Appendix 1: A

Canada;

Canada provides its citizens with a with universal health insurance coverage, at a cost of 8.6 % of GNP. It uses provisional government (each provisional government has its own insurance program) as the principal payer in health care, and that has not only controlled the cost but assured the quality as well. The vital component of this policy is the enhanced co-operation between the federal and the provisional government, and between provider and the consumers

. The federal government conditionally promises each province that it will prepay roughly 40 % of the cost of all necessary medical care, as long as the provinces health insurance program is universal (covering all citizens), comprehensive (covering all conventional hospitals and medical care), accessible (no limit on service and no extra charges to the patient), portable (each province recognizes the others' coverage), and publicly administered (under control of public, non-profit organization). The provisional ministry of health is the only player in each province, reducing the administrative cost to a minimum. Not surprisingly each of the 10 provinces have their own insurance program / schemes which fits these criteria.

The other features of the Canadian system include;

- Most of the hospitals are non-profit community institution
- Physicians receive fee-for-service payment and negotiate hospital budget and physicians fees with provisional governments annually.
- Patients choose their own doctors.

Appendix 1: B

New Zealand;

In New Zealand, the government provides most hospital services but majorities of the primary health care services are privately owned. That means that the primary and the secondary health care services are separately funded. That has resulted in fragmentation in patient care and cost is also shifted.

Appendix 1: C

Germany;

Germany is another example of a social insurance scheme. Insurance premium are deducted from the payroll and the individual can choose for them to be paid into district, national or factory insurance funds of which there are about 1,100. There is a strict separation of inpatient and ambulatory health care services and hospitals are not permitted to have outpatient departments. The local general practitioners are largely specialist and they act as gatekeepers to the more expensive hospital services.

The insurance funds negotiate with the provider hospitals on a regional basis but the large number of funds makes it difficult to exert real purchasing power over the provider. It might be argued that this is not social insurance at all but a hypothecated payroll tax in which the proceeds are 'ring fenced' for the provision of health care. But this has permit a greater public influence over the level of expenditure in health acre than in other system such as NHS in UK.

Appendix 1: D

NHS in United Kingdom;

The National Health Services in the United Kingdom provides 100.00 % coverage of the population through a service financed by the general taxation and National Insurance contribution. The service is largely free at the point of need and there are few charges apart from the prescription charges for the pharmaceutical and the appliances and charges for the optical services such as: sight test. These charges are not levied on those with low income, the elderly, the children, pregnant woman, or chronically sick.

Parliament votes a sum of money on an annual basis to NHS in competition with the other government departments. This is then allocated using a capitation system to local health authorities that contract for services from autonomous, but largely public, NHS trust hospitals and community health services. Access to the secondary health care is controlled by the gatekeeper general practitioners that practice in-groups with a family medicine orientation.

There is no direct access to the specialist health care apart from the accident and emergency department of the local hospital. Private health insurance is limited to the 10 % of the population who often share the cost of premiums with their employers through occupational-based schemes. Private health care is largely limited to the elective surgery and provides convenience and a higher standard of hotel facilities than is usually available in the NHS.

General practitioner fund holding schemes now cover more than 50 % of the population and are an attempt to increase the range of general practice activity, thus reducing the demand for more expensive secondary care and increasing the number of purchasers in NHS market and so the incentives for hospitals to increase efficiency and responsiveness. The GP's are funded by a combination of funds for services; a capitation payment based on the list of registered patients, and fees for service payments for special activities.

The UK spends a comparatively low proportion of its GNP on health care and might be thought to be economic.

Appendix 1: E

Netherlands;

The Netherlands operates a social insurance in which the low and the middle incomes (61 %) are obliged to pay for health care insurance and remaining high income (39 %) chooses to pay health care insurance. Both group receives an employer's contribution and retirement and unemployment funds are required to have a health insurance element to cover those who are not employed.

The insurers are obliged to accept all middle and low-income people regardless of conditions and risks, operates as economically as possible, and negotiate the lowest fees and hospital budgets from the providers.

The general practitioners are the gatekeepers and there is a minor system of co-payments to try dampening demands. There is an exceptional medical expense arrangement operated through the sickness funs and insurers which covers the whole population for long term care which would go beyond the range of insured entitlement.

Appendix 1: F

France;

France has got the most expensive health care system in the EU, and the government has been trying very hard to reduce the cost of the health care. The social security scheme is largely occupationally based and the patients have the right to consult specialist or generalist in the community but must be referred to hospital specialists. The social security funds provides about 74 % of the funds, mutualist insurance a further 7 %, and co-payments a further 19 %.

The cost of the ambulatory care is billed directly to the patient, who is then reimbursed 75 % of the fee in few days. For the first 30 days in the hospitals the patient is billed and similarly receives 80 % reimbursement, after which the bill is paid directly by the sickness fund. The patient pays a small fee for accommodation while in hospital, charged on a daily basis. Individuals are free to take out supplementary insurance to cover the additional of cost, which is not reimbursed.

Appendix 1: G

United State of America;

The America has the most expensive health care system in the world. It is based on the assumption of private insurance taken out by the employed, supported by a vast safety net scheme for elderly, poor, mentally ill, and those who are not insured.

Approximately about 88 % are insured through a variety of private and NFP insurer and will have a limited entitlement for health care. This group is likely to experience the best health care in the world while their entitlement holds out. Some of this group is prove to be underinsured or will experience health episodes which exhaust their cover, meaning that they have to rely on their own resources, family or other charitable funds.

The military and the veterans have their own high-quality health care system, which may make use of military facilities or may contract for care with private hospitals or other health care institutions.

The elderly are covered through a scheme called Medicare, in which the cost of their health care are shared between federal and state governments. A similar cost sharing arrangement applies to the poor, some of whom are covered through the Medicaid scheme. Both of these schemes are designed to enable eligible persons to receive care through the private hospitals rather than being dependant upon the local state hospitals or emergency rooms which are frequently undersourced and overcrowded, providing as their name suggests basic health care to those who have no alternative.

The Americans have had the most incentives to try to reduce the cost of the health care and so many of cost control mechanism such as prepayment mechanism, diagnosis-related groups, global hospitals budgets, health maintenance organizations, and co-payment mechanisms among other have

been attempted and developed in USA. That none of them have been entirely successful is seen by the very high cost of the US health care system.

Appendix 2

Managed Care Organization -- concerns

There are various issues related to MCOs from payer, provider, and user prospective

Concern of doctors

- Capitation may be insufficient
- Patients with multiple problems
- Restrictions on referrals
- Doctor-patient relationship
- Loss of patients confidentiality
- Practice guidelines

Concerns for patients

- Designated doctors
- Visits to doctors restricted
- Choice of medicine restricted
- Referrals by panel doctors only
- Difficult to get specialist of own choice
- Distrust of system

Cost containment

- Has impact on users and providers
- It is not cost cutting / saving
- Cost of services can not remain unchanged

- Cost of services are expected to rise with improvement in quality and inflation

For employers

- Saving in manpower cost
- Lower medical leave days
- Lesser visits to the doctors
- Easier to budget health care cost

Marginalized groups;

- Poor
- Handicapped
- Old
- Very young
- indigent