

Introduction
consumers and
political factors
continue to make



**ASSIGN
BUSTER**

\n[[toc title="Table of Contents"](#)]\n

\n \t

1. [Introduction](#) \n \t
2. [Health Care in USA](#) \n \t
3. [Health Care in the UK](#) \n \t
4. [Health Care in Canada](#) \n \t
5. [References](#) \n \t
6. [Appendix](#) \n

\n[/toc]\n \n

Introduction

To give some insight into different approaches of resource usage a comparison of Health Care operation and management in various countries may be useful. It is for this reason this reason this paper will provide a brief comparison of the operation and management of Health Care in the UK, USA and Canada. This is important due to relative scarcity of resources in both rich and poor countries that has caused inadequacy of available public resources for health care to meet the demand (Brandeau, Sainfort, & Pierskalla, 2004). Based on this observation the work of policy makers and health care providers involves determining how to make the best use of the limited resources available. Despite the scarce resources human health noted significant improvements in the past 50 years. Life expectancy which was 47 years in 1950, rose to 61 years in 1980 and finally to 67 years by 1998 (Brandeau et al.

, 2004). Much of this improvement was due to improved nutrition, sanitation and medical innovations and their role in low and middle income countries. However, despite the use of varied approaches to Health Care significant differences still exist in various countries. This is evident upon observation of data from these countries.

It has been mentioned that though the US spends the most per capita on Health Care, the country also has the largest amount of out of pocket expenditure for Health Care services (Peterson & Burton, 2008). This suggests that policy may need to be changed to allow for better and more comprehensive national Health coverage. Due to issues such as disease prevalence and prevalent economic conditions, governments must determine at the highest level what amount of resources they will spend on health care. The government is also expected to design and implement feasible payment schemes for physicians and other health care providers (Brandeau et al.

, 2004). In addition to the above decisions, governments must also make crucial decisions in relation to the structure of health care systems. The government decides on geographic areas to allocate resources, specific programs to allocate resources and specific health issues to allocate resources (Brandeau et al.

, 2004). In addition to these economic and structural decisions the government must also handle policy issues that have a major impact on health care. In this paper the discussion presented will discuss health care

operation and management in England, Canada and the USA along these lines.

Health Care in USA

Currently health care is the biggest service based business around the world (Patel & Rushefsky, 2008). This is supported by data that indicates that between 1960 and 1997 the percentage of the GDP (Gross Domestic Product) spent on health care by 29 members of the OECD (Organizations for Economic Cooperation and Development) doubled from 3.9% to 7.6% (Saito, Wickramasinghe, Fujii, & Geisler, 2010). Of these countries, the USA was the highest spender in 1997 with a reported 13.

6% of the GDP being allocated to health care (Saito et al., 2010). Health care in the USA is funded through a combination of private and public sources (Sultz & Young, 2010). Based on this arrangement it is noted that most working Americans under the age of 65 are covered by private insurance which is provided by their respective employers. On the other hand the main financing for public sources comes from Medicare which covers health services for individuals over 65 and Medicaid which caters for the low income segment of the population (Sultz & Young, 2010). However, the influence of various stakeholders such as providers, employers, consumers and political factors continue to make changes to the existing system. This is seen in the varied topics discussed in the national health care reform debates (Sultz & Young, 2010).

Through such discussions tensions often arise such as those about the role and responsibility of the government as a payer, consumers, relationships

between cost and quality and the impact of systems on quality. The two most significant challenges in this plan include dealing with an estimated 47 million uninsured or underinsured and controlling rising health care costs (Sultz & Young, 2010). In recent years the increasingly prominent role of technology has led to the continued effort to increase the role of technology in operations. The main reason behind this stems from the fact that this can reduce operation costs, improve cost effectiveness and service delivery (Saito et al., 2010).

Surprisingly despite the increased use of technology there has been a continuous marked increase in the cost of health care across the US and is evident on observation of organizational budgets. It has been reported that on average in the US the annual budget for health care institutions increases by between 5% and 15% (Langabeer, 2008). This position would only be possible if expenses could be maintained thus allowing the institution to maintain similar pricing levels for services. There are several reasons that have been suggested to be the cause of this trend within the US health care industry. Because of this escalating costs health care has become an issue of major dissatisfaction among the American public (Patel & Rushefsky, 2008). Despite changes that have been made to policy it seems the upward trend has continued as this century progresses (Greenwald, 2010). This is especially an issue due to the fact that most of the payments for health care services are based on health insurance. It is reported that in the 1970's most Americans never paid anything out of pocket for health care (Greenwald, 2010).

The current situation is significantly different with public and private insurers continuously seeking ways to reduce coverage for individuals. As a result health care costs are higher and more Americans are likely to cater for these expenses out of pocket ((Naden, 2010). The escalating cost of health care has begun to raise serious concern in many quarters. For example, the American employers complain that the high cost of employee coverage has strangled international competitiveness (Greenwald, 2010). On the other hand the recipients of health care are indicating a lack of comfort with increasing out of pocket expenditure. Due to this some studies have indicated that health care costs are the main contributing factor to the majority of bankruptcies in the US. It is reported that programs to provide health care to the poor and elderly consume a portion of the federal budget far in excess of defense expenditure (Greenwald, 2010).

Because of this obligation to provide health care to the poor the nation is under serious financial stress forcing it to make cuts on other essential budget areas such as infrastructure maintenance and education to satisfy health care obligations (See Appendix A). At the same time Americans began to show concern for the quality of service that they were receiving (Patel & Rushefsky, 2008). This due to data that suggested the quality of service was below what was seen in other similar countries.

For example, despite having the highest per capita expenditure on health care, the infant mortality rate was higher than in most other wealthy industrialized countries (Porter & Teisberg, 2006). Statistics from 2004 indicate that Singapore has the best performance in prevention of infant mortality and records two infant deaths per 1000 live births. During the <https://assignbuster.com/introduction-consumers-and-political-factors-continue-to-make/>

same year the US recorded 6.8 infant deaths per 1000 live births. At the same time despite increased life expectancy, it has been reported that by 2003, the US was ranked 16th in life expectancy worldwide (Greenwald, 2010). The economic downturns that were part of the early 21st century are in part responsible for the current situation in the US (Trough, Wagner & Doz, 2010). It is reported that at this time many Americans received health insurance coverage through their employers or the employers of parents and spouses (Greenwald, 2010).

Following the major global economic events of the beginning of this century, it was estimated that by 2009, almost 3.7 million Americans had lost their health cover due to unemployment (Greenwald, 2010). This trend caused even greater concern among millions who though employed realized the possibility of losing health insurance if the economy continued its downward trend. Due to problems with the health care system many citizens have started to raise questions in relation to the application of social justice within the system. This comes to light due to the fact that it appears the health care system serves the nation unevenly (Greenwald, 2010). This is evident in reports that suggest inequality in provision of health care services is prevalent when racial groups and economic strata are considered (Patel & Rushefsky, 2008). Based on this it has been reported that individuals with higher incomes, advanced education, and do not come from minority communities tend to receive more services, have better health status and live longer than their less advantaged counterparts (Byrd & Clayton, 2002). One point that is slowly becoming clear is that there are serious knowledge

gaps in relation to the health care industry and this has led to disillusionment among the American public (Sultz & Young, 2010).

This is due to the fact that the public originally had a perception of healthcare as a necessity provided by physicians who adhere to scientific standards in the provision of service. However, the current system contains major variations in therapeutic and diagnostic procedures that do not seem to produce a major variation in the outcome. The solution to the problem lies in major system wide reforms that should bring about increased efficiency in the system. This especially important given that the country spends far more on health care than many of its counterparts (Sultz & Young, 2010). It has been noted that despite the massive expenditure on health care the US is currently unable to provide health cover to almost 17% of the population. This comes in addition to the fact that the country ranks poorly in terms of system wide measures such as life expectancy and infant mortality (Sultz & Young, 2010). The problems with the health care system continue to cause major problems within the country and even the health care system employees are beginning to become discouraged. This comes in light of institutional and agency administrators who suggest they care for patients but must reflect over riding budget considerations in every action (Sultz & Young, 2010).

Such administrators have caused much confusion and demoralization among health care employees. It should be noted that most employees in health care chose a health occupation because of a sense of caring and social justice (Sultz & Young, 2010). The realization that the tradeoffs made to

pursue these careers and the reality is different has caused significant loss of moral among the staff.

Health Care in the UK

In the United Kingdom the main body concerned with health care is known as the National Health Service (NHS) (Henderson, 2011). The NHS serves the purpose of providing services in a manner that provides social equality and collective compassion. The NHS was formed under the Health Authorities Act of 1995 that saw the 110 District Health Authorities and 90 Family Health Service Organizations merge to create 100 Unitary Health Authorities (Henderson, 2011). Each of these authorities serves the needs of about 500,000 people. The NHS is the largest employer in the UK with an annual budget of approximately 160 billion pounds and one million employees.

The NHS can be traced to the early nineteenth century that saw the establishment of labor unions and other fraternal associations that provided health care to their members (Henderson, 2011). These activities that typically took place through much of Europe saw employers encourage workers to join these mutual aid societies to reduce public demand for charity care. In 1911, the UK was under the leadership of Prime Minister Lloyd George when the British parliament passed the first national Health Insurance Act (Henderson, 2011).

This act served the purpose of strengthening the voluntary insurance program and provision of a funding mechanism for indigent care. Although membership to mutual aid societies was not mandatory most workers joined and coverage included prescription drugs and services of a General

Practitioner (GP) (Henderson, 2011). This did not cover specialty care and hospitalization which were catered for under Local government support and charity care. Following the World War II, there was a profound change in the attitude towards health care (Greener, 2009). Before the end of the War, the Prime Minister, Winston Churchill gave instructions to study the health care system and provide recommendations for change. These actions lead to the implementation of the National Health Service Act in 1948 (Moran, 1999). The passing of this Act signified that the entire population was covered under a single plan that provided a comprehensive package of benefits.

These benefits would be provided from general tax revenues and were provided free to patients at the point of use (Moran, 1999). The emergence of a single payer concept and limited supervision of service providers kept administrative cost of the system low, despite the fact that the NHS was underfunded and dominated by the medical community (Henderson, 2011). These budgetary constraints coupled with the effects of slow growth during some years lead to politicization of health care delivery and several crises emerged. This trend saw almost one crisis emerge every three years between government policy makers and the medical practitioners (Henderson, 2011). It should be noted that the NHS inherited a resource distribution system that favored metropolitan areas in and around London. This caused some difficulty given that one of the goals of this new system was to address and eliminate existing inequality (Henderson, 2011). This saw targets to increase service provision in underserved regions and reduce expansion in over served regions of the Kingdom.

However, even with these changes there remains disparity in the per capita hospital spending with difference of as much as 40% across regions. Under this system of care every citizen is registered with a GP and is able to access primary and preventive care in this setting. It is reported that there are about 35, 000 GP's in almost 9, 000 practices responsible for almost 90% of all patients (Henderson, 2011). This GP thus serves as the family doctor for the patient and is also a gatekeeper for specialists or consultants within the system. Any patient in the system that requires extensive testing or specialized treatment is directly referred to a specialist or admitted directly to hospital (Henderson, 2011).

Based on this system, it is procedure that anyone requiring an elective procedure is placed on a waiting list. This includes procedures such as cataract surgery, hip replacement, coronary artery bypass and breast reconstruction following mastectomy (Henderson, 2011). This position suggests that any non life threatening procedure is allowed to wait for a while. Statistics from 2007 indicated that there were almost 750, 000 people on waiting lists for hospital admission, a figure that translates to one percent of the population. The target for 2008 in relation to hospital admission was 18 weeks and currently less than 50% manage to gain admission before completion of the duration. It is clear to see that because of the waiting lists those who can afford private supplementary health insurance have purchased it.

For this reason it has been reported that about 12% of the population have health insurance especially in the high income earning bracket and individuals in managerial positions (Henderson, 2011). Of the portion with <https://assignbuster.com/introduction-consumers-and-political-factors-continue-to-make/>

private coverage, two thirds receive it through risk rated policies that are given by employers. The premiums for such coverage must be covered by pretax income and any benefit from the coverage is subject to an income tax and a 5% premium tax (Henderson, 2011). The patients with private care still to a great extent use NHS for emergency and chronic care. The private coverage is mainly to cater for quality of life issues such as hip replacement, gall bladder disease and hernia repair among others. Only about 20% of non emergency surgery is paid for using private coverage and thus it appears this coverage is a safety valve for the NHS.

The private system has been criticized for taking the pressure off the NHS thus slowing the pace of change within the institution. In addition to that, it has been suggested that it facilitates a two tiered system that fosters inequality (Henderson, 2011). This may be true in part given that the average net earnings of self employed practitioners was 161, 624 pounds while that of hospital based practitioners was from 85, 000 to 120, 000 (Henderson, 2011). This difference in salary tends to support the claim as it appears privately employed physicians can earn significantly more than their counterparts in government employ. It is reported that the NHS inherited almost 3, 000 hospitals at inception.

The reorganization within the system today has seen far fewer hospitals in five major categories namely, specialist hospitals, major acute hospitals, elective centers, local hospitals and poly clinics (Henderson, 2011). The number of hospital beds also declined significantly from 480, 000 in 1948 to 165, 000 in 2008. The most recent figures on bed occupancy stand at 84. 5%

for all hospitals. The system is to some degree paternalistic and is mainly concerned with resource allocation.

It has been suggested that the patients in the UK are poorly informed when compared with others in the developed world (Henderson, 2011). For this reason, the physician is the sole determinant on the needs of a patient and as such it is possible that their decisions are governed to a greater degree by rationing than clinical decision (Henderson, 2011). In 1993 the system underwent some degree of reform that saw the inclusion of choice and competition in the system.

Unfortunately competition failed to create the desired improvements due to weak incentives (Harrison & McDonald, 2008). As a result to become a provider of health services, a health organization was required to become a NHS trust. These trusts became independent organizations competing for patients while many GP's became fund holders with their individual budgets (Henderson, 2011). As a result of these changes, by 1995, all health care was being provided through NHS trusts. In addition to that GP's who did not want to become fund holders had budgets centrally controlled by the NHS. Based on this change patients began to receive better treatment from fund holders bringing an end to the complaints from the patient population. This also led to the emergence of a two tiered system (Henderson, 2011).

This disturbing trend came to an end with a change of government that pledged to end the internal market arising within the NHS. The GP fund holding was changed and some 30, 000 GP's were placed in one of 500 primary care trusts (PCT). Each PCT has a budget and provides primary care,

community health services and all other medical services for a population of between 50, 000 and 250, 000 (Henderson, 2011). These reforms shifted the emphasis from a market based model to a government run system based on collaboration and cooperation.

In addition to those changes the new NHS unveiled a 10 year plan that promised more hospitals, physicians, cleaner facilities among other changes. This was promised while the NHS continued to be underfunded and thus suggested an increase the budget. This increase was expected to take place between March 2000 and end of 2005 and would see an average annual increase in NHS spending by 6.

3% (Henderson, 2011). Despite the numerous changes to the health care system it has been noted that inequalities still exist as is evident based on life expectancy between managerial and unskilled groups (Henderson, 2011). The need to reform continues to receive strong opposition as the majorities believe in equal access in preference to quality care (Greener, 2009). Currently the new government is in the process of making changes that will improve the equity of the system (Watson & Ovseiko, 2005). Among the changes will be a freedom to select the service provider to allow for a more patient centered approach to treatment.

Health Care in Canada

The Canadian health care system is based upon attempts at using the Aristotelian model of finding the golden mean.

This is because it is believed that this principle is useful when thinking about health care as both extremes in funding health care are dangerous
<https://assignbuster.com/introduction-consumers-and-political-factors-continue-to-make/>

(Fierlbeck, 2011). It has been observed that the golden mean is based on desirable qualities of the given health care system. Such qualities include cost containment, efficiency, equity, universality, comprehensiveness and responsiveness (Fierlbeck, 2011). The main objective of the Canadian health care system is to provide a national mechanism that satisfies such requirements (OECD, 2001). The current health Canadian health care system can be traced to 1947 and the efforts of Tommy Douglas through the introduction of a publicly funded university hospital in Saskatchewan (Fierlbeck, 2011).

However, others mention that it was not until 1972 that the Canadian health care system was fully established. These points are both true to some extent due to the fact that Canada does not have one health care system but has 13 due to the role of each territory on health care in its jurisdiction (Fierlbeck, 2011). Based on this therefore it is observed that some provinces such as Ontario had publicly financed health care in place from the early twentieth century. However, it was the Saskatchewan universal hospital insurance plan that acted as a model for the subsequent developments in various states.

Following these actions in Saskatchewan, by 1957 Ottawa agree to cost share the program with any province that would agree to conform to four basic principles namely, universality, comprehensiveness, portability and public administration (Fierlbeck, 2011). Based on this the 1966 Medical Care Act formed the basis for the current Canadian Health Act (CHA) of 1984 (Naylor, 1992). Based on the provisions of this legislation all provinces were involved in both cost sharing programs with the federal government. The <https://assignbuster.com/introduction-consumers-and-political-factors-continue-to-make/>

voluntary coordination of health services in all provinces by the federal government is what generally constitutes the Canadian Health Care system (Fierlbeck, 2011).

The Canadian Health care system is a fragmented system controlled by various federal governments but coordinated by the state with consent of the provinces. Based on this arrangement the larger part of hospital and physician care is covered through public insurance in Canada (Fierlbeck, 2011). However, many medical goods and services are not included in this coverage.

The health services are generally catered for by private practitioners who are either reimbursed by public or private insurance and in some cases out of pocket payments (Fierlbeck, 2011). The majority of hospitals in Canada are private not for profit institutions that are funded through a global budget from provincial departments of health. While all Canadians are free to select their GP (Or switch GP's as they please), the territories use a gatekeeper system under which patients have access to specialists only through referral by a family physician (Fierlbeck, 2011). Both the GP's and specialists are reimbursed by the provinces based on guidelines and fee schedules determined in discussions with the professional associations. Services that are publicly funded include GP services, hospital care and diagnostic services performed in hospitals.

Most of the funds used to cater for these expenses come from the provinces respective tax bases, where less than 20% of health care expenditure is transferred to provinces from Ottawa (Fierlbeck, 2011). In Canada two

provinces namely, British Columbia and Quebec levy health care premiums which are considered taxes as they go directly into general revenue as opposed to health care programs. Access to all publicly insured services is granted to all regardless of whether the premiums have been paid or not. In four states, Manitoba, Ontario, Quebec and Newfoundland, the authorities levy payroll based taxes those these are not like true payroll based schemes where only those who pay can benefit (Fierlbeck, 2011).

Rather these funds are earmarked for payment and go directly into general revenues to be distributed among the general public. It should be noted that long term care and services such as pharmaceuticals are not covered under the CHA (Fierlbeck, 2011). However, several provinces have programs that cater for these through a varied approach to finance (Baylis, 2011). This is because while CHA does not cover pharmaceuticals, most Canadians have insurance for pharmaceuticals (Fierlbeck, 2011). This is seen in territories such as Quebec which require employees to enroll for private insurance for drug coverage. Others territories such as Saskatchewan, Manitoba and British Columbia have income based pharmacare programs. Other states also include drug coverage for seniors or catastrophic drug requirements. However, the majority of Canadians simply have voluntary private drug coverage (Fierlbeck, 2011).

This health care system is influenced by pressures for change and attempts to identify channels to implements change as with any other health care system (Caulfield & Tigerstrom, 2002). The primary difference is that these decisions rely on a largely on legal institutions (Constitution and CHA), economic pressures, politics, versus the voters (Fierlbeck, 2011). These <https://assignbuster.com/introduction-consumers-and-political-factors-continue-to-make/>

opposing forces often have very different demands and the key to maintaining the balance in the system have been the golden mean principle that guided the formation of the CHA (Caulfield & Tigerstrom, 2002).

References

Baylis, F.

(2011). Health Care Ethics in Canada. Printed in the USA: Nelson Education Ltd. Brandeau, M., Sainfort, F.

, & Pierskalla, W. (2004). Operations Research and Health Care: A Handbook of Methods and Applications. Norwell, MA: Kluwer Academic Publishers. Byrd, M., & Clayton, L.

(2002). An American Health Dilemma: Race, Medicine, and Health care in the United States. London: Routledge. Caulfield, T., & Tigerstrom, B. (2002). Health Care Reform & the Law in Canada: Meeting the Challenge.

Edmonton: The University of Alberta Press. Fierlbeck, K. (2011). Health Care in Canada: A Citizens Guide to Policy and Politics. Toronto: University of Toronto Press.

Greener, I. (2009). Health care in the UK: Understanding Continuity and Change.

Bristol: The Policy Press. Greenwald, H. (2010). Health Care in the United States: Organization, Management, and Policy.

San Francisco, CA: Jossey Bass. Harrison, S., & McDonald, R. (2008). *The Politics of Healthcare in Britain*: London: SAGE publications Ltd.

Henderson, J. (2011). *Health Economics and Policy*. Mason, OH: South-Western. Langabeer, J. R.

(2008). *Health Care Operations Management: A Quantitative Approach to Business and Logistics*. Sudbury, MA: Jones and Bartlett Publishers. Moran, M. (1999). *Governing the Health care state: A Comparative Study of the United Kingdom, the United States and Germany*. Manchester: Manchester University Press.

Naden, C. (2010). *Health Care; A Right or a Privilege?* White Plains, NY: Marshall Cavendish Corporation.

Naylor, C. (1992). *Canadian Health care and the State: A Century of Evolution*. Printed in Canada: McGill-Queen's University Press.

Organization for economic Development and Cooperation (OECD) (2001). *Canada*. France: OECD Publishing. Patel, K., & Rushefsky, M. (2008). *Health Care in America: Separate and Unequal*.

New York: M. E. Sharpe, Inc. Peterson, C., & Burton, R. (2008).

The US Health Care Spending: Comparison with other OECD Countries. New York: Nova Science Publishers Inc. Porter, M., & Teisberg, O.

(2006). Redefining Health Care: Creating Value based Competition n Results. Boston: Harvard Business School Publishing. Saito, M., Wickramasinghe, N., Fujii, M., & Geisler, E.

(2010). Redesigning Innovative Healthcare Operation and the Role of Knowledge Management. Hershey, PA: Medical Information Science Reference. Sultz, H., & Young, K. (2010).

Health Care USA: Understanding its Organization and Delivery. Boston, MA: Jones Bartlett Learning. Truth. C., Wagner, M., & Doz, P. (2010). Universal Health care Problems in the United States of America.

Victoria, Canada: Friesen Press. Watson, J., & Ovseiko, P.

(2005). Health Care Systems: Major Themes in Health and Social Welfare. Abingdon, UK: Routledge.

Appendix

Appendix A: Growth in Health care costs (Greenwald, 2010). Appendix B: Comparison of Healthcare Expenditure among OECD Countries (Peterson & Burton, 2008). Appendix C: Health Care Expenditure in OECD Countries (Peterson & Burton, 2008).