingdom

Public Expenditure on Health as % of GDP (2013)	7.6	IMR/MMR (2015)	4/9	Life Expectancy (2013)	81

Community Healthcare

1.Primary care services are delivered by a wide variety of providers including General Practitioners (GPs), dentists, optometrists, pharmacists, walk-in centres and NHS 111. There are more than 66351 general practitioners in UK providing primary care services

2.Community health services are delivered by foundation and non-foundation community health trusts. Services include district nurses, health visitors, school nursing, community specialist services, hospital at home, NHS walk-in centres and home-based rehabilitation.

Tertiary Care

Acute trusts provide secondary care and more specialised services. The majority of activity in acute trusts are commissioned by Clinical Commissioning Groups(CCG). However, some specialised services are commissioned centrally by NHS.

Accountability

Revalidation is the process by which clinicians have to demonstrate to their regulatory bodies (for example, General Medical Council and Nursing and Midwifery Council) that they are up to date and fit to practice. It is a way of regulating the professions and contributing to the ongoing improvement in the quality of care delivered to patient

Incentives/Performance

Clinical Excellence Awards Scheme, merit pay schemes based on individual performance; NHS scheme is still attempting to assess and reward individual performance, when the NHS and many private sector workplaces rely on the activities of teams.

Health Information Data

The Health and Social Care Information Centre (HSCIC) was formed in April 2013 as an executive, non-departmental public body and the national provider of information, data and IT systems for patients, service users, clinicians, commissioners, analysts, and researchers in health and social care base

Drug Supply

Under laws governing the supply of medicines, medicines can be obtained under three categories:

1.**Prescription-only medicines** need a prescription issued by a GP or another suitably qualified healthcare professional. One can take the prescription to a pharmacy or a dispensing GP surgery to collect the medicines.

2.Pharmacy medicines are available from a pharmacy without a prescription, but under the supervision of a pharmacist.

3.General sales list medicines can be bought from pharmacies, supermarkets and other retail outlets without the supervision of a pharmacist. These are sometimes referred to as over-the-counter medicines.

Universal Coverage

National Health Service (NHS) is a public funded healthcare system in all the four regions of the UK. The NHS is made up of a wide range of organisations specialising in different types of services for patients. Together, these services deal with over 1 million patients every 36 hours. Providers of 'primary care' are the first point of contact for physical and mental health and wellbeing concerns, in non-urgent cases. These include general practitioners (GPs), but also dentists, opticians, and pharmacists (for medicines and medical advice)

The money for the NHS comes from the Treasury. Most of the money is raised through taxation.

Mexico

Public Expenditure on Health as % of GDP (2013) 3.2

IMR/MMR (2015) 11/38

Life Expectancy (2013) 77

Primary Care :

Mexican health system is fragmented based on employment status and respective insurance institutions. Each institution has respective independent network of primary, secondary and tertiary service providers and necessary infrastructure. In addition, many pharmacies in Mexico have a doctor on staff or next door who charges a few dollars for a basic consultation. These pharmacy clinics continue to grow and provide underserved populations in semi urban and rural areas with an inexpensive and convenient way to obtain medications.

Tertiary Care :

Hospitals and clinics that provide medical care for social security recipients are of variable quality. While major urban institutions may provide adequate to excellent tertiary care, rural hospitals often have outdated equipment, long waits and inadequate staffing.

Drug Supply :

Although many drugs in Mexico are available over the counter at a pharmacy, certain prescription drugs in Mexico do require a prescription from a Mexican pharmacist. Mexicoís social insurance programmes achieve very significant savings over the retail cost of medicines through a system on which manufacturers of interchangeable generics bid for business, designating the price at which a particular volume of medicines can be offered.

Universal Coverage

Mexico recognises health as a constitutional right and offers basic levels of universal healthcare. Introduction of "Seguro Popular" in 2003 was a landmark event towards universal coverage. In spite of the availability of basic universal healthcare, approximately 20% of Mexicans remain uncovered and health equality in Mexico remains low even for those with healthcare coverage

Finance

Mexico's public healthcare sector, which is predominantly funded by taxes, consists of social security institutions and government-sponsored healthcare. Each of these public sectors covers approximately 40% of the Mexican population. The social security institutions cover private employees, retirees, and their families. Those who are not eligible for social security have the option to subscribe to Seguro Popular (SP; Popular Insurance), which is government-sponsored health insurance.

Health Information Database

Mexico has disjointed data systems and patient registers to monitor quality and outcomes. To change this, New Mexico Health Information Collaborative (NMHIC) is envisaged to provide a statewide Health Information Exchange (HIE) that allows authorized healthcare professionals with patient consent to quickly access the patient's history in one centralized record.

Accountability

Poor monitoring and evaluation of reforms are important impediments which led to inefficient healthcare system.

Incentives for Performance

Affiliation to the Seguro Popular is voluntary, yet the reform includes incentives for expanding coverage. States have an incentive to affiliate the entire population because their budget is based on an annual, per family fee.. The voluntary nature of the affiliation process is an essential feature of the reform that helps democratize the budget by introducing an element of choice. It discourages adverse selection and provides incentives not only for universal coverage, but also for good quality and efficiency.

Sri Lanka

Public Expenditure on Health as % of GDP (2013) 1.4

IMR/MMR (2015) 8/30

Life Expectancy (2013) 74

31

Community Healthcare :

Community healthcare service is provided through 'Health Units' comprising up to 80,000 to 100,000 inhabitants. The activities of the health unit are as following: 1) Conduct a general and special health survey on all aspects of the health problems in the district, 2) Collect and study vital statistics of the area, 3) Promote health education, 4) Undertake measures to control infectious disease, 5) Organize maternal and child health programs, 6) Conduct school health programs, 7) Develop rural and urban sanitation projects

Tertiary Care :

Curative care is provided through teaching hospitals, provincial general hospitals, district general hospitals and base hospitals (type A and type B). Secondary hospitals provide four basic specialties (medicine, surgery, pediatric, obstetrics and gynecology) and manage patients needing specialist care that are not available in primary care hospitals, while tertiary hospitals provide added specialties.

Drug Supply :

State Pharmaceuticals Corporation(SPC) of Sri Lanka procure and supply drugs to the Health Ministry and to the private sector market through an open competitive tender procedure. SPC distribute drugs to the general public through island wide network of Rajya Osu Salas,Franchise Osu Salas and distributors. In Sri Lanka there are about 5000 pharmacies for 21 million people. The total pharmaceutical market of Sri Lanka today is approximately US$ 365 million of which the private retail market accounts for approximately 60% of sales while the government hospital purchases account for approximately 28%, private hospitals account for approximately 10% and dispensing family physicians account for approximately 2% of the total pharmaceutical business.

Incentives for Performance

Performance-based non-financial incentives such as career development, training opportunities and fellowships were found to be appropriate for central and provincial managers, while hospital managers preferred financial incentives

Universal Coverage :

Sri Lanka's model of primary health care, available free through a government health system with island wide availability, forms a sound basis for providing universal health coverage. However, with high burden of non-communicable diseases (NCDs), increasing elderly care needs and the growing out of pocket expenditure for chronic diseases, this system is under pressure. Whilst the government's commitment to maintaining universal health services of good quality for all continues, the need for change has been recognized. Primary health care in Sri Lanka developed as two parallel services: Community health services and Curative services.

Finance

Financed mainly by the government, with some private sector participation as well as limited donor financing. Public sector financing comes from the General Treasury, generated through taxation. Public sector services are totally free at the point of delivery for all citizens through the public health institutions distributed island-wide, while private sector services are mainly through 'out-of-pocket expenditure' (OOPE), private insurance and non- profit contribution.

Health Information Database

The following systems are present: Patient Administration System (PAS), Laboratory Information Management System (LIMS), Electronic Medical Records (EMR), Electronic Health Records (EHR) and Management Information System (MIS)

Accountability

Sri Lanka is an example of how democratic politics can provide a means of government accountability for services to the poor (World Bank 2003). The small size of electorates encouraged a form of "parish pump politics," in which national politicians, some elected by as few as 5,000 voters (Wriggins 1960), competed to ensure that the government built dispensaries and further, hospitals in their constituencies.

Thailand

Public Expenditure on Health as % of GDP (2013) 3.7

IMR/MMR (2015) 11/20

Life Expectancy (2013) 74

Community Healthcare :

Community hospitals are at the district level and further classified by size: Large community hospitals have a capacity of 90 to 150 beds, Medium community hospitals have a capacity of 60 beds, Small community hospitals have a capacity of 10 to 30 beds. While all three types of hospitals serve the local population, community hospitals are usually limited to providing primary care, while referring patients in need of more advanced or specialised care to general or regional hospitals.

Tertiary Care :

The inpatient care is provided differently in all the three schemes namely – Civil Servant Medical Benefit Scheme (CSMBS), Social Security Scheme (SSS) and Universal Coverage Scheme (UCS). The idea is to provide universal care while incentivising the fiscal prudence. For example, while care is provided under UCS, it is capped at global budget. Similarly, under CSMBS, Diagnosis Related Group (DRG) payment system is used to disincentivise over-treatment

Drug Supply :

The drugs are procured by the National Health Security Office (NHSO) and distributed through primary distribution system (in which the government drug procurement office establishes a contract with a single primary distributor, as well as separate contracts with drug suppliers) attached to each of the clinics. The drugs can be sourced at subsidised price on furnishing prescription.

Health Information Database

Ministry of Public health is currently reforming its health information system to streamline its administrative, financial management and to assess health outcomes of the intervention in order to improve targeting. The UCS contributed significantly to the development of Thailand's health information system through hospital electronic discharge summaries for DRG reimbursement, accurate beneficiary datasets and data sharing. The creation of the NHSO's disease management system increased better achievement of outcomes

Finance

Mainly funded through taxation and co-contribution of both employer and employee

Universal Coverage :

99.5% of the population is covered under three of the schemes i.e., CHMBS, SSS and UCS

NHSO
National Health Security Office

Accountability

Various mechanisms established by the NHSO to protect beneficiaries: a "1330" hotline, a patient complaints service, a no-fault compensation fund, stepwise quality improvement and tougher hospital accreditation requirements.

Incentives for Performance

The government enforces a three-year compulsory public service for new medical graduates and many financial incentives for rural doctors, including hardship allowances, no-private practice allowances, overtime payments, and non-official hours special service allowances. These financial incentives have been allowed to increase up to 20 percent after the implementation of the universal coverage scheme. Measures to hire retired physicians is also implemented. For long term measures, the government approved a project to accept additional 10,678 medical students from 2005-2014 (The Secretariat of the Cabinet 2004). In order to ensure equity of education, longer rural retention, and local acquaintance, the additional new medical students will be recruited from the rural provinces/districts and trained in provincial hospitals.