A Comparative Analysis of the United Kingdom and the United States Health Care Systems

Abbie McClintock Roe, MSHSA; Aaron Liberman, PhD

With America entering a new period of debate about the future of its health care system and with several alternative models now being tested in individual states, this article explores the similarities and differences between the National Health Service of the United Kingdom and America’s varying approaches to addressing the health services needs of its citizens. The focus of this article is in identifying opportunities to benefit from the relative strengths and avoid or correct the weaknesses inherent in each system. Key words: employer-based system (USA), National Health Insurance, National Health Service (UK), universal health care

Health care financing and delivery systems are popular topics of study throughout the world. Their popularity is due not only to the universal human need for health care, but also to the various means of the delivery systems and financing around the world. These many differences depend greatly on each country’s political culture, history, and level of wealth.

As a topic that has a profound impact on the current and future generations, health care is a central theme of the political and social culture in the United States. In particular, access to health care is frequently highlighted on television news programs, heard throughout political “promises,” and discussed within social groups. This suggests that the American public is coming closer to demanding better access to health care. A common misconception throughout the United States is that countries who offer national health care systems, such as Canada and the United Kingdom, provide “free” health care. Although many services are provided “free at the point of delivery,” generally speaking, these national health care systems provide services predominantly through the means of citizen taxation.

Americans are considering increased government involvement in health care; therefore, it is important to understand how this could be accomplished and the impact it could have on society.

This article is designed to review two countries’ health care financing and delivery systems: the United States of America and the United Kingdom. These two countries have close historical and cultural ties, but when it comes to health care, the United States and the United Kingdom are significantly different. Because they differ so greatly, both countries could learn from each other to create better policy and systems and thus improve health care delivery to their respective citizens.

International Comparison

The World Health Organization, a United Nations agency, issued a report in June 2000 that ranked the health systems of 191 countries across the world, which was the first of its kind to include such a large scope of the globe. The United Kingdom ranked 9th and the United States ranked 17th highest in overall system performance. These
results were behind France (first), Italy (second), Spain (third), Austria (fifth), and Portugal (sixth). The study also showed that only 57% of the UK population said they were either fairly or very satisfied with their health system. That percentage was even lower for the United States at 40% fairly or very satisfied.³

The Organisation for Economic Co-operation and Development (OECD) is an organization headquartered in Paris, France, that studies comparative data of 30-member countries.⁴ These 30 industrialized countries are Australia, Austria, Belgium, Canada, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Japan, Korea, Luxembourg, Mexico, Netherlands, New Zealand, Norway, Poland, Portugal, Slovak Republic, Spain, Sweden, Switzerland, Turkey, and of course, the United Kingdom and the United States.⁵

According to a 2006 OECD comparative data study, the total health expenditure in 2004 by the United Kingdom was 8.3% of their gross domestic product (GDP) and the United States was 15.3% of their GDP, whereas the mean of all 30 countries was 8.9%. This same study reports health expenditure in the United Kingdom as US $2,546 per capita and US $6,102 per capita in the United States, whereas the 30-country mean was US $2,550. Not surprisingly, public spending differs quite significantly between the United States and the United Kingdom as well. Of their respective 2004 total health expenditure, public spending in the United Kingdom was 85.5% and in the United States was 44.7%, whereas the 30-country mean was 73%.⁶

The United States ranked highest by far of all 30 countries in total health expenditure percentage of GDP and per capita spending and lowest of all 30 OECD countries in public expenditure percentage. The United Kingdom was slightly lower than the mean for both health expenditure percentage of GDP and per capital spending and the fourth highest of the 30 countries in public health expenditure.⁶ This tells us that the United States spends considerably more money in total and per capita on health expenditure than many other comparable countries and that it is the American people and private organizations that are spending the majority of this money. It is important to focus on the percentage of GDP because of the economic concept of opportunity cost, which says that the higher the percentage of GDP spent on health care, the lower GDP available for other goods and services.⁷

The OECD releases many other pieces of comparative data, including life expectancy at birth, remuneration of health professionals, health expenditure by function, and tobacco consumption. Taking 2 comparative pieces of data, in 2004, 25% of the population in the United Kingdom and only 17% of the population in the United States reported to partake in daily consumption of tobacco.⁸ And as of 2003, the life expectancy at birth was 78.5 years in the United Kingdom and 77.5 years in the United States.⁹ There are many factors that could play a role in these results; however, taken factually, although the United States has a lower rate of tobacco consumption and spends a higher percentage of their GDP on health care, the United Kingdom has a higher life expectancy at birth. These results are a clear indication that it is essential for the American public and health care managers to understand health care spending and delivery to progress to a more productive and effective health care system in the United States.

TYPES OF HEALTH CARE SYSTEMS THROUGHOUT THE WORLD

There are many trends and patterns of health systems throughout the world. Olin Anderson and Milton Roemer both developed analytical models to chart these different types of systems, and each of these 2 models places the United States and the United Kingdom at opposite ends of the spectrum. As illustrated by Anderson’s model, all health systems in the world can be placed on a “continuum based on the level of government involvement in the financing and organization of health services.”¹¹ Anderson describes the role of government as
either market maximized, characterized by limited government, or market minimized, characterized by government programs based on distributive justice\(^1\) which promotes the equal allocation of goods and services to all members of society.\(^{10}\) On this scale, Anderson places the United States at the far end of market-maximized and the United Kingdom’s National Health Service (NHS) at the far end of market-minimized.\(^1\)

As defined by his work in *National Health Systems of the World*, Roemer’s analytical model places health systems into 3 base categories. These categories are the entrepreneurial model, the mandated insurance model, and the NHS model, which are each organized by wealth and degree of government involvement. The entrepreneurial model is one based on the purchasing of private health insurance by individuals or employers. The United States’ health system is an example of an entrepreneurial model. Scientific medical advancement in technology and research and cost-saving practices are both beneficial results of the entrepreneurial model. One of the key disadvantages of the model, however, is the apparent inequality of the distribution of health care resources. An example of this inequality is seen in the rising number of uninsured in the United States.\(^1\) As of the most recent Census Bureau data available, there were approximately 46 million uninsured Americans in 2005, which is approximately 15.9% of the US population.\(^{11}\) This figure has risen steadily since the expansion of Medicaid in the 1980s.\(^{12}\) Entrepreneurial models, such as the United States, operate under a voluntary insurance market, which is one where “employment-based health insurance is purchased from private companies.”\(^{11}\) These countries also tend to encourage, produce, and depend on the private ownership of health care resources and private employment of health care staff.\(^1\)

The mandated insurance model is one in which insurance coverage is compulsory and is generally funded by social insurance. Social insurance, also known as social security, is one in which the health system is funded through insurance purchased with contributions made by workers and employers. The German health system is an example of a mandated insurance model. In the early 1990s, the Clinton administration borrowed from the German System in an attempt at US health care reform.\(^1\) Although the Clinton administration was unsuccessful at full-scale national health care reform,\(^{13}\) on April 12, 2006, Massachusetts Gov Mitt Romney signed Chapter 58, what is better known as Massachusetts’ “universal” health insurance bill. Chapter 58 is based on the mandated insurance model as it is designed to provide health insurance to nearly all residents of Massachusetts.\(^{14}\)

The NHS model is “characterized by universal coverage, general tax-based financing, and national ownership and/or control of the factors of production.”\(^{13}\) This model is exemplified by both the United Kingdom and Canada’s national health programs and uses general tax revenue for the majority of its financing. In NHS countries, the government itself is most likely to own the health care resources and employ the health care staff.\(^1\)

**THE UNITED KINGDOM**

The United Kingdom of Great Britain and Northern Ireland is more commonly known as the United Kingdom. This country is made up of 4 constituent countries, which includes the 3 occupying the island of Great Britain: England, Wales, and Scotland, and the northeast territory of the island of Ireland, simply called Northern Ireland. The UK government estimated the population in the United Kingdom in mid-2005 to be 60.2 million, and of this total, 50.4 million, or 83.7%, lived in England.\(^{15}\) According to *Department of Health: Departmental Report 2006*, England’s “Identifiable Expenditure on Services” for the 2003-2004 fiscal year was GBP £58.3 billion, whereas Scotland reported GBP –£18.3 million, Wales reported GBP –£148.4 million, and Northern Ireland reported GBP –£1.9 million.\(^{16}\) Each of these 4 countries has its own operating NHS. There are similarities and ties between all 4 organizations, so essentially, they are all...
NHSs, but they operate separately to serve the needs of their respective citizens.\textsuperscript{17}

The government of the United Kingdom guarantees the right to health care access to all citizens through its program called the National Health Service.\textsuperscript{1} The NHS is a market-minimized, national health service model\textsuperscript{1} and is the prominent means for one to obtain health care services in the United Kingdom.\textsuperscript{18} It is made up of multiple subsystems broken down by each of the 4 countries and further into local organizations or “trusts.” The NHS, however, is essentially one system, one organization that provides health care access to the citizens and residents of the United Kingdom. This fully comprehensive system includes health care facilities and staff, technology and pharmaceuticals, financing, coverage, and delivery.\textsuperscript{17} There is a growing private health care industry in the United Kingdom,\textsuperscript{18} its 2 largest private insurers being AXA PPP Healthcare and BUPA.\textsuperscript{19} However, for purposes of this discussion and for direct comparison, the NHS in England will predominantly be explored during this analysis.

**Evolution of the UK health care system**

Although it has only been approximately 60 years since the establishment of the NHS, not surprisingly, there were quite a few health policy provisions introduced throughout British history before the NHS. Dating back to the 17th century, workhouses served as institutions where the poor of Britain could find the means to meet such basic needs as nourishment, shelter, health care, and available work. Although the conditions at the workhouses were notoriously horrendous, these establishments served as the public solution to meet the basic needs of the poor. As a means to control their health services, the 1834 Poor Law Amendment Act was intended to limit outdoor relief, defined as medical care provided outside the workhouses, and encourage indoor relief, defined as medical care provided within the workhouses.\textsuperscript{20}

As another public health initiative, the 1848 Public Health Act was established to construct the water and sewage systems as a means to control and limit the spread of infectious disease. The 1867 Metropolitan Poor Act began the development of Poor Law infirmaries, which were actual separate buildings from the workhouses that provided health services to the poor. Although this Act seems to have been in direct conflict with the 1834 Poor Law Amendment which sought to limit outdoor relief, it served as an important step toward the recognition of the state’s responsibility to provide hospitals to the poor and thus the development of the NHS.\textsuperscript{20}

Other notable public health policies in British history include the 1906 Education (Provision of Meals) Act that led to the development of a school meals service and the 1907 Education (Administrative Provision) Act that began school medical service. The 1911 National Insurance Act provided free general practitioner (GP) care for certain groups of working people who earned less than GBP £160 per year, and the 1929 Local Government Act resulted in the government control of administering workhouses and infirmaries at the county level. Only 17 years before the National Health Service Act, the Local Government Act was yet another step toward a government-provided and government-controlled health system.\textsuperscript{20}

Before the NHS’s inception, receiving appropriate health care in the United Kingdom tended to be a luxury, not a right. Those who could not afford to pay for traditional health care relied upon sometimes dangerous home remedies, on the charity of medical professionals providing free services to the poor, or from those services provided within the deplorable conditions at workhouses. The Great Depression encouraged the popular perception in Britain to demand health care as a right, not a privilege.\textsuperscript{21} The creation of the NHS did not essentially begin as a means to provide new or different health services to the population, but as a way to provide appropriate and responsible health services to all, regardless of the ability to pay.\textsuperscript{20} It began as a political and social movement at the end of World War II which led to the National Health Service Act in 1946\textsuperscript{20};
however, the NHS itself did not begin operations until July 5, 1948.22

UK health care systems and infrastructure

Department of Health—The government body responsible for the NHS in England is the Department of Health. The Department of Health’s objectives are simply to improve the overall well-being of the people of England. This is executed by directing, supporting, and leading NHS and social care organizations to provide fair, high-quality health services and to offer choices to patients and value to taxpayers.23

This government body is led by democratically elected members of parliament (MPs) and headed by the Secretary of Health, currently Patricia Hewitt MP. The additional roles leading the Department of Health are Minister of State for Health Services, Minister of State for Delivery and Reform, Minister of State for Quality, Minister of State for Public Health, and Parliamentary Under Secretary of State for Care Services. Each of these roles is filled by elected MPs, parliament being the legislative body in the United Kingdom which is similar to the US Congress. Although these MPs are elected by the masses, they are appointed to their respective roles in the Department of Health by the Prime Minister of the United Kingdom, currently Gordon Brown.23

There are many other levels of individuals who make up England’s Department of Health leadership. These roles include department directors and board members such as the NHS chief executive, permanent secretary, chief medical officer, chief nursing officer, and director of finance and investment. There are also national clinical directors for such areas as emergency access, mental health, heart disease and stroke, primary care, learning disabilities, cancer, diabetes, children, influenza, and kidney services.23

National Health Service—Introduced in 1948, the NHS is the name given to the overriding government national health organization in the United Kingdom. Since 2002, the NHS in England is essentially run at a local level by organizations known as strategic health authorities (SHAs) and trusts. There are 10 SHAs throughout England, and each is responsible for a number of various types of trusts. Primary care trusts (PCTs) are made up of GPs, dentists, pharmacists, and opticians and tend to be at the heart of orchestrating the health care delivery and experience to patients. National Health Service trusts, also known as acute trusts, are a secondary level of care and are made up of NHS, or government-run, hospitals. Ambulance trusts are the local organizations responsible for responding to and assessing emergency situations. Care trusts are essentially social services organizations that are designed to coordinate multiple services to meet the needs of those patients who might require a more complex level of treatment. Mental health trusts provide services to those patients who have more severe mental health conditions.17

The NHS also offers many other services besides those that are directly provided by trusts. National Health Service walk-in centers, NHS direct and NHS direct online, the Information Centre for Health and Social Care, and non–NHS-related key partners are also important functions and services provided through the NHS.17

Strategic health authorities—Strategic health authorities are the strategic body of the NHS at a local level, and as of July 1, 2006, there were 10 SHAs throughout England. They support and link their local citizens, PCTs, and other local and national NHS organizations by monitoring service performance, developing improvement plans, and increasing the health services and resources available. Strategic health authorities are also the governing body to carry out the initiatives and programs of the national NHS brought down to the local level.17

Primary care trusts—Introduced in April 2002, PCTs are predominantly responsible for meeting the health needs of their local community. They are local organizations to which most patients of the NHS must use as their initial points of health care delivery. Although few, there are some circumstances
when it is not required by the NHS for
patients to first visit a PCT when seeking
medical treatment. When PCTs were first
introduced, if a patient needed to visit a
medical professional, one would be required
to visit the PCT based on the postcode of his
or her registered place of residence. Al-
though these assigned PCTs still exist and
NHS and the PCTs encourage compliance
to the assignment, it has only been recently
that NHS patients can visit a PCT outside
their designated area.

As the nerve center of the NHS, PCTs are
in control of approximately 80% of the total
NHS budget. The NHS organization per-
ceives the use of these local PCTs as the best
way to understand the needs of the com-

munity on a local level. The role of the PCT is
to direct the health needs of each individual
to the correct practitioner or group to re-
ceive health services, such as to GPs, hos-
pitals, and dentists. Primary care trusts also
act as representatives to the NHS of their
local community and assess the GP practices
in their area. Primary care trusts truly serve
as the lead organization in providing and
orchestrating the health care needs of the
population in England.

There are many services and practitioners
provided through the PCTs. Primary care
trusts manage one’s primary care, which is
considered the initial contact when one
seeks medical services. These organizations
are made up of multiple GP practices, dental
offices, optical care locations, and pharma-
cies. There are currently 152 PCTs, and each
reports to 1 of the 10 SHAs. Each PCT has
a headquartered location, such as at a hos-
pital, and is governed by executive manage-
ment and board members.

National Health Service general practices
are those that are made up of GPs and nurses
and can include many other health profes-
sionals such as midwives, physiotherapists,
and occupational therapists. They provide
a wide range of diagnosis, treatment, edu-
cation, and medical testing to their NHS
population. There are approximately 300 mil-

lion visits to a GP per year in England. Every
citizen of the United Kingdom has the right
to register with their local GP, and NHS pa-

tients are never charged to visit a GP. If the
GP is unable to provide the service needed,
he or she should then refer the NHS patient
to an NHS hospital or specialist.

National Health Service trusts (acute
trusts)—The NHS trusts, also known as acute
trusts, are responsible for the NHS hospi-
tals. Acute trusts manage the hospitals’ de-

delivery of high-quality health care and fiscal
efficiency, as well as develop strategic im-

provement of health services. Acute trusts
may be training hospitals attached to medical
universities or a regional or national center
for specialized care, or may also provide ad-
tional community services such as health
centers, clinics, or home health services.

Introduced in April 2004, NHS foundation
trusts, also known as foundation hospitals,
are hospitals with exceptional performance
ratings and are distinguished through an
NHS application process. Foundation hospi-
tals are run by local managers, staff, and
members of the public with little bureau-
cratic control from the centralized NHS. Al-
though they still operate as a part of the NHS
and within NHS standards, foundation hospi-
tals have much more freedom in manag-
ing and providing health services to their
local community than the other nondistin-
guished NHS hospitals. There are currently
54 NHS foundation trusts in England.

National Health Service hospitals and
acute trusts employ a significant amount of
the NHS workers. This includes not only
clinicians, such as doctors, nurses, and phar-
macists, but also physiotherapists, radiolo-
gists, language therapists, psychologists, and
nonmedical professionals such as adminis-
tration, reception, information technology,
engineers, and security.

National Health Service hospitals operate
as a means to meet the demand for second-
ary care in the United Kingdom. Secondary
care is considered either emergency care or
elective care. Elective care is usually when
an NHS patient is referred to the hospital
through primary care services, such as by a
GP, for specialized medical care. Examples
of elective care are hip replacements or
kidney dialysis. Emergency care is attended to in the hospital department known in the United Kingdom as accident and emergency department (A&E). Patients are treated in or admitted through the accident and emergency department generally because of their need for health services in response to sudden trauma, such as chest pain or an automobile accident.17

Ambulance trusts—Ambulance trusts are responsible for responding to conditions that require immediate action, the transportation of patients in need, and certain after-hours care needs. Urgent needs are generally generated through the 999 emergency system (similar to the United States’ 9-1-1 emergency service). When a call is placed to 999, the ambulance trust control room will categorized the emergency as either category A: immediately life threatening; category B: serious, but not immediately life threatening; or category C: nonurgent, non-life-threatening condition.17

For all 3 categories, a rapid response team may be sent to the scene. The ambulance or paramedic team will assess if the patient needs to go to the hospital and, if so, treat and stabilize the patient for transportation. For those patients who have been assessed to not be transported to the hospital, the highly trained medic team may treat on the scene and then provide advice for follow-up care. If the ambulance trust control room does not feel it necessary to send an ambulance to a category C condition, then they are trained to provide over-the-phone suggestions such as treatment advice, referral to one’s GP, or even a referral to a local NHS walk-in center.17

Care trusts—Care trusts are NHS trusts in England that coordinate the health care and social care service needs of an NHS patient. They provide combined health and local authority social care under one organization as a means to protect the patient from falling through the cracks when one is in need of services from multiple organizations. Care trusts may carry out such services as primary care, social care, and/or mental health care and cater to those who require this type of combined effort, such as the elderly who tend to need multiple levels of service. There are currently only 10 care trusts in operation in England; however, there are plans to introduce more in the future.17

Mental health trusts—Mental health trusts work with local council social services departments to provide health and social care to those who have mental health problems. These services range from psychological therapy to specialized care for severe mental health conditions. Less severe mental health problems, such as depression, bereavement, or anxiety, are traditionally treated by primary care services and are not necessarily managed by the mental health trusts. These services can include medication, counseling, and/or support groups.17

Other NHS services—There are many additional services offered by the NHS that do not necessarily fall under the direct responsibility of any of the aforementioned trusts. National Health Service walk-in centers are designed to offer NHS patients access to health care services without the need for appointments. They are often located near accident and emergency departments of NHS hospitals or in public locations such as train stations and “high streets” which is the term used for the central business district of UK towns.17

National Health Service direct and NHS direct online offer health advice and information 24 hours a day, 365 days a year. National Health Service direct is available via live telephone discussions with staffed nurses and health advisors. National Health Service direct online provides NHS information and health advice via the internet at http://www.nhsdirect.nhs.uk/. Services provided on NHS direct online are a self-help guide, a health encyclopedia, answers to common health questions, a mind and body magazine, as well as the ability to search for one’s local health services.17

Current initiatives and future proposals in the United Kingdom—The NHS Plan

Announced in the year 2000, “The NHS Plan” is a 10-year government program
designed to modernize and improve the NHS system. Because there had not been significant reform since the NHS's inception in 1948, The NHS Plan has been described as the biggest overhaul since its founding. The NHS Plan's purpose is to create a 21st century health care system that puts the patients at the heart of decision making and creates a more consumer-driven service. In part, The NHS Plan places blame for its current problems on the politicking it took in 1948 to create physician buy-in for the new program and that it will take a great effort for physicians to give up power to the people.

The NHS prepared to fulfill The NHS Plan through increased funding and organizational renovation. In fact, the NHS is the only health system in the industrialized world that is committed to increasing, not decreasing, its health expenditure. The goal of The NHS Plan is to mirror the European Union's average spending of 8% of GDP on health care. It has been several years since the launch of The NHS Plan. Some of the initial goals have been and are on their way to being achieved; however, there have also been some new and reformed goals since 2000.

This national program was the first of its kind. There were 4 key initiatives set forth by The NHS Plan. First was the general utilization of 2 new health service programs. National service frameworks were set to create national treatment standards for such medical illnesses as diabetes, cancer, and kidney conditions. Originally established in 1999, the National Institute for Health and Clinical Excellence was created to attain the highest level of care in the NHS by providing guidance on public health, health technologies, and clinical practice. Another initiative set forth by The NHS Plan was a change in the financial rewarding and training of health care professionals to improve quality and better meet patient needs. Yet another initiative of The NHS Plan was to create a higher level of autonomy for those health services and systems that performed well and greater support for those that needed improvement. Lastly, The NHS Plan introduced an initiative for more information and choices for patients, including more highly responsive health services from the NHS.

Some of the patient-specific initiatives of The NHS Plan in 2000 were to cut hospital waiting times to 3 months for outpatients and 6 months for inpatients by 2005, provide for GP appointments within 48 hours by 2004, and offer a free NHS retirement health check. Some of the workforce-specific initiatives were to create new quality-based GP contracts; develop 335 mental health teams to increase crises response time, create new roles, responsibilities, and better training for NHS staff; and to employ 20,000 more nurses, 7,500 more physician consultants, 2,000 new GPs, and 6,500 other health professionals. General service and organizational initiatives were to create 7,000 extra hospital beds and 100 new hospital plans by 2010, provide an extra GBP £900 million to develop intermediate care to improve patient recovery, make medical nursing care in nursing homes free, create agreements between the NHS and the private sector for use of private facilities, develop a national independent advisory panel for major hospital changes such as closures, and merge the budgets of social services with the NHS.

As a result of The NHS Plan, the NHS budget had doubled from 1997 to October 2006, and it is expected to triple by 2008. As of March 2007, there have been a number of The NHS Plan initiatives addressed and accomplished within the NHS in England. In January 2007, the number of people on the inpatient waiting lists was 774,000, one of the lowest since the NHS began collecting the data in 1988. This wait list total is down 2,000 from 776,000 in December 2006 and down from 1,158,000 in 1997. There was an increase by 42% of critical care beds from 2,362 in January 2000 to 3,359 in January 2007, which includes an increase of 84% of high-dependency beds. Responding to urgent GP referrals for cancer treatment, more than 95% of patients
only waited a maximum of 2 months (62 days), which exceed the NHS operational standard.\textsuperscript{34} Between 1997 and March 2007, a total of 116 new hospitals and 188 new primary care facilities have opened throughout England, which exceeds the goal of 100 new hospitals proposed in The NHS Plan in 2000.\textsuperscript{35} Also since 1997, there are 85,305 more nurses in the NHS in England, and approximately 30,000 NHS nurses have benefited from leadership programs.\textsuperscript{36} Detailed earlier, care trusts and NHS foundation trusts were both results of the initiatives laid out in The NHS Plan in 2000.

In 2005, the Department of Health questioned and surveyed more than 140,000 people on their thoughts, ideas, and concerns for the NHS in England in relation to The NHS Plan. The Department of Health publication, \textit{Our Health, Our Care, Our Say: A New Direction for Community Services}, addresses the results of this national quest and sets a new and extended course for improvement in the NHS in England over the subsequent 5 years. This resulted in numerous new and extended initiatives within the NHS. For example, information prescriptions are to be directly provided to long-term patients and their caregivers to further educate them on their condition and where within the NHS system they could gain further access to information and services. The new NHS life check is a self-assessment tool designed to help to determine one's health risks and decide whether to consult a health trainer to establish a personal health plan. Individual budgets were to be introduced within the NHS for those long-term care patients in need of health and social care, and by 2008, all PCTs should provide access to an integrated personal health and social care plan to these patients through a joint health and social care team. The prime minister’s 1999 Strategy for Carers, which promotes caregivers’ rights and provides financial grants, was to be updated to provide further support to caregivers. To meet the needs of their communities, GPs will be required to conduct and respond to surveys given to their patients regarding the medical services at the GP practice.\textsuperscript{37}

\section*{Pricing structure and responsibility of payment in the NHS}

National Health Service medical services received by NHS patients are considered “free at the point of delivery.”\textsuperscript{12} Therefore, when an NHS patient uses an NHS service, such as a PCT, acute care trust, NHS walk-in center, or NHS direct online, they do so free of charge—they are not asked for money upfront, nor do they receive a bill for services received. However, it is important to understand that NHS subsystems and their respective providers receive compensation for treating NHS patients, just not directly from the patient at the time services are received. National Health Service compensation is funded by general taxation,\textsuperscript{38} and because the NHS is made up of government-salaried employees, provider compensation is usually in the form of a salary and/or bonuses, and subsystem funding is usually based on a contract between the provider and the NHS.\textsuperscript{24}

In 2004, 8.3\% of the UK total GDP expenditure was spent on health care.\textsuperscript{6} The percentage of public expenditure of health care GDP in the United Kingdom was 85.5\%,\textsuperscript{6} which would make private expenditure 14.5\%. Although the NHS is “free at the point of delivery,”\textsuperscript{12} this private expenditure amount clearly shows that there are some instances where private parties do contribute toward the purchasing of health care products and services.

There are some NHS services that are not “free at the point of delivery.” The Department of Health imposes flat charges to NHS patients to receive pharmaceutical, dental, or optical products or services. For example, when an NHS patient fills a prescription at the pharmacy in England, they must pay a flat rate to receive the pharmaceutical product. As of April 1, 2007, the fee per prescription is GBP £6.85, which is up from the former GBP £6.65. This is a flat fee and does not depend on the price of the pharmaceutical; therefore, the out-of-pocket (OOP) cost to the patient is the same whether the
pharmaceutical is a high-cost specialty medication or a low-cost maintenance medication such as for diabetes or high blood pressure.39

This charge of GBP £6.85 per prescription is only some of the total health care expenditure spent by private parties in the United Kingdom. Another example of money paid by private parties is by those that choose to purchase access to private health care. Although the NHS is funded through general taxation,58 there is a growing market for private health care in the United Kingdom.18 The private health care system in the United Kingdom is provided through private health insurance, private physicians, and private hospitals, all of which are separate from the NHS services.19 United Kingdom residents are not mandated to use the health care services provided by the NHS; however, there is no concession to those who purchase their own private insurance to visit private physicians and hospitals. This means that those who purchase private insurance still are paying for the NHS services through general taxation.40

Primary care trusts control 80% of the NHS’s budget.17 Because of initiatives set forth by The NHS Plan, contracts between the PCTs and GPs are considered quality-based, because although the NHS still promotes its recipients to register with the PCT assigned to their postcode, these new contracts have introduced the ability to visit trusts outside their geographic region.24 Primary care trusts are funded through allocation from the Department of Health. The Advisory Committee on Resource Allocation uses a weighted capitation formula to determine the distribution of resources across primary and secondary care in England. Weighted capitation allows for resource commissions at similar levels of health care for populations with similar health care needs.31

THE UNITED STATES OF AMERICA

The United States is the only industrialized country that does not offer universal health care to its population42; therefore, in direct opposition to the United Kingdom and all other industrialized nations, access to health care in the United States is not guaranteed by the government.1 The US government has historically played a passive role in health care. Not only does the government not mandate universal health care, but it also does not require citizens to obtain health insurance coverage on any level. Under the Employee Retirement Income Security Act of 1974, the United States allows full employer discretion on health insurance offerings.12

The health care system in the United States differs greatly from that in the United Kingdom. Whereas the United Kingdom is considered a market-minimized national health system, the United States health care system operates as a market-maximized entrepreneurial system. This is one in which the government has minimal influence and financial responsibility for the health care of the masses and where private parties are encouraged and promoted to reign responsible.1 Also as stated earlier, the United States sits at the far end of highest health care spending per capita, highest health care spending percentage of GDP, and least public financial contribution of the 30-member countries in the OECD.4

Of the approximately 300 million people in the United States, 46 million were considered to have been uninsured in 2005.11 In the United States, those without insurance coverage are meant to pay for the health care services they receive. That being said, the most common reason for bankruptcy in the United States is due to unmet health care bills. A recent study done by Harvard University found that 68% of those who filed for medical debt bankruptcy had some form of health insurance, 50% of all bankruptcies involved medical debt, and every 30 seconds someone in the United States files for bankruptcy because of a serious health problem.43

Evolution of the US health care system

By the end of The Great Depression and World War II, there was a significant hospital bed shortage in the United States. Not only
did hospital construction slow during this time, but many hospitals closed because of the economic downturn of the country. The Hospital Survey and Construction Act of 1946, more commonly known as the Hill-Burton Act, represented the United States' involvement in regulating the availability of hospital beds by providing funding through federal grants. This Act essentially called for the construction and refurbishment of the hospital systems throughout the United States. At the inception of the Hill-Burton Act, 3.2 community hospital beds per 1,000 people in a geographic region were available, and although the Hill-Burton program was terminated in 1974, its goal of 4.5 per 1,000 was accomplished by the 1980s.44

Private health insurance in the United States also grew out of The Great Depression. In 1929, Baylor Hospital began allowing for 21 days of hospital stays per year to those who paid a 50-cent premium each month. This “prepayment” concept spread with encouragement from the American Hospital Association. Also in 1929, the first Blue Cross plan was established to guarantee hospital coverage for childbearing-aged schoolteachers in Dallas, Texas. Blue Shield began in the early 1900s in the Pacific Northwest when mining and lumber camps paid physicians to provide medical care for their laborers. The Blue Cross and Blue Shield Association is the merger between the two, Blue Cross representing hospital coverage and Blue Shield representing physician services. Today, approximately 25% of insured Americans are covered by a Blue plan, which is a part of a network of 43 independently and locally run Blue Cross and/or Blue Shield organizations.45

As one of the first attempts to curtail the increase of health care spending in the United States, the National Health Planning and Resources Development Act of 1974 created a network of government health planning organizations, called health systems agencies. These health systems agencies were intended to control the allocation of health resources and the increasing cost of medical care in the United States. The Act required states to enact certificate-of-need laws that required hospitals to apply for a certificate of need from their host state before acquiring major equipment or beginning construction. Although many states still require some kind of certificate of need, federal funding to the health systems agencies ceased in 1986.44

The current private health insurance industry, which is extremely complex and multifaceted, grew out of the managed care movement in the early 1990s. Managed care is essentially a term coined as an attempt to control health care costs by controlling, or limiting, the access to care. Before the managed care movement, in fee-for-service or cost reimbursement models, providers had much more leniency to decide what services to provide and what fees to charge for those services. The managed care movement attempted to control what health insurance companies and employers saw as an overutilization of medical services by providers.45

**US health care systems and infrastructure**

Health care services in the United States can either be public health care or private health care. Public health care is the health care that is considered a function of the public or the government. Areas in which public or government agencies provide a level of public health care are in the prevention of diseases, the promotion of health, the reporting and controlling of communicable diseases, the control of environmental factors such as air and water quality, and the study and analysis of indicators of data on the health of the public.45

The US Department of Health and Human Services is the principal federal agency that controls many of the subagencies that perform these government health care services. These organizations include the Centers for Disease Control, Food and Drug Administration, National Institutes of Health, and the Agency for Healthcare Research and Quality.45

Each geographic region in the United States tends to be made up of multiple regional
health delivery systems. In most metropolitan areas, there are many different systems. For instance, in the central Florida area, there are 3 health systems: Florida Hospital, Orlando Regional, and Healthsouth. Each system traditionally is made up of networks of health professionals and institutions such as physician practices and hospitals.

When one seeks medical attention in the United States for an episodic or nonchronic condition, it is typical for one to first visit a primary care physician. Primary care is defined as the first point of contact with medical services with the intent to provide initial diagnosis and treatment. Primary care providers (PCPs) are typically GPs, pediatricians, internists, obstetricians, nurse practitioners, physician’s assistants, and midwives. Primary care providers tend to see patients from all ages, genders, and ethnicities who are experiencing a wide range of medical conditions. Therefore, PCPs must be widely educated on a large variety of illnesses and frequently work with secondary and tertiary care specialists in providing a full level of treatment to the patient.

Secondary care is a stage of medical services when a patient is in need of specialized medical attention often received in the hospital setting and attended to by specialty physicians. Whereas primary care focuses on episodic or nonchronic conditions, secondary care addresses more chronic, persistent, or traumatic conditions. Often, a secondary care physician works with PCPs to treat the patient and return them to the PCP’s care. Secondary care represents a growing proportion of the health care needs of Americans due to a growing level of chronic conditions in the United States.

Emergency care is a form of secondary care and is defined as the care received when the absence of immediate medical attention may result in permanent injury or death. Depending on the severity, emergency care is usually treated in a hospital as triaged through the emergency department. Urgent care services attend to less severe emergency care, and if one does not choose to visit a hospital or physician office, there are numerous urgent care/walk-in facilities located throughout the United States. These urgent care/walk-in facilities can either be affiliated with a hospital system or as an independent entity. A new phenomenon in the United States is called retail health care, where retail stores such as Wal-Mart, are offering walk-in health care facilities that are often run by nurse practitioners and provide limited services for fairly minimal fees.

Tertiary care is really considered a higher level of specialized, or subspecialized, secondary care. It requires intensive inpatient care and often a prolonged length of stay in the hospital. Patients receiving tertiary care often have complex illnesses that require highly technical medical care, such as coronary artery bypass grafts or organ transplants. Tertiary care centers and providers are often affiliated with academic medical institutions. Similar to secondary care, tertiary care providers work closely with the patient’s PCP to gain access to the patient’s medical and personal history.

**Health insurance and coverage in the United States**

As of 2000, 84.2% of the non-elderly US population had some form of health insurance coverage, and two thirds of this coverage was employer sponsored. The United States is essentially an employer-based system, which is a large contributor as to why the unemployed are also generally uninsured. There are multitudes of health coverage organizations, plans, and systems throughout the United States. The basic concepts of some of the more popular means of health coverage will be discussed in this article.

Health insurance is a contractual relationship and a shared financial risk between the insured (ie, patient member) and the insurer (ie, insurance company). The insurer is providing or reimbursing all or some of the cost of medical care provided to the insured if the insured seeks medical attention covered under the policy or contract. The insured is paying a premium usually in the form of a monthly payment to protect
oneself against the risk of a full payment for seeking medical care. Many times, the insurer is not only responsible for the monthly premium, but is also responsible to pay for some of the medical care received in a form of deductibles, coinsurance, co-payments, and OOP maximums.\textsuperscript{45}

Government-sponsored health care in the United States—As discussed previously, although the United States health system is considered predominantly funded by private parties, there is a considerable contribution (44.7\% of health care GDP\textsuperscript{6}) made by public funding. Medicare, Medicaid, which includes the State Children’s Health Insurance Program (SCHIP), and Veteran Affairs is considered government- or public-sponsored health care. The Centers for Medicare and Medicaid is a federal agency that is responsible for the administration of the US Medicare and Medicaid programs. As a result of 1965 Amendments to the Social Security Act, both Medicare and Medicaid serve as the major forms of public health insurance in the United States and are the combination of previously smaller programs.\textsuperscript{45} Although Medicare and Medicaid are both government-funded health programs in the United States, both are generally administered through private intermediaries, such as Blue Cross, Blue Shield, or other managed care organizations.\textsuperscript{12}

Medicare—The Centers for Medicare and Medicaid is the federal agency that manages the Medicare and Medicaid programs in the United States. Medicare is a federal health insurance program designed to provide coverage to those older than 65 years as well as to the disabled. Recipients must be a citizen or permanent resident of the United States and must have worked themselves or been married to someone who has worked for Medicare-covered employment for at least 10 years. Medicare-covered employment deducts payroll taxes under the Federal Insurance Contributions Act as a means to fund the Medicare program.\textsuperscript{45} Medicare has been one of the fastest growing federal programs in the United States, growing at 15\% each year in its first 30 years. The program began on July 1, 1966, with 19.1 million enrollees, and as of 2004, there were approximately 42 million enrollees. Medicare has a powerful influence on the US health care industry, because it is a major source of revenue for health care providers and its policies and regulations tend to have a “ripple effect” on US health care delivery.\textsuperscript{47}

Medicare coverage is broken down into 4 distinct parts, A-D. Part A is considered institutional care (ie, hospital care). Part B is a voluntary enrollment plan that requires a small monthly premium and covers professional services, such as physician visits.\textsuperscript{45} Part C is a mandate of the Balanced Budget Act of 1997 and offers parts A and B recipients the option to enroll in one of many private managed care plans to combine the two under one benefit.\textsuperscript{44} Part D is a prescription drug benefit that operates under a complex system of multiple private entities and formularies. In December 2003, the Medicare Prescription Drug, Improvement, and Modernization Act was signed in by the president of the United States; however, the benefit itself was not available until its launch in February 2006.\textsuperscript{48}

Medicaid is not a fully comprehensive health coverage program and in fact relies on significant OOP expenses from Medicare recipients. To cover these OOP expenses, most Medicare recipients enroll in additional coverage such as Medicare health maintenance organizations (HMOs), retirement coverage from former employers, Medigap plans, and Medicaid.\textsuperscript{45}

Medicaid—State Medicaid programs are combined federal and state-funded health insurance plans that are offered to qualified recipients who fall below a particular level of income and also take into account one’s assets and resources. Most Medicaid recipients are children, the elderly, blind, disabled, and those who qualify for federal income assistance. The cost share formula between state and federal funding is based on the ratio of state to federal per capita income. Each state can differ in their income qualification and in the means of providing Medicaid. A significant difference between Medicare and

Copyright © Lippincott Williams & Wilkins. Unauthorized reproduction of this article is prohibited.
Medicaid is that Medicaid programs tend to cover long-term care (ie, nursing homes) and in fact are the largest single contributor to long-term care services at more than 44% of its total expenditure in the United States.\textsuperscript{45}

As a function of Medicaid programs, the SCHIP was created as a result of the Balanced Budget Act of 1997. The SCHIP serves as a way for states to meet the growing number of uninsured children. There are 3 options under SCHIP, which are to create a fully standalone program, expand the Medicaid program to include children, or use a combination of both strategies.\textsuperscript{45}

Veterans Affairs—The US Department of Veterans Affairs, formerly called the Veterans Administration, offers health care benefits to those who qualify through the Veterans Health Administration. Eligibility for Veterans Affairs benefits is based on those nondishonorably discharged from active military service in the army, navy, air force, marines or coast guard (as well as the merchant marines who served during World War II). The Veterans Affairs is a complex health care system that provides medical services to qualified recipients at a number of hospitals, long-term facilities, medical centers, and clinics, including dental, mental health, and substance abuse, located throughout the United States.\textsuperscript{49}

Private-sponsored health care in the United States—There are many different ways one can obtain private health care coverage in the United States, but the most common means is through an employer benefit program. It is estimated that two thirds of non-elderly Americans who carry health insurance are covered under employer-sponsored programs.\textsuperscript{45} This is where an employer contracts with one or more private health care companies to provide health insurance to its employees. Those employees are usually only eligible if they meet a minimum required number of hours of work per week, such as 30 hours. Because employer-sponsored health insurance is usually offered to a large group of employees, it is also known as group insurance.\textsuperscript{50} Group insurance is a beneficial means of obtaining health insurance as it tends to offer less expensive premiums because of the risk of the insurance company paying out claims is lower when the risk is spread out over the entire group.\textsuperscript{44}

Of the insured non-elderly Americans, approximately 6.6% purchase their health insurance individually.\textsuperscript{45} Individual insurance is usually the same type of health insurance offered through an employer, but the premiums tend to be higher because the risk is not shared among a group\textsuperscript{51} and many require the recipient to submit a physical examination. Because of the concept of risk sharing, group insurance usually does not require the individual member of a group policy to take a physical examination.\textsuperscript{45} Most states allow for insurers to deny coverage due to an undesirable risk, such as in the case of pre-existing conditions.\textsuperscript{51}

There are generally 4 types of health insurance in the United States: conventional coverage, HMOs, preferred provider organizations (PPOs), and point-of-service (POS) plans. As of 2002, of the Americans workers covered under employer-sponsored programs, 5% were in a conventional plan, 26% were in an HMO, 52% in a PPO, and 17% in a POS plan.\textsuperscript{45} Conventional coverage is a type of health insurance that offers coverage from practically all physicians and hospitals in the local region, sometimes including all physicians and hospitals in the local region, sometimes including coverage throughout the United States.\textsuperscript{45}

Health maintenance organizations were created as a direct attempt to control access and cost. Traditionally, in HMO plans, a gatekeeper is used as a means to authorize a referral to a specialist, a pharmaceutical product, or a procedure. These gatekeepers can either be nursing staff of the HMO plan or health professionals at primary care physician practices. In fact, HMOs tend to require insured members to register directly with a primary care physician. Health maintenance organizations are essentially a network of health care providers throughout a designated region who are contracted to provide health services to the enrolled patient population of the HMO network. Those insured under the HMOs must attend these network providers for the HMO to
cover the cost of their services. The incentive to the provider to become a member of the network is often an increase in patient volume. The contracted rates between the HMOs and providers can therefore be at a significantly discounted rate because of this increased volume.\(^4\)

Preferred provider organizations were developed as a result of negative patient and physician reaction to the HMO/gatekeeper model. Although the premiums can be 50% higher than HMOs, when PPOs were first introduced, the network of providers tended to be less limiting and did not require a relationship with a PCP or gatekeeper. Preferred provider organizations encourage their insured members to use their network providers by covering a higher cost (ie, 90%); however, if an insured member chooses to attend an out-of-network provider, the PPO may still cover a smaller percentage of cost (ie, 60%). Because of the popularity of the PPO system, HMOs have begun to move away from the need for referrals, allowing for what is called open access, and in an attempt to control costs, PPOs have begun to add HMO-like services such as programs to manage utilization. These current trends suggest a movement in the US health insurance industry to merge these 2 concepts and find a middle ground.\(^4\)

Point-of-service plans are thought to be that middle ground. Those insured under a POS plan are encouraged to attend a PCP for a referral to an in-network provider, or specialist, when needed; however, it is not required. When visiting an in-network provider, the POS plan–insured patient tends to pay a small amount and little or no deductible. If one chooses to visit an out-of-network provider, POS plans tend to require a deductible to be met, or the patient must pay a higher coinsurance; however, the out-of-network visit does not require a referral by a PCP.\(^4\)

Employers can also offer health insurance through a concept called self-insurance. Approximately 60% of all US workers are covered by these self-funded health plans. As opposed to offering employees access to health insurance from a health insurance company, self-insurance is when the employer has the opportunity to purchase a number of health services either directly from medical groups or hospitals, or they contract as a part of a network of health services. Third-party administrators are organizations that administer and manage the health insurance of self-insured employers.\(^4\)

Labor unions are another means for one to obtain health insurance coverage. These are organizations of workers who band together as either employees of the same organization or with those in a similar labor industry to negotiate with employers on such topics as wages, hours, and working conditions. Union members collectively work together to accomplish these negotiations to their benefit by threatening to or by withholding labor to drive up the price of production.\(^4\) Many labor union organizations provide some level of health insurance coverage to their members similar to employer-sponsored insurance in the form of group insurance.\(^4\)

There are many different areas of coverage health insurance that organizations can offer to their members. Although most health insurance coverage refers specifically to hospital and/or physician services, there are additional areas that can be added on as a higher level of benefit. These areas include prescription, optical, dental, and mental health, among others. These benefits tend to be managed differently than the hospital and physician services and can also be managed by outside vendors. For example, prescription benefit managers are organizations that contract directly with health insurance plans to manage and provide prescription services to their insured members by providing a network, a formulary, customer service, and claim processing.\(^4\) This can sometimes be recognized by the insured as a separate card, known as a drug card. Some recognizable names of national prescription benefit managers are Medco, Caremark, and Express Scripts.
Current initiatives and future proposals in the United States—universal health care

Universal health care is when an entire population is guaranteed the right to some level of access to health care services. Health care is considered a "public good" in many countries throughout the world, which means that it is primarily provided by the government.\(^1\) Universal health care can be in many forms such as in the United Kingdom as one health system, the NHS, or in Germany as a mandated health insurance program.\(^1\) Although the United States does not offer universal health care to its entire population, the federal government does provide fairly comprehensive health care services to specific populations, such as to those who qualify for Medicare, Medicaid, or Veteran Affairs coverage.

The United States is the only industrialized country in the world that does not offer universal health care to its population.\(^4\) In 1993, both Democrat and Republican leaders, as well as nearly every major health care interest group including the American Medical Association and the Health Insurance Association of America, supported an employer mandated universal coverage health care program in the United States. On September 23, 1993, President Bill Clinton announced his plan for mandatory insurance to the House of Representatives which received positive feedback. But within a year, focus on the economy, the Whitewater scandal, and direct opposition ended this health care reform movement. Americans seemed less worried about access to health care because of a decrease in the unemployment rate, and inflation has slowed, leaving employers less concerned about the rising health care costs.\(^5\)

Although universal health care did not catch on in the 1990s, it seems as if health care reform will be an important topic during the 2008 election season.\(^5\) As president of Kaiser Family Foundations, an organization that has tracked US health care reform efforts for decades, Drew Altman says the idea of universal health care has made a charging comeback since the most recent elections in November 2006. Although national exit polls in the 2006 election season did not include any questions on universal health care, in early 2007, health care reform has not only been heard throughout statements made by the emerging presidential hopefuls but also addressed by George W. Bush, the residing US president.\(^5\)

It is the Democratic Party that is focusing on "universal health care." Sen John Edwards of North Carolina, Sen Hillary Clinton of New York, and Sen Barack Obama of Illinois have all announced their intention of providing universal health care to the entire US population if elected president in 2008.\(^5\) Although as of March 2007, most Democratic candidates had not announced their official plans for health care reform, there is a common thread in their ideology, such as providing health coverage at an affordable price to individuals and families and requiring employers to provide or help finance employee health insurance by reducing costs and creating new tax credits.\(^5\)

These candidates’ plans for universal health care are similar not only to the Clinton administration’s unsuccessful attempt at health care reform in the 1990s,\(^1\) but also to the 2006 Massachusetts Health Care Reform Plan. The Massachusetts bill seeks to provide health insurance to all Massachusetts residents by requiring employers to provide health insurance to employees as well as expanded coverage and requirements for covering children and illegal immigrants.\(^5\) In the United States, Massachusetts is the first of many that have begun to plan or implement universal health care programs.

Other states such as Connecticut, Maryland, New Hampshire, New Jersey, Vermont, West Virginia, and 4 counties in California have begun to reform their SCHIP programs to widen their coverage for children. Also in 2006, Illinois passed a state bill called All Kids to expand its SCHIP program and provide health care coverage to all children in the state of Illinois.\(^5\) Although the
pseudomanded insurance model failed in the 1990s, because of Massachusetts’ and these other states’ initiatives, a more accepting position on universal health care in the United States is gaining momentum especially in regard to covering children.

There are 4 main alternatives being explored in the United States regarding this “children first” approach to universal health care. First is a single federal program to cover all children that is similar to the single federal Medicare program. The second is a hybrid program of the Medicaid and SCHIP programs, which seeks to insure those children not covered under employer-sponsored or private plans. The third is a federal wraparound program that would insure those children not covered under employer-sponsored, other private or public programs such as Medicaid and SCHIP. Although it did not pass in Congress, an example of a wraparound program was the MediKids Health Insurance Act of 2005. The fourth children-first approach calls for an expansion of the current SCHIP program that would relax eligibility criteria and require parents to provide health insurance to their children.

Although President George W. Bush has not focused much of his administration’s attention on the US health care system, his January 2007 State of the Union address unveiled a new change in the taxation of health insurance premiums, which is designed to help more Americans afford private health insurance. The president’s health care reform plan contains 2 parts. First, it proposes a standard health care deduction so that all Americans can receive the same tax breaks when paying for private health insurance regardless if they are purchasing health insurance through an employer or individually. The second part is to provide federal funding to states for them to assist their citizens in obtaining private health care.

Health care reform essentially focuses on the growing population of uninsured Americans. The uninsured patients pose a concern to the United States because those without coverage are increasing health care costs to the whole population. As a result of cost shifting and increased health care GDP, they will likely to put a strain on taxpayers who finance Medicare and Medicaid. The position of the main Democratic presidential candidates is that universal health care is the solution through mandated insurance. The current Republican position is that, by providing tax incentives, more Americans will benefit from lower cost health care and be able to invest in the private health care industry. Essentially, the result is the same behind these 2 concepts—to create access to affordable, quality health care to all Americans.

**Pricing structure and responsibility of payment in the US health care system**

Financing of the health systems in the United States varies just as greatly as does the means for access to health care coverage. There are many entities and parties involved in financing the health care system of the United States. As stated earlier, in the United States, 44% of the health care GDP is spent by government or public funds, and therefore, approximately 56% of health care GDP is spent by private parties. In 2004, the total percentage of GDP spent on health care in the United States was 15.3%. According to current projections, national health care expenditure will reach US $2.8 trillion in 2011, 17% of GDP, and grow at a rate of 7.3% between 2001 and 2011. Because of this increase, it is essential for US health care managers and the American public to understand how health care is financed to contribute to the solution of this ever-growing problem.

One of the most unique features of the health care industry in the United States is its dependency upon agency relationships, which is when one party acts on behalf of another. For instance, a health insurance organization acts as an agent for its member when processing payment for medical services. A medical group’s administrator acts as an agent for a physician when negotiating a contract. And a physician acts as
an agent for a patient when treating or referring that patient for treatment. Health care in the United States is distinguished by these agency relationships, specifically in the financing of the industry. Third-party payers, or simply “payers,” is a term used for health insurance organizations that provide payment or reimbursement for medical services, whether it is a public plan, employer group, or others. Essentially, payers are the ones who “pay” on behalf of their members.59

The 2 agencies usually responsible for paying for most of the health care services provided in the United States are payer organizations and patients. Regardless if the payer is for-profit, nonprofit, or public, payers must be fiscally responsible and mindful businesses, not altruistic organizations; therefore, they must make a profit to survive. With some exceptions, when one obtains a policy with a payer in the United States, one is usually contractually obligated to pay a monthly or bimonthly premium for his or her coverage. It is common for employers to pay for some or all of their employees’ premiums, which is called cost sharing, and they do so at a discount when offering group insurance.44 Payers seek to make a legitimate profit from these premiums as they are taking a financial risk on their members that the premiums that they receive for the policy will be in their financial favor. Therefore, for this system to be effective and for them to continue to provide insurance, the total money they take in for premiums must exceed the total money they pay out in claims or reimbursement.45

Most health insurance policies will require that the insured members not only pay premiums, but that they also contribute to the cost of the medical care that they receive in the form of deductibles, co-pays, and/or coinsurance. A deductible is a fixed amount that the insured must first pay OOP before the payer will contribute to any medical services.45 These deductibles vary greatly from policy to policy, from payer to payer. For instance, one could have an individual deductible of US $500; therefore, that individual must pay for the first US $500 worth of medical services received before the payer will contribute.

Even after the insured members meet their deductible amount, they are usually still responsible to pay for part of each medical service received as co-pays or coinsurance. Co-pays and coinsurance are similar in that they are partial contributions to medical services received. A co-pay is a flat amount paid by the insured for a medical service, such as a visit to a physician’s office or hospital. Co-pay amounts usually increase with the level of medical services received. For instance, under the same policy, a visit to a PCP may be a US $10 co-pay, whereas a visit to a specialist may be a US $25 co-pay or to the emergency room a US $100 co-pay.44

Coinsurance is when the insured pays for a percentage (ie, 20%) of the total cost of medical services received. Coinsurance percentages may remain the same regardless of the level of care, but because the cost for services increases from a PCP to a specialist to the emergency room, the patient is usually incrementally paying more in coinsurance.44 Additional benefit services, such as pharmacy, optical, dental, and mental health, also operate under this co-pay or coinsurance model, depending on the policies.

Many polices also include stop-loss provisions called OOP maximums and lifetime benefit limits. An OOP maximum is an amount the policy outlines up front as the total amount the policyholder would have to pay for covered medical services in a given time period, which is usually 1 year. Amounts paid by the policyholder for deductibles, co-pays, or coinsurance applies to the OOP maximum; however, premiums do not. An OOP maximum will differ between individual and family plans and can, for example, be anywhere from US $1,500 to US $5,000 or more. Some policies may also carry a lifetime benefit limit, which is the total amount a payer is willing to pay during the lifetime of the policy for all covered medical services. Lifetime benefits limits tend to be either US $1 or $2 million.44
It is important for one to take into account the medical services that one feels may be in their or their family’s future when selecting a policy. For instance, it might be appealing if a coinsurance-modeled policy has a lower premium than a co-pay modeled policy. However, one must keep in mind that paying higher premiums yet flat rate co-pays may suit one’s needs if there is an expectation for a large medical bill, such as for a chronic condition or birthing delivery. Therein lays the financial risk. It is impossible to fully predict one’s future health care needs. If an insured finds himself or herself at a financial disadvantage because of an unexpected surgery, accident, or illness, he cannot change his mind midpolicy, especially as a member of group insurance. Employer-sponsored group insurance can usually only be changed or obtained during a time period called “open enrollment,” in which many times are offered once a year for a 30-day period. Generally, if a policy offers a high level of coverage, meaning the payer is contracted at a higher risk to pay more for medical services, the higher the price of the premiums.

Employer-sponsored coverage is federally tax exempted for the employer, and certain laws allow for personal tax deduction as well. Approved health care contributions are medical care deductions approved by the Internal Revenue Service such as insurance premiums, hospital services, long-term care, and dental, chiropractic, and acupuncture treatment. There is a growing industry of organizations designed to help manage the individuals’ financial contribution to their health care. For example, flexible spending accounts can be offered from employers as a part of a benefits package, which allows for the employee to deduct a voluntary amount from their salary to reimburse Internal Revenue Service–qualified OOP medical expenses. Health savings accounts are voluntary tax-exempted accounts set up with a health savings accounts trustee to pay for or reimburse Internal Revenue Service–qualified medical expenses. Health savings accounts are only available to those who are uninsured and those with high deductible individual health insurance.

The charge for medical services in the United States depends greatly on the means for providing payment. Payers contract with providers at negotiated rates. These rates tend to be based on either the Prospective payment system (PPS) or usual, customary, and reasonable charges, which are predetermined charges for medical services based on particular geographic region. Prospective payment system was established through the language of Amendments to the Social Security Act in 1983. Prospective payment system imposes a system of reimbursing hospitals for services provided to Medicare recipients. Hospitals are reimbursed based on a diagnostic code, or codes, assigned to the patient called diagnostic related groups. Under PPS and based on the assigned diagnostic related groups, hospitals are paid a set fee to provide treatment to Medicare patients regardless of the cost of treatment. When PPS was originally introduced, there was a concern that patients may be discharged “quicker and sicker,” because the hospital only received that flat payment regardless of treatment provided. This turned out not to be the case as care processes were found to have improved and mortality rates were found to have either lowered or remained unchanged. Many private and state Medicaid plans have adapted the PPS as a means to set charges in their own contracting.

Capitation is a managed care concept often used by HMOs as a means to control health care costs. It is when an HMO pays a set amount per member per month to a medical care provider in order for that provider to make contracted medical services available to those registered members. The per-member-per-month covers all contracted medical services provided to the registered member at no additional cost to the HMO. This becomes a problem to the health care provider when there is a risk of excess utilization because of the need for a high volume of services. Capitation is used as a means to shift some of the financial risk.
off of the HMO to the provider and is used as an incentive for the provider to limit unnecessary services. Because the provider does not get paid for any additional care, capitation serves as a deterrent to overutilize.\textsuperscript{50}

The Emergency Medical Treatment and Active Labor Act of 1986 was designed to prevent hospitals from turning away those who showed up at emergency rooms, even if the situation was not considered an emergency, yet were unable to show an ability to pay.\textsuperscript{45} The Emergency Medical Treatment and Active Labor Act results in what is known as charity cases, which is when one is treated by or admitted to the hospital when there is no expectation to receive payment for services. Uncompensated care is considered a combination of charity, such as those receiving services protected by the Emergency Medical Treatment and Active Labor Act, and bad debt, which is generated by those admitted with a commitment to pay, such as in the form of coinsurance, but do not make the payment. Accounting regulations do not allow hospitals to consider uncollected charges on charity cases as generated revenue because there was never an expectation of collected payment. Bad debt, however, is considered an expense for accounting purposes, which is similar practice in other industries regarding uncollected accounts receivables.\textsuperscript{45} Uncompensated care is found to indirectly affect those able to pay by shifting and dispersing these uncollected expenses to those that are able to pay. Cost shifting is when a hospital, or any health care provider for that matter, raises prices to one set of buyers while reducing the cost to another set of buyers. This can be directly in the form of cost-shifting fees charged to patients or applied to managed care in the form of cost-shifting premiums collected from members.\textsuperscript{45}

**COMPARISON OF THE HEALTH SYSTEMS OF THE UNITED KINGDOM AND THE UNITED STATES**

The current health systems in the United Kingdom and the United States largely grew out of The Great Depression and World War II. Facing similar economic challenges in a postwar world, both governments experienced political and social pressure to provide their respective population better access to health care. They have since progressed in opposite directions in their system development.

The British government’s solution was universal health care with one fully comprehensive national health system. This system, the NHS, answered the British people’s immediate demand for a guarantee to health care access when it began operation in 1948. At the end of World War II, it was the private sector in the United States that largely took on the responsibility of health care access. Beginning with the development of Blue Cross and Blue Shield, the US market saw a steady increase in health insurance companies and programs, including the creation of the government Medicare and Medicaid programs in the 1960s. Because the United States does not offer universal health care, the private health industry, along with Medicare, dictated much of the inevitable progression toward the managed care movement.\textsuperscript{45}

Although the US and the UK health systems differ significantly in the level of government involvement and social responsibility, both systems operate very similarly in terms of delivery. Both tend to use primary care as the first point of entry and operate under regional, functional, and specialty subsystems. Although these subsystems are owned and operated by the government in the United Kingdom and by private entities in the United States, it is truly in the responsibility of payment where there is an obvious deviation.

The UK population has access to NHS health care facilities and services that are funded through general taxation. Although health care access is provided and paid for by the UK government, it is the people, through taxation, who essentially pay for their own health care. The NHS Plan seeks to greatly involve the patients and frontline staff in its future, yet the administration of
the entire NHS system really serves as a function of the UK government.

In the United States, access to health care facilities and medical services are largely paid for by a combination of payers (whether public or private), employers, and patient contribution. The US health system relies on the function and policy influence of both public and private organizations to operate as an enterprising, free market. Although approximately 44% of US health care expenditure is publicly funded, essentially all funding originates from private households in the form of payroll deductions, taxes, and donations.12

Although health care funding in the United Kingdom is government controlled and health care funding in the United States is predominantly private controlled, both essentially are only made possible by the contributions made by the people. The main differences are the level of government involvement and mandatory taxation versus voluntary contributions. The United Kingdom provides health care access to all using a similarly run health delivery system to the United States, whereas the United States is suffering the economic burden of their uninsured. Therefore, the United States has essentially failed in providing Americans with affordable health care options and education on the impact it has on the economy.

The United States is fundamentally founded upon its guarantee of rights and freedoms to its citizens. Formal education is considered and accepted as a right to all in the United States. Not only does the United Kingdom recognize similar rights and freedoms as the United States, but it also includes the right to receive proper access to health care.1 And just as if one chooses private over public education in the United States, one has the opportunity to choose private over public health care in the United Kingdom.40

Although there is a movement in the United Kingdom for greater involvement between the NHS and private health care,63 there is also a movement in the United States for health care reform that may include the implementation of a universal health care system. Therefore, 2 health care systems that have historically been considered at opposite ends of the spectrum have begun to explore new ways of approaching their respective systems and have found benefits in the function and delivery of each other. Essentially, these systems are more similar than they are different, and their goal is the same—to provide high-quality, affordable access to health care to their respective populations.

REFERENCES