Single Payer Summaries
Revised: July 19, 2005

	Australia	Canada	Denmark	Finland	Italy
Population	19 million	31million	5.3 million	5.2million	58 million
US-sized population	New York	California	Minnesota	Minnesota	California +Texas
Government	1901: Constitutional parliament Parliamentary government	1867 Constitutional monarchy Parliamentary government	1849: Constitutional monarchy Parliamentary government	1917: Constitutional republic Parliamentary government	1948: Parliamentary republic Parliamentary government
National Health Service started	1984	1968	1970	Long standing	1978
NHS Major Modification	1999	1984 2004	1973 1993		1992 1998
Defined benefit package	No	No	No	No	No
Public satisfaction		Broad public support but push for greater Federal spending	High		Low
Excluded population	None	None	None	None	None Illegal immigrants get fewer services
Funding sources	Taxes	Taxes— Primarily provincial Alberta and BC require premium	Taxes Primarily local	Regional taxes	Taxes— + social health insurance
Funding distribution	National and Provincial budgets	National and Provincial budgets	National budget negotiations	Weighted capitation using age and health status	Weighted capitation to local health unit using age and health

					status
Out of pocket payments	Yes MDs unless physician accepts assignment Drugs	No--except excluded services	Yes Dental, Drugs copays Glasses Physiotherapy	Set by counties capped by national limit for individuals Inpatient: 8.5 Euros/day Drug copays	Copays for Diagnostic procedures, Drugs, and Specialists Outpatient copays capped at 36 Euros.
% private expenditures	11%	30%	18%	24%	32%
Tiers of Admin	Three— National States Counties (Shires)	Two: Federal Provincial	Three National, County Local	Three National Municipal 20 Hosp districts	Three National Regional Local
System governance	States	Provincial	County	Municipal government	Regional governments
Care Delivery: Primary care	Self-employed practices	Self-employed practice	Self-employed practices with number and location controlled by counties	Primary care centers	Independent contractors to NHS
Care Delivery: Secondary and above	Hospital based but mix of self-employed and salaried physicians	Hospital based	County hospitals	Public hospital based	Hospital based—public and non-profit
Care Delivery: LTC	Private sector		Local government	Local government	
Payment to hospitals	Public and private hospitals are paid by state and private insurance. Public payment not described.	Global budget adjusted by historical Volume and case mix Capital paid separately	Moving from global budget to per discharge using DRGs	Perspective payment per discharge or visit—increasing use of DRGs	Per discharge PPS using DRGs

	Private insurance by contract agreement				
Payment for Physicians	Fee-for-service	Fee-for-service with cap	Primary Care: combination FFS+capitation Non-hospital specialist: fee-for-service Hospital specialist: salary	Primarily salaried	Primary care: Capitation plus FFS for minor surgery Bonus for efficiency. Specialist: Salary
Choice of MD	Primary Care Yes Specialist: Referral generally required	Yes	Primary Care: Yes Gatekeeper model for specialists	Primary Care: Limited choice	Primary Care Yes Gatekeeper model for specialists (Broad referral to specialty rather than person)
Hospital governance	Mixed: Public and private hospitals	Local boards	County or Copenhagen Hospital Corp		Tertiary hospitals are quasi-independent public agencies Secondary hospital are within local health units
Pluralistic delivery system	Mixed	Yes	No Local government	No Local government	61% public hospitals 39% nonprofit
Excluded services	Glasses, Dental, Podiatry Cosmetic surgery	Dental care Routine eye care Drugs Ambulance	Glasses	Glasses	
Private insurance	Yes for Broader choice of	Yes for excluded services	Yes for copays and out of pocket costs	Yes but only 0.8% of spending	Yes for exclusions, copays and out of pocket costs

	physician and hospital, Payment for excluded services Community rating only				

	New Zealand	Portugal	Spain	Sweden	UK
Population	3.8 Million	10 million	39 Million	8.8 million	60 million
US-sized population	South Carolina	Michigan	Ohio +Michigan +Illinois +Wisconsin	Georgia	California + Texas
Government	1840 Constitutional Monarchy Parliamentary government	1974: Constitutional republic Parliamentary government	1978: Parliamentary monarchy Parliamentary government	Parliamentary monarchy Parliamentary government	Parliamentary monarchy Parliamentary government
National Health Service started		1974	1986	1946	1948
NHS Major Modification	1993 1999 2001 (change to 3 year budets)	1985 1996 2002		1970 1980 1995	Several reforms since 1990
Defined benefit package	No—but excludes ineffective services	No	Yes	No	No—but excludes ineffective services
Public satisfaction			Increasing		Broad public support but push for greater spending

Excluded population	None	25%	None	None	None
Funding sources	Taxes	Taxes	Taxes	Taxes Primarily regional	Taxes
Funding distribution	Moving from historical budgets to needs-weighted capitation	Based on historical spending	Un-weighted capitation	Because funding is primarily by county councils, little national distribution	Weighted capitation
Out of pocket payments	Primary care Drugs Dental care for adults in means -tested	Yes 30% of expenditures	Drug copays	County determined for outpatient care and drugs	Copays for working adults for drugs, eye, exams, glasses, dental
% private expenditures	22%	47% (private insurance plus out-of-pocket)	16.9%	2%	15% (1998)
Tiers of Admin	Two National 21 Health districts	Two National Regional	Two National Regional	Three National Regional Local	Three National Country Local
System governance	21 Health districts	National government	Regional	21 County councils	Local agency
Care Delivery: Primary care	Private group practices	Mixed Public—health centers Private--	Mixed Moving from private practice to publicly owned health centers	Local health centers and hospital outpatient departments	Private group practices
Care Delivery: Secondary and above	Hospital based	Hospital based	Hospital based	Government hospitals	Government hospitals
Care Delivery: LTC		Family	30% public beds 70% private beds	Local government	Local government
Payment to hospitals	Prospective fixed budget paid on a per discharge basis using DRG rates	Case-mix adjusted global budget+ outpatient volume	Prospective payment for targeted budget	Global budget plus FFS for highly specialized service	Moving to payment per discharge using Health Related Groups

	Separate capital budget process				
Payment for Physicians	Primary Care: Fee for service Specialists: Salary		Salary	Salary	Primary Care: Primarily capitation Specialist: Salary
Choice of MD			Primary Care: yes Gatekeeper model for specialist	Primary Care: Health center and hosp opt	PC: Open choice within in residential area Gatekeeper model for specialist
Hospital governance	Mixed >50% public <50% private	Mixed 110 public 40+ NFP 40+private		Local government	
Pluralistic delivery system			No Public hospitals	No Government hospitals	No 5% private beds
Excluded services					
Private insurance	Excluded and supplementary services				