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Health Care Systems -- The Four Basic Models

An excerpt from correspondent T.R. Reid's upcoming book *The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care*, to be published by Penguin Press in the summer of 2009.

There are about 200 countries on our planet, and each country devises its own set of arrangements for meeting the three basic goals of a health care system: keeping people healthy, treating the sick, and protecting families against financial ruin from medical bills.

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But we don't have to study 200 different systems to get a picture of how other countries manage health care. For all the local variations, health care systems tend to follow general patterns. There are four basic systems:

THE BEVERIDGE MODEL

Named after William Beveridge, the daring social reformer who designed Britain's National Health Service. In this system, health care is provided and financed by the government through tax payments, just like the police force or the public library.

Many, but not all, hospitals and clinics are owned by the government; some doctors are government employees, but there are also private doctors who collect their fees from the government. In Britain, you never get a doctor bill. These systems tend to have low costs per capita, because the government, as the sole payer, controls what doctors can do and what they can charge.

Countries using the Beveridge plan or variations on it include its birthplace Great Britain, Spain, most of Scandinavia and New Zealand. Hong Kong still has its own Beveridge-style health care, because the populace simply refused to give it up when the Chinese took over that former British colony in 1997. Cuba represents the extreme application of the Beveridge approach; it is probably the world's purest example of total government control.

THE BISMARCK MODEL

Named for the Prussian Chancellor Otto von Bismarck, who invented the welfare state as part of the unification of Germany in the 19th century. Despite its European heritage, this system of providing health care would look fairly familiar to Americans. It uses an insurance system -- the insurers are called "sickness funds" -- usually financed jointly by employers and employees through payroll deduction.

Unlike the U.S. insurance industry, though, Bismarck-type health insurance plans have to cover everybody, and they don't make a profit. Doctors and hospitals tend to be private in Bismarck countries; Japan has more private hospitals than the U.S. Although this is a multi-payer model -- Germany has about 240 different funds -- tight regulation gives government much of the cost-control clout that the single-payer Beveridge Model provides.

The Bismarck model is found in Germany, of course, and France, Belgium, the Netherlands, Japan, Switzerland, and, to a degree, in Latin America.

THE NATIONAL HEALTH INSURANCE MODEL

This system has elements of both Beveridge and Bismarck. It uses private-sector providers, but payment comes from a government-run insurance program that every citizen pays into. Since there's no need for marketing, no financial motive to deny claims and no profit, these universal insurance programs tend to be cheaper and much simpler administratively than American-style for-profit insurance.

The single payer tends to have considerable market power to negotiate for lower prices; Canada's system, for example, has negotiated such low prices from pharmaceutical companies that Americans have spurned their own drug stores to buy pills north of the border. National Health Insurance plans also control costs by limiting the medical services they will pay for, or by making patients wait to be treated.

The classic NHI system is found in Canada, but some newly industrialized countries -- Taiwan and South Korea, for example -- have also adopted the NHI model.

THE OUT-OF-POCKET MODEL

Only the developed, industrialized countries -- perhaps 40 of the world's 200 countries -- have established health care systems. Most

In rural regions of Africa, India, China and South America, hundreds of millions of people go their whole lives without ever seeing a doctor. They may have access, though, to a village healer using home-brewed remedies that may or not be effective against disease.

In the poor world, patients can sometimes scratch together enough money to pay a doctor bill; otherwise, they pay in potatoes or goat's milk or child care or whatever else they may have to give. If they have nothing, they don't get medical care.

These four models should be fairly easy for Americans to understand because we have elements of all of them in our fragmented national health care apparatus. When it comes to treating veterans, we're Britain or Cuba. For Americans over the age of 65 on Medicare, we're Canada. For working Americans who get insurance on the job, we're Germany.

For the 15 percent of the population who have no health insurance, the United States is Cambodia or Burkina Faso or rural India, with access to a doctor available if you can pay the bill out-of-pocket at the time of treatment or if you're sick enough to be admitted to the emergency ward at the public hospital.

The United States is unlike every other country because it maintains so many separate systems for separate classes of people. All the other countries have settled on one model for everybody. This is much simpler than the U.S. system; it's fairer and cheaper, too.

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