A Critical Analysis of Global Healthcare from a Socio-Economic Perspective

Centre for Studies in International Relations and Development (CSIRD)

Mohan Rajagopal

Abstract

Healthcare is an arena which is vital to the survival of humanity, no matter what the social or economic class and position. Healthcare systems pose interesting economic as well as social perspectives, as they operate outside the standard model of economics controlled by the forces of supply and demand. For example, there exists a third-party in the form of the insurance providers, apart from the patients (buyers) and the healthcare providers (sellers). Patients often cannot evaluate the quality of care they receive, externalities may often arise, and the allocation of resources is not determined by the market price mechanism alone, but also the rules established by the insurers. With the various types of healthcare ranging from private to public, as well as a single-payer system and so on, health policy can often be complex and vexing, and the number of influencing factors only confound governments even more as to which route is the best to be taken: a problem for which a definite answer still has not been found. Although healthcare is not the only good or service in the economy that departs from the standard model of demand, supply, and the "invisible hand", it may be the most important that so radically shifts from this benchmark.

From a sociological perspective, healthcare can be regarded as a human right: as with all fundamental rights, there will also be a certain level of inequality and injustice in the provision of these same rights to minorities, and economically weaker sections of society. For instance, in the USA, there is a wide disparity in the excess burden of deaths and illness among the African-American community, as well as other minority groups in the nations, as compared to that among the population group as a whole. Additionally, the life expectancy of the wealthiest Americans now exceeds that of the poorest by 10–15 years.

This research paper will be exploring the economic principles at work in the market of healthcare, and analysing the structures of different healthcare systems and insurance schemes in 8 nations, using the case study method. Assessing the efficacy of private vs public healthcare and the economic conditions necessary for the establishment of universal healthcare is also another area of focus. Additionally, a study of sociological factors such as differences in socio-economic positions through class, race, gender etc in determining access to and quality of healthcare is also necessary for a holistic study of the phenomenon. The main objective of the paper will be to identify the shortcomings of the global healthcare structures, and suggest measures for its economic improvement, its development in terms of inter-sectional inclusivity, and the attainment of a universal healthcare system that benefits the citizens at large.

The case studies will be covering a total of 8 nations: Canada, India, Netherlands, Sierra Leone, South Korea, United Kingdom, United States, Venezuela, chosen in order to display a vast variety in terms of economic development, quality of healthcare provided, as well as the forms of the insurance offered. It is through an analysis of these case studies on different parameters that the best route for the aforementioned improvements in the healthcare systems can also be determined.

Introduction to Healthcare Systems

1.1: Basics Of Healthcare

Healthcare generally refers to the process of maintenance or improvement of health through the prevention, diagnosis and treatment of any illness or injury, both physical as well as mental. It involves professionals working in fields of dentistry, pharmacy, nursing, optometry, psychology, physical therapy, and any other medical field in general[1]. Healthcare poses a complex interaction of a number of institutional factors within a nation: other than the obvious medical aspect, it also contributes to the sociological and economic status of a country.

From an economic standpoint, healthcare serves to be one of the largest markets in the world. Moreover, it caters to the very individuals that make up the economy in and of itself, and as a result plays an unparalleled role in determining the welfare of the citizens: it is important to note that the holistic economic development of a nation depends not only on the wealth and assets possessed, but on the economic welfare of its constituents as well.

Healthcare systems are usually organisations within a nation or regional specification, that rallies its resources, institutions and peoples in order to effectively cater to the medical needs of the population. According to the World Health Organisation (WHO), "a well-functioning health care system requires a financing mechanism, a well-trained and adequately paid workforce, reliable information on which to base decisions and policies, and well maintained health facilities to deliver quality medicines and technologies"[2].

Modern healthcare depends on the delivery of medical assistance through the organisation of trained professionals and paraprofessionals coming together to form interdisciplinary teams. This delivery can take several forms, depending on the severity of the illness or injury to be treated, the time required to be treated within the system, as well as the regional location that they operate within[3]:

1. Primary Care: it refers to the first point of consultation by an individual for any ailment, involving professionals such as a general practitioner or a family physician. It provides the widest scope of healthcare in the system, catering to patients of different age groups and socio-economic backgrounds, as well as providing assistance in the case of a large number of acute and chronic physical and mental health problems. Due to the general nature of this delivery system, physicians often refer patients to secondary and tertiary care for more specific and effective treatment.
2. Secondary Care: it involves acute care, or treatment for a short period of time for a brief, but serious illness, injury or ailment. In several nations, depending on the national health policy or if it is a mixed market healthcare system, a prior referral from a primary care physician is necessary in order to avail further treatment under the secondary care system. Allied health professionals, such as physical therapists and speech therapists, generally work in secondary care, and the services provided in a hospital emergency room provide a good example of the system.

[1] Institute of Medicine, Access to Health Care in America, ed. Michael Millman (Washington, DC: The National Academic Press, 1993), p.2
[2] "Health Systems Governance", World Health Organisation, accessed June 6, 2020, https://www.who.int/health-topics/health-systems-governance.
[3] "Definition of Terms", World Health Organisation, accessed June 6, 2020, https://web.archive.org/web/20110303183810/http://www.wpro.who.int/NR/rdonlyres/45B45060-A38E-496F-B2C1-BD2DC6C04C52/0/44Definitionofterms2009.pdf.

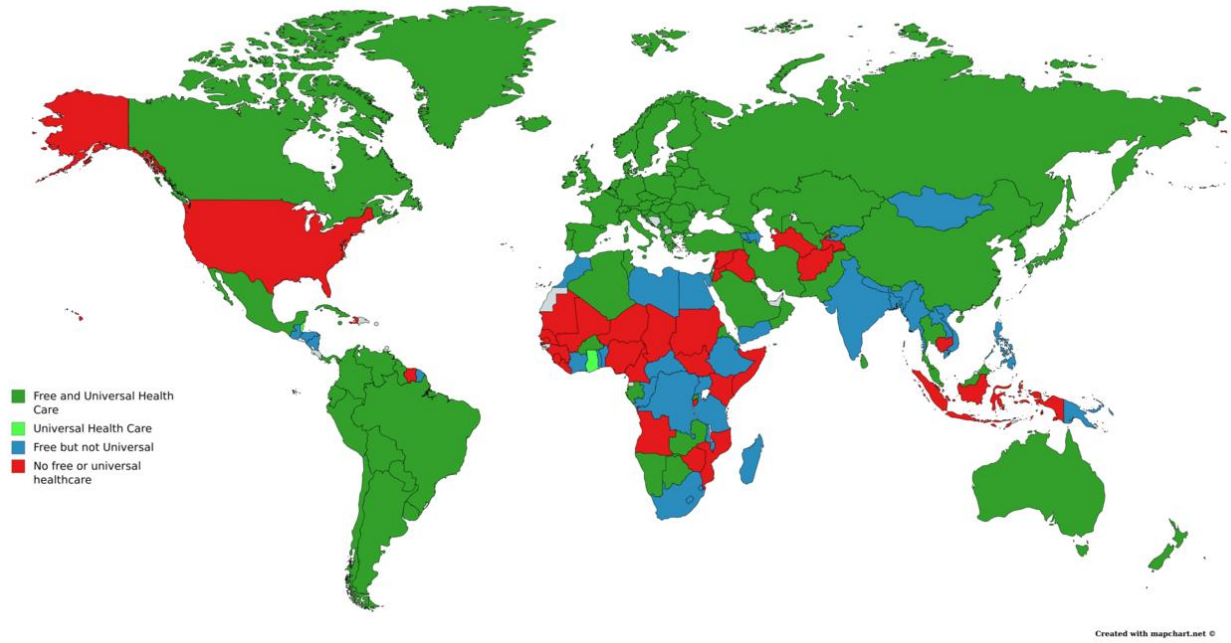
3. Tertiary Care: it is an extremely specialised delivery system provided on consultation with a primary or secondary care professional, used to treat dangerous ailments that cannot be adequately dealt with in a more general setting, such as cancer therapy, cardiac surgery, and plastic surgery.

Although the basic framework of the delivery systems remains the same in nearly all nations, each healthcare system operates on a different principle, with its own funding model, legislations, and coverage. In spite of the differences in the implementation of healthcare, the nations share a common objective with respect to the medical system: the establishment of universal healthcare. It refers to a healthcare system where all residents of a nation are guaranteed access to healthcare. The system may be organised in such a way as to ensure access to the entire population, or only to those who cannot afford health services on their own without financial assistance, but the end goal remains to improve the accessibility and outcomes of the health system. Under the Sustainable Development Goals set in 2015 by the United Nations General Assembly, all member states have agreed to work towards worldwide universal health coverage by 2030[4].

While universal healthcare refers only to the access and coverage prescribed by a given healthcare system, another concept that refers to the costs is free healthcare. It means that all citizens receive essential healthcare at no cost or at a minimal cost: in reality, healthcare is never truly free even in such nations, as it is funded by taxes and revenues paid by the citizens to the government. Additionally, in many nations, free healthcare extends to only the citizens, and not foreign travellers or expatriates.

As observed in the attached world map, an overwhelming majority of countries already provide free and universal healthcare (as depicted by the nations in green). However, this does not mean that such healthcare systems are perfect: improvements can always be made in terms of increasing efficiency and equity, becoming more cost-effective, and reducing disparities, to name a few parameters. Additionally, it is imperative that the remaining nations, especially those in red, can be made to implement policies that ultimately lead to the provision of free and universal healthcare.

[4] "Universal Health Coverage", World Health Organisation, accessed June 6, 2020, https://www.who.int/en/news-room/fact-sheets/detail/universal-health-coverage-(uhc).



Source: "Healthcare Industry", Wikipedia.

1.2: Economic Factors at work in the Healthcare Market

For the sake of the economy, healthcare can often be viewed as an economic market in itself, forming the boundary of study for the branch of health economics. This branch of economics is concerned with the efficiency, effectiveness, value and behaviour observed in the production and consumption of healthcare[5]. Essentially, in the healthcare market, health and its treatment is viewed as a commodity to be bought and sold. Health economics provides an important insight into improving health outcomes through the interaction of patients and practitioners in a clinical setting.

The World Health Report[6] allocates four different roles for individuals in most healthcare markets: contributors, providers, citizens, and consumers. The demand for healthcare is largely derived from the demand for health itself; it is demanded such that citizens may accrue larger stocks of "health capital". Unlike most other goods in the economy, individuals allocate resources both for the consumption as well as the production of health.

This idea of individuals playing the role of producer as well as consumer in the healthcare market was first delineated by Michael Grossman, in 1972. Grossman's model of health production[7] views health as a stock which needs regular investments, in order to prevent its depreciation, hence treating health as a capital good. Investment in health requires payment of time and other resources, making it costly. Health is considered both a consumption good which provides direct satisfaction and utility through the curing of an ailment, as well as an

[5] "What is Health Economics?", John Hopkins Bloomberg School of Public Health, accessed June 7, 2020, https://www.jhsph.edu/departments/international-health/global-health-masters-degrees/master-of-health-science-in-global-health-economics/what-is-health-economics.html.
[6] "World Health Report", World Health Organisation, accessed June 7, 2020, https://www.who.int/whr/en/.
[7] Michael Grossman, "On the Concept of Health Capital and the Demand for Health", Journal of Political Economy (1972): 80 (2).

investment good which yields indirect utility by reducing an individual's number of sick days. The model attempts to make predictions regarding the effects on the healthcare market through changes in prices of commodities, labour markets, and technological advancements. It is these predictions and further theorems proposed in Grossman's model that form the bulk of the econometric research undertaken in health economics.

Within health economics, the five types of healthcare markets usually analysed are[8]:

1. Healthcare financing market
2. Physician and nurses services market
3. Institutional services market
4. Input factors markets
5. Professional education market

Although several assumptions of textbook models of economic markets may apply to healthcare markets, there are also important deviations. Standard markets operate on the theory of supply and demand, based on the following parameters[9]:

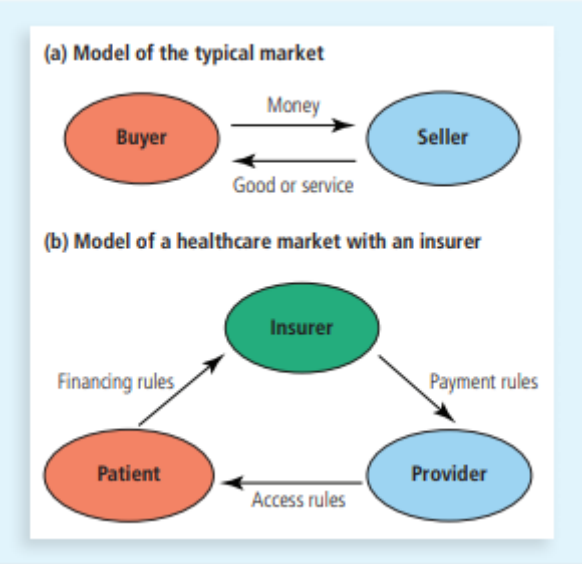
1. There are two main parties involved in the market: the buyers and the sellers.
2. Buyers are able to assess the quality of the commodity they receive from the seller.
3. Buyers directly pay the seller for the commodities they receive.
4. The decisions made by producers and consumers are usually controlled by market mechanisms within the economy.
5. Efficient allocation of resources is undertaken by the principle of the invisible hand, which states that if consumers are free to choose the commodities they wish to consume, and producers are free to choose the commodities they wish to produce, then the market will automatically determine the allocation of resources that benefits the entire community as a whole.

However, none of these features and assumptions can apply to a typical healthcare market for the following reasons[10]:

1. The market involves not only buyers and sellers as the main participants, but also third parties in the form of insurers and government bodies.
2. Patients are unable to evaluate the quality of the healthcare they receive as they are untrained in the medical field. Additionally, it is also difficult to assess the effects of the treatment they receive, as many cures take long periods of time to be implemented, and may also be a result of the natural healing process of the body as opposed to the actual treatment provided.
3. Healthcare providers are not paid directly by the patients, but rather by insurance companies or government services.
4. Allocation of resources is determined not by the market mechanisms, but by the rules and policies set in place by the insurance companies and governments.

[8] "Health Economics", Wikipedia, accessed June 7, 2020, https://en.wikipedia.org/wiki/Health_economics#Healthcare_markets.
[9] "The Economics of Healthcare", Harvard University, accessed June 7, 2020, https://scholar.harvard.edu/files/mankiw/files/economics_of_healthcare.pdf.
[10] Ari Mwachofi and Assaf F. Al-Assaf, "Health Care Market Deviations from the Ideal Market", Sultan Qaboos University Medical Journal (2011): 11(3): 328-337.

5. Due to these deviations from the standard market, the invisible hand cannot undertake its automatic allocation of resources, and as a result the allocation tends to be skewed and inefficient.



Source: "The Economics of Healthcare".

An important phenomenon that takes place within the healthcare market is the prevalence of externalities. An externality is defined as a situation that arises when the economic activities of one individual affects the well-being of a bystander, even though the individual receives no compensation or payment for this effect[11]. Oftentimes, individuals are unaware of the externalities that underlie their health decisions, especially those that are economic in character, and hence the effects of such decisions tend to be unexpected and inefficient. The most common example of an externality refers to the administration of vaccines. If an individual decides to get vaccinated, they would not only be shutting off any risk of contracting the specified disease, but they would reduce the potentialities of being a carrier of the disease and spreading it to those around them. Such an externality is an important factor to be taken into consideration: if getting vaccinated incurs some cost which may take the form of money, time, or adverse side effects, an individual may choose not to get vaccinated. However, the prevalence of externalities is often ignored in this decision-making process, and the person considers only themself and not the benefit of the society as a whole. Hence, the economic decision to not get vaccinated represents a negative externality for the entire community, resulting in a degradation of the healthcare market.

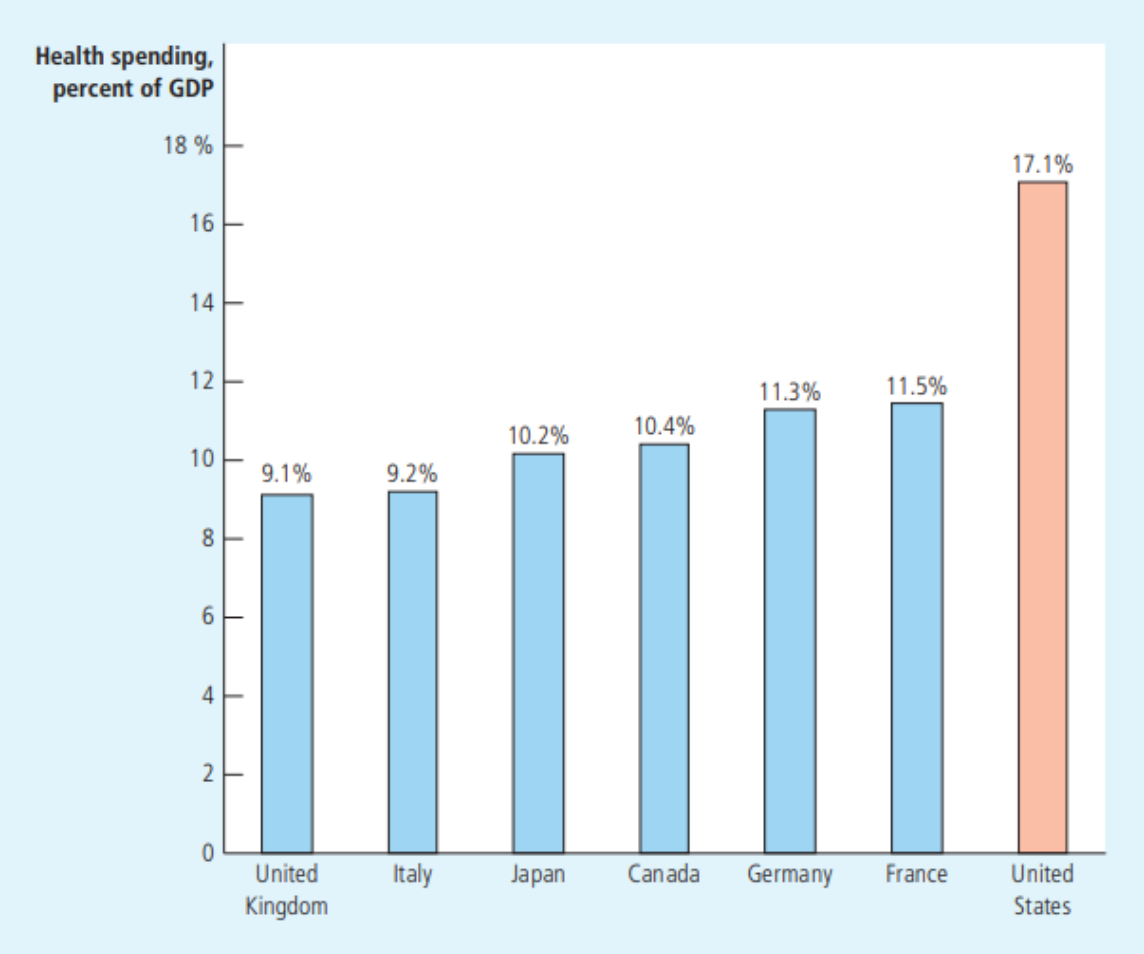
As mentioned above, the difficulty in monitoring the quality of healthcare is a serious issue within the market, which not only hampers the welfare of the patients, but also impedes the proper economic development of the healthcare structure. As a result, the World Health Organisation has denoted six parameters on which the quality of healthcare is to be assessed: effectiveness, efficiency, equity, patient-centredness, safety and timeliness[12]. Additionally, governments all over the world have set strict restrictions in place, requiring doctors, nurses and other practitioners to obtain a license before they are legally allowed to practice medicine. Similarly, nations have set up governing bodies to oversee the testing and release of pharmaceutical drugs, ensuring their safety and effectiveness. However, these restrictions

[11] "The Economics of Healthcare".
[12] Sachin H Jain, "How Do You Measure Quality in Health Care?", Forbes, June 25, 2019, accessed June 7, 2020.

have been met with mixed reactions by economists. Some argue that the stringent measures required to obtain a license have essentially made the healthcare market a monopoly: by reducing the numbers of doctors, their salaries automatically increase, as do the costs of treatment and medicine for the patients. Governing bodies such as the Food and Drug Administration (FDA) in the United States have also been accused of being too slow in ratifying the introduction of new drugs into the market, as a result of which critical patients have been deprived of a chance at a potential cure.

Financing remains a hugely relevant aspect within the market of healthcare, and as such, there are five main levels of funding models[13]:

1. General taxation to the state or municipality
2. Social health insurance
3. Voluntary/Private health insurance
4. Out-of-pocket payments
5. Donations to health charities



Source: "The Economics of Healthcare".

The selected model of funding varies from nation to nation, but most countries choose to have a mix of all five. The overall expenditure of a nation on its healthcare system is represented as a portion of its Gross Domestic Product (GDP). In an analysis by Bloomberg

[13] "Regional Overview of Social Health Insurance in South-East Asia", World Health Organisation, accessed June 7, 2020, http://whqlibdoc.who.int/searo/2004/SEA_HSD_274_eng.pdf.

on the correlation between health expenditure and life expectancy, it was found that in member states of the Organisation for Economic Co-operation and Development (OECD), the life expectancy fell by 0.4 years for every 1000 USD more spent on healthcare. Although life expectancy is not the only parameter for assessing the quality of healthcare, the study indicates that excessive spending may not always be the answer, as seen in the case of the United States of America, where although the health expenditure is roughly 17.4 percent of its GDP, other nations like France (11.5 percent), Canada (10.4 percent) and Japan (10.2 percent) have a higher quality of healthcare. Hence it is the efficient and useful allocation of resources and funding that better contributes to an improved healthcare system.

1.3: Health Insurance Structures

Due to the great demand arising in the healthcare market, as well as the intense amount of capital required in the form of technology, infrastructure, etc, there exists a need for proper funding models within the market: both to finance the efficient operation of the system, as well as to assist the citizens in being able to afford the healthcare that is required by them. It is for this reason that all nations have implemented different forms of insurance systems, in order to provide financial aid for a commodity that is more or less considered a fundamental right for people.

Simply put, health insurance is a contract between an insurance provider (a private company or a government) and an individual, whereby the provider covers the whole or part of the health risks incurred by the individual, including medical expenses[14]. The concept of health insurance is based on the principle of risk aversion, whereby people would prefer to incur a definite smaller cost, rather than run the risk of incurring a much larger cost in the future. For instance, if a contagious disease has the probability of being contracted by 2 percent of the population, there is a 2 percent chance of a specific individual contracting it. In case this does happen, the individual would be required to pay a tremendous cost of, say, 10,000 USD, whereas if they apply to a health insurance scheme, they would only be required to pay around 100 USD per month to reduce the costs later. People would prefer a 100 percent chance of paying 100 USD per month over a 2 percent chance of paying 10000 USD once, and this phenomenon of disliking uncertainty is entitled risk aversion. As such, insurance markets play a pivotal role in reducing financial risks within healthcare, but two conditions hamper it from doing so completely: moral hazard and adverse selection[15].

Moral hazard refers to the tendency of a person who remains unmonitored to engage in dishonest or otherwise undesirable behaviour. Within the context of insurance, when more costs are covered by such schemes, individuals will no longer have an incentive to restrict their spending to a reasonable level, as they are no longer completely responsible for the financial burden. For example, if insurance was wholly responsible for medical expenses, then people would freely visit the physician even at the excuse of minor illnesses and injuries, serving to rack up expenses for the insurance providers and incurring losses. As such, in order to encourage more cost-effective behaviour, insurance providers implement various policies to ensure that the individuals themselves are held accountable for their financial

[14] Andre Pekerti, Quan-Hoang Vuong, Tung Manh Ho, and Thu-Trang Vuong, "Health Care Payments in Vietnam: Patients' Quagmire of Caring for Health versus Economic Destitution", International journal of environmental research and public health (2017): 14(10).
[15] "The Economics of Healthcare".

decisions. These policies for the individual's obligations vary from provider to provider, and some of them are as follows[16]:

- Premium: It is the amount of money an individual is required to pay in order to purchase the insurance plan in the first place. The payments for the premium may occur on an annual, semi-annual or a monthly basis.
- Deductible: It refers to the minimum amount that is required to be paid before the insurance scheme is activated and the provider extends financial assistance. For example, one may have to pay a minimum of 50 USD on a medical process, in order for the rest of the amount to be covered by the insurance scheme. Deductibles may be calculated as fixed costs, or as percentages of the total bill.
- Co-payment: It is a fixed amount for specific services that must be paid every time a service is availed, regardless of whether or not the individual is signed up to an insurance scheme.
- Coverage limits: Some insurance providers apply a maximum cap to the financial aid that they offer individuals, upto a certain amount. If the medical expenses cross said amount, the individual is expected to pay for it out of their own pocket.
- Out-of-pocket maximums: Calculated similarly to coverage limits, an out-of-pocket maximum prescribes an amount of money which is the highest that an individual is expected to pay. The individual's payment obligation ends once this amount is crossed, and the insurance provider is expected to complete the rest of the payment.
- Exclusions: Insurance schemes often are not all-encompassing, but exclude a number of medical procedures, as well as higher costs as a result of taxes. In such cases, all payments are expected to be made by the patients themselves, out of their own pocket.

Although the solution to moral hazard was relatively simple in increasing the financial accountability of the patients, adverse selection poses a more difficult and deep-rooted problem within the system itself. It refers to the tendency of the mix of unobservable attributes to become undesirable to an uninformed party (the insurance providers and the patients, in this case)[17]. For the insurance market, the unobservable attributes are the underlying health conditions of the individuals, such as their eating habits or whether they smoke or not. Obviously, a person with greater health problems will be more likely to sign up for health insurance, and hence the costs of the provider must reflect that of a sicker-than-average individual. As a result, individuals with healthier constitutions would be put off by the unnecessarily high prices, and forego the insurance schemes.

As the attributes of an individual remain unknown, the next logical assumption for the providers was to base their costs on the average member of society, but this would give rise to another problem within the market known as the death spiral[18]. With costs set at average prices, healthier individuals may choose to drop out of the insured pool due to the higher costs. The insured pool would then consist of sicker individuals, and hence the costs would be driven up. The next healthy group of individuals would then drop out, and the process would continue with increasing costs and a decreasing population within the insured pool. Finally, the insurance market would disappear, failing at its objective of reducing the financial risk involved in healthcare.

[16] "How Health Insurance Companies set Health Premiums", HealthCare.gov, accessed June 7, 2020, https://www.healthcare.gov/how-plans-set-your-premiums/.
[17] "The Economics of Healthcare".
[18] David M. Cutler and Richard J. Zeckhauser, "Adverse Selection in Health Insurance", in Frontiers in Health Policy Research, ed. Alan M. Garber (Massacheussets: Massachusetts Institute of Technology, 1998), p.1-32

In order to prevent the occurrence of the death spiral, stricter measures were put in place when screening people for insurance schemes, following which they would be sorted into groups of individuals with similar health conditions, known as risk pools. Rather than operating within a single insured pool and risk the healthier individuals from dropping out, a number of pools were divided based on the health of the members. To facilitate this, individuals were required to give records of their past ailments, as well as provide details on their smoking and drinking habits, and their lifestyles in general.

While the basic foundations of insurance structures remain largely the same, countries differ to a great extent in the implementation of these structures, be it the source of the finances used by the providers, or the policies and benefits offered to the patients. A Columbia University paper by Sherry A. Glied states that "universal health care systems are modestly redistributive and that the progressivity of health care financing has limited implications for overall income inequality"[19]. In a bid to attain free and universal healthcare, nations have come up with their own insurance systems which are broadly based on five models of insurance:

1. Compulsory Insurance: This is a form of insurance usually ensured through legislation, where all citizens are required to subscribe to an insurance scheme, whether privatised or provided by the government. Many nations have embarked on compulsory insurance policies so as to ensure universal healthcare coverage. In nations where universal healthcare is observed through private insurance schemes, a risk compensation pool is used to equalise the risks between funds, in an attempt to reduce adverse selection. In such pools, healthier and younger members of the population are required to contribute finances, while sicker and older portions of the populace receive funds from the pool. In this way, insurance services cannot be denied to anyone, but rather are decided on the basis of prices and services. Hence, risk-adjusted capitation payments ensure an inclusive coverage of healthcare to all members of the society.
2. Tax-based Financing: Under this system, insurance structures and the healthcare market are largely funded through the taxes paid by the citizens. While some nations choose to find healthcare directly from taxes as the sole source, other nations choose to be more equitable in the distribution through social security arrangements for weaker sections of society, with the governments either paying for the entire medical bill, or the premium required for health insurance.
3. Social Health Insurance: Based on the first universal healthcare system introduced in Germany in the 19th century by Chancellor Otto von Bismarck, the system involves finances being contributed by all citizens, including enterprises and the government itself, into single or multiple funding pools, similar to risk pools. Through government policies, finances for the healthcare system are then further drawn from these funding pools, which remains the public property of the entire society at large.
4. Single Payer: Also known as public health insurance, this system has the government covering all healthcare costs for its citizens, rather than private insurers. However, such a structure refers to only the funding model and the fact that a single body finances the operations of the healthcare market, and does not relate to the delivery system in any way. In several nations, healthcare is delivered through private

[19] Sherry A. Glied, "Health Care Financing, Efficiency, and Equity", (Working Paper, National Bureau of Economic Research, 2008).

organisations, though funded by the government, and in others, it is solely the government that owns healthcare resources and personnel and runs its own market.

5. Private Health Insurance: In such a system, the individuals, families, employers and associations directly pay premiums to private companies, that in turn provide insurance benefits to the patients. While insurance schemes are usually compulsory in social insurance programmes, private health insurance tends to be voluntary. Private insurers may include commercial firms, non-profit firms, and local community insurers, who create risk pools across their membership base. A particular form of private health insurance that has emerged is similar to social health insurance, known as community-based health insurance, whereby all individuals within a specific community contribute to a local fund. Unlike social insurances, community funds are privatised, and the contributions are not made on the basis of risk. Individuals can draw finances from the local fund as and when required, in light of any medical necessities.

Universal healthcare systems around the world vary in relation to the extent of government involvement. In some countries where the government is highly involved within the healthcare market, access and coverage is determined not by purchase of services, but on the basis of residential rights. On the other hand, in more privatised nations, a more pluralistic delivery system functions, funded by employers and beneficiaries jointly, and determined by salaries and income.

1.4: Sociological Factors at work in the Healthcare Market

When undertaking an in-depth study of the healthcare system and access of citizens to it, it is important to take into consideration not only the macro-economic perspective, but also the sociological perspective of groups of citizens on a more micro-level. Access to proper healthcare is a phenomenon that varies not only amongst various nations due to their different structures of healthcare, but also within one nation itself, due to the health disparities that exist. Health disparities are differences in health and healthcare that are found between groups as a result of social, economic, or environmental disadvantages[20]. These disparities occur in various dimensions, including race and ethnicity, gender, old age, sexuality, disability status, location, and so on.

The reasons for health disparities can be briefly explained using the concept of dynamism and inadequate infrastructure[21]. Within each of the groups mentioned above, there are bound to be a number of changes and dynamisms, be it in terms of food habits, regional location, body chemistry, etc, which all contribute to the health conditions of an individual. Varying factors within a group result in varying health conditions, putting a lot of pressure on the infrastructures of healthcare systems which are usually suited to cater to the needs of the majority groups within the population. Hence, the minorities are either left behind, or they are forced to adapt to the living situations and atmospheres of the majority groups, leading to their marginalisation.

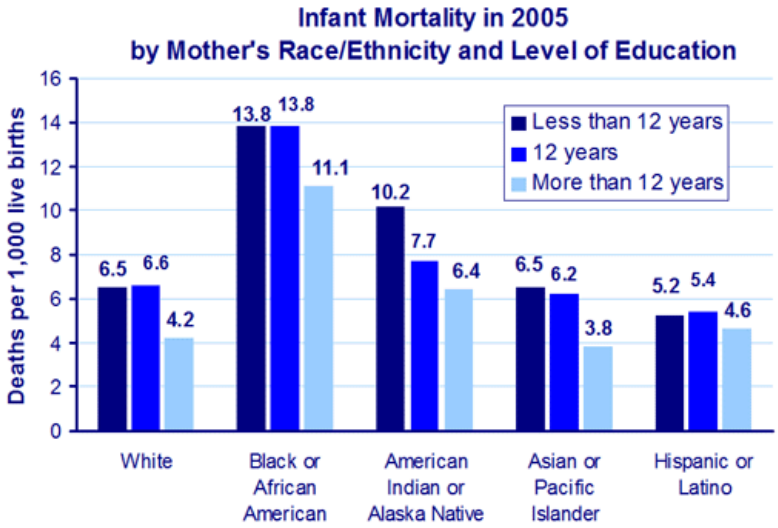
Although such minorities form only a small percentage of the population, their needs cannot be afforded to be ignored: healthcare being a fundamental right, applies to all individuals

[20] United States Department of Health and Human Services, HHS Action Plan to Reduce Racial and Ethnic Health Disparities, (Washington, DC: Department of Health and Human Services, 2011).

[21] Sara Heath, "How Does Socioeconomic Status Impact Racial Health Disparities?", Patient Engagement Hit, December 2, 2019.

regardless of their background or socio-economic position. Health disparities are a very real systemic problem that is deep-rooted within the healthcare system and cannot be removed without intense restructuring of the system. With such aims, the Office of Minority Health in the United States of America conducts annual research programmes in order to delve into the conditions of minority health within the US healthcare system.

The 2020 report[22] largely focused on the health disparities found within racial, ethnic and gender groups, in terms of patient experience and quality of clinical care provided, at the national level. Although only a few gender differences were found, it revealed that African-American and Hispanic beneficiaries reported worse quality of care than a majority of Caucasians, while in the case of American Indians, Alaska Natives, and Pacific Islanders, the patient experience was much worse than it was for most Caucasians. This systemic issue is one that pertains not only to the USA, but nations all over the world, and hence inadequate, inaccessible, and/or poor medical care further exacerbates increasing healthcare costs that have broad implications for the overall quality of care experienced.



Source: National Center for Health Statistics, USA.

Most health disparities among racial and ethnic groups arise due a difference in group incomes, since minority groups have a higher probability of being high school or college dropouts[23], which goes on to have further effects on their access to healthcare[24]:

- Lack of financial resources: Although this is a barricade to most people, access to healthcare is a major problem for nearly all minority groups. Due to their lower incomes, minority groups are usually forced to subscribe to limited insurance schemes that do not provide them with all the necessary services, as well as restricting the number of insurance providers they can access. As a result, such individuals are likely to delay obtaining the required medical assistance and go without the medication they should have been prescribed.
- Irregular source of care: Due to racial prejudices and financial problems, it is unlike for minority groups to be able to visit the same physician or doctor regularly. Instead,

[22] Office of Minority Health, "Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage" (Centre for Medicare and Medicaid Services, 2020).

[23] "How Does Socioeconomic Status Impact Racial Health Disparities?"

[24] Dr Ananya Mandal, "Disparities in Access to Health Care", News Medical, February 26, 2019.

they must rely on emergency rooms and clinics. Due to the irregularity of this healthcare, individuals would find it more difficult and cumbersome to attain the required prescription and attend appointments. From the point of view of the physician, they are likely to make incorrect diagnoses without any relevant background information on the patient's medical history.

- Legal obstacles and structural barriers: Due to the lack of proper legislation covering the rights of minorities, they are likely to face legal obstacles, preventing them from accessing quality healthcare. For example, immigrants in the United States are not permitted to obtain public health insurance until they have resided in the nation for at least five years. Further, structural issues such as lack of proper infrastructure and long waiting times dissuade an individual from making use of their healthcare advantages, if they have any.
- Lack of healthcare providers: In areas with high concentration of minority residence, it is difficult to access proper healthcare practitioners and diagnostic facilities. Additionally, lack of poor English language skills by certain groups make it even more difficult to communicate with physicians and comprehend the nuances of healthcare.
- Old age: Since most senior citizens make their living through some fixed income in the form of a reduced pension, it is difficult for them to afford healthcare. Moreover, disabilities and lack of mobility compounds transportation difficulties, reducing access even further. With the elderly not being adept with internet services, applying for an insurance scheme becomes all the more difficult without proper assistance.

Health economists and sociologists have agreed that the concept of Minority Diminished Returns[25] (the passing on of socio-economic disadvantages down generations) are worth looking into, since it proves that racial and ethnic imbalances would not eventually disappear, but remain repressed within the society. In recent years, health policymakers have attempted to remove social and environmental barriers to the wellness of minority groups in a bid to make their respective healthcare systems more equitable. The economy of a nation will remain frozen in stasis if only the needs of the majority populations are catered to. If health disparities are not reduced and eventually eradicated from within the healthcare market, an imbalance of groups between the upper echelons and economically weaker sections of society would serve to disrupt the economic activities of a nation and wreak havoc.

Case Studies of National Healthcare Schemes

2.1: Canada

Canada essentially has a decentralised, public, universal healthcare system, entitled Canadian Medicare. The nation consists of 13 provinces, which are the main administrators of healthcare funding and insurance within Canada. Each province operates on its own insurance plan, and receives financial assistance from the federal government on a regular basis. Canada is often lauded for its free and universal healthcare, through which citizens receive all essential medical procedures at practically no cost at all. Any excluded services, such as dental care or optometry, are offered at minimal costs, making it one of the most affordable healthcare systems in the world. In spite of having a public healthcare system,

[25] "How Does Socioeconomic Status Impact Racial Health Disparities?".

nearly two-thirds of the population of Canada have also signed up to private insurance schemes as well.

Health Insurance:

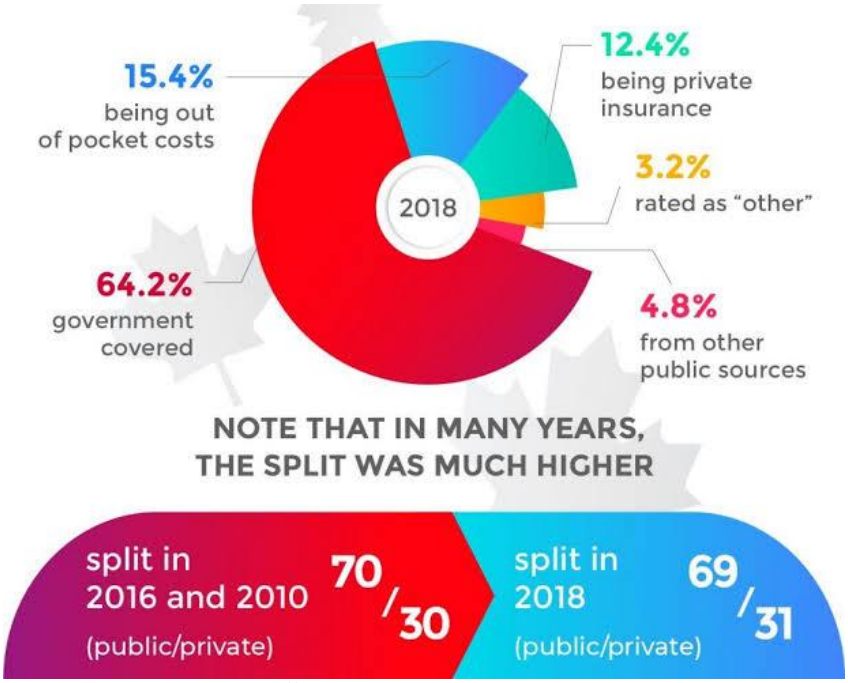
Canada's first attempts at implementing a universal healthcare system was through legislations passed in 1957 and in 1966, although these were eventually overruled by the Canada Health Act of 1984, which sets necessary provisions and standards for medical care within the nation. As each of the 13 provinces and territories operates its own health insurance schemes, federal financial contributions would only be provided if the provincial/territorial insurance complied with the five pillars of the Canada Health Act:

- Publicly administered
- Comprehensive in coverage conditions
- Universal
- Portable across provinces
- Accessible

The main role of the Canadian federal government is in providing financial assistance to the provinces and territories. Additionally, the government also runs schemes and programmes for certain populations, such as eligible First Nations and Inuit peoples, war veterans, members of the Canada Armed Forces, and refugees[26]. The federal government also plays a role in monitoring the safety and efficacy of medical devices and pharmaceutical drugs, and oversees a number of public health programmes at the national level.

Canadian healthcare sees an interesting fusion of both public as well as private healthcare. The total health expenditure is estimated to be around 11.5 percent of the GDP, of which 70 percent is in the public sector, and 30 percent in the private sector[27]. Public health insurance is provided through the provinces and territories of Canada. Most essential medical services are covered under this insurance. Temporary legal visitors to Canada, as well as illegal residents in the form of immigrants or individuals who have extended their stay beyond the duration of a legal permit, are not covered under any insurance schemes, although it is not ethically possible to refuse service to such individuals in the times of a medical emergency. While public health insurance is largely funded through taxation and revenue by the provincial governments themselves, approximately 24 percent of the funding is sourced from the Canada Health Transfer[28], the programme through which the federal government provides financial assistance.

[26] Sara Allin, Greg Marchildon, and Allie Peckham, "Canada", The Commonwealth Fund, June 5, 2020.
[27] Canadian Institute for Health Information, "National Expenditure Trends 1975–2017".
[28] "Federal Transfers to Provinces and Territories", Department of Canadian Finance, accessed June 8, 2020, https://www.fin.gc.ca/fedprov/mtp-eng.asp.



Source: Effective Public Healthcare Panacea Project

Those services which are not covered under the public healthcare system, or Medicare, are covered by complementary private health insurance. Nearly 67 percent of Candians have access to private health insurance, with nearly 90 percent of all such schemes being paid for by employers and organisations under a group insurance scheme[29]. Such schemes cover less essential medical services such as dentistry, vision care, rehabilitation, private hospital rooms, and so on. However, in order to protect the financial interests of those without private health insurance, the Canadian government has also set up a number of safety net programmes, targeting people on the basis of social requirement and retirement age. In Quebec, all those financially eligible for private health insurance are required to sign up to a scheme, while those unable to do are linked up to a private scheme via the public sector. Meanwhile, in Ontario there exists a universal drug programme, whereby seniors, adults, and youth are given access to prescription drugs at minimal costs.

At the federal level, there is great interest in covering drug costs which are excluded from primary public insurance. In 2018, the Advisory Council on the Implementation of National Pharmacare came into being with renewed interest in a pan-Canadian drug coverage system, publishing an interim report in 2019. If a national programme results from such endeavours, it will be the largest such endeavour in Canada since the conception of the Medicare system itself.

Quality of Care:

Much like the health insurance schemes, the Canadian provinces and territories are responsible for their own measures to monitor quality of care within the regions under their jurisdiction. Such provinces have many agencies in place in order to produce healthcare system reports and to monitor health system performances. Additionally, on a national level, the Canadian Institute for Health Information also provides regular reports on system performances and intricacies within the health and insurance structure of the nation.

[29] "National Expenditure Trends 1975–2017".

Several measures have been set in place for the efficient monitoring of the quality of care[30]:

- The Canadian Foundation for Health Improvement is a federally funded programme which works in conjunction with the provincial and territorial governments in order to bring about performance improvements within the system.
- The Optimal Use Projects programme, which is conducted by the Canadian Agency for Drugs and Technologies in Health, recommends the appropriate prescribing, purchasing, and use of medicines to producers and consumers.
- The federally funded Canadian Patient Safety Institute promotes proper practices within the medical system, while also coming up with innovative strategies and protocols for its improvement.
- Quality councils within each province facilitate process improvements in order to introduce healthcare of a higher quality.

Cost Containment:

Cost containment is mainly catered to by the system of single-payer purchasing, and any increase in spending habits can be attributed either to investments made by the government, or budgetary overflow. A number of agencies and governing bodies have been established to ensure cost containment measures as well.

The Canadian Agency for Drugs and Technologies in Health is responsible for carrying out cost-based reports and research studies within the Canadian healthcare system. The information provided about clinical effectiveness, cost effectiveness, and the efficacy of drugs and technologies within the healthcare market are often used by the Canadian government in implementing new drug policies and programmes which aim at cost containment as well as access and evidence-based resource allocation.

The Patented Medical Prices Review Board is a federal organisation that serves to decide the entry-level prices of pharmaceutical drugs and medicines. However, it has no control over the wholesale prices of such drugs, nor over the treatment and clinical fees of physicians. Additionally, the Pan-Canadian Pharmaceutical Alliance has been lobbying since 2010 for the fair pricing of drugs and medical substances, succeeding in reducing the prices of 95 name-brand drugs and generics[31]. Furthermore, each province has its own laws set in place regarding the pricing of these substances, and hence there is further inter-provincial variation in the costs. However, some shared attempts at cost containment are as follows[32]:

- Mandatory global budgets for hospitals, clinics, infirmaries, etc, so as to do away with any unforeseen and unnecessary costs within the economy.
- Restriction in unnecessary investment in capital and technology.
- Negotiated fee schedules for insurance and healthcare providers.
- Resource restrictions for doctors and nurses.
- Drug formularies for drug plans with provinces and territories.

Health Disparities:

[30] Renee Carter et al., "The Impact of Primary Care Reform on Health System Performance in Canada: A Systematic Review", BMC Health Services Research (2016): 30(3): 324.
[31] Council of the Federation Secretariat, "The Pan-Canadian Pharmaceutical Alliance".
[32] Allin, Marchildon, and Peckham, "Canada".

At both the federal as well as provincial and territorial level, health and social disparities are a primary cause of concern for indigenous and non-indigenous Canadians, such as the Inuits, and the low-income families too. Although there is no formal agency devoted to measuring such disparities within the nation, bodies such as the Canadian Institute of Health Information and Public Health Agency of Canada address the inequalities that are rampant within society.

The 2018 budget provided for a sum of 5 billion CAD (3.9 billion USD) for indigenous people, which compounds previous budgetary allocations to a total sum of 11.8 billion CAD (9.3 billion USD). These sums have been set apart for the education, environment, and health and social services of such minorities[33]. In 2018, the Truth and Reconciliation Society released a series of calls to action, a number of which pertained to addressing health disparities within Canadian minorities. For First Nation citizens, Ontario started a public programme in 2016, consisting of investments in better infrastructure within the healthcare system, cultural competency and education training for health professionals, and mental health resources.

2.2: India

In India, all government healthcare facilities offer free inpatient and outpatient services to the patients. However, the public system suffers from a severe lack of staff, resources, and quality of control, as a result of which a number of individuals opt for private services. The individual states are responsible for running their own healthcare systems, with financial aid being provided by the national government. Although private voluntary insurance is available to some extent, not many opt for it.

Health Insurance:

According to the Constitution of India, healthcare is legally considered to be a fundamental right for all citizens, as per which, each state is required to provide universal health coverage. However, Indian healthcare suffers from the severe problem of underfunding, which means that in reality, universal healthcare is still a distant reality. In the financial year of 2017-18, only around 37 percent of the Indian population was covered under any insurance scheme[34], mainly due to the ineffective public insurance schemes and low uptake for commercial insurance[35]. Long wait times and inefficient infrastructure within healthcare facilities further compound the inaccessibility of healthcare in India. As a result, a number of national public health insurance schemes have been implemented by the government in targeting specific populations. There are two major types of health insurances found in India: indemnity plans which cover the basic hospitalisation charges, and fixed benefit plans, where a fixed amount is paid for pre-determined diseases.

The public sector accounts for around 25 percent of the health expenditure within India, while public health insurance is possessed by 64 percent of all insured individuals[36]. In 2008, the National Health Insurance Programme, also known as Rashtriya Swasthya Bima Yojana (RSBY), was implemented in order to reduce the financial vulnerability of the lower-income populations. As of 2016, although nearly 41 families were enrolled under this scheme, it has

[33] "Reconciliation", Government of Canada, accessed June 8, 2020, https://www.budget.gc.ca/2018/docs/themes/reconciliation-reconciliation-en.html.
[34] Ministry of Health and Family Welfare, "National Health Profile, 2018".
[35] B.S. Perappadan, "Corruption Plagues Govt. Hospitals", The Hindu, July 19, 2005.
[36] Ministry of Health and Family Welfare, "National Health Accounts, Estimates for India".

not made a reasonable mark in reducing out-of-pocket spending for the poverty-stricken section of society[37], and hence has been subsumed under the Pradhan Mantri Jan Arogya Yojana of 2018. The scheme covers the bottom two quintiles of the incomes within India, and eligibility is decided by the level of depravity as measured in the Socio-Economic Caste Census. The PMJY extends a sum of 5 lakh INR (6615 USD) per family per year, in order to cover secondary and tertiary healthcare[38]. It extends to around 100 million poor and vulnerable families, and beneficiaries can avail the benefits of the scheme in the form of cashless transactions as well.

Funding for most public insurance schemes is split between the Central and State governments on a 60:40 basis, such as in the case of the National Health Insurance Programme. Due to the vast population of 1.4 billion, it is inefficient for the Central Government to carry out healthcare schemes across the nation, and hence the State governments run their own schemes under the RSBY. However, the Central Government has also been responsible for a number of specific programmes to cater to the varying categories within the population. For example, the Central Government Health Scheme, run by the Ministry of Health and Family Welfare, provides coverage and access to alternative forms of medicine such as allopathy and homeopathy to current and retired Central Government employees, under which there are nearly 3.6 million beneficiaries, as of 2019[39].

The Employees' State Insurance Scheme is the only true health insurance scheme in India to which both employees as well as employers contribute. Organised by the Ministry of Labour and Employment for the workers of companies with more than 10 employees, it is open to workers earning at least 21000 INR (294 USD) per month. Currently, employees contribute 0.75 percent of their wages while employers contribute 3.25 percent; the cost sharing between the Central and State Governments for the scheme is 87.5:12.5. The scheme provides coverage for maternity, as well as any disability or death benefits resulting from any employment-related injuries. [40]

36 percent of insured individuals have private health insurance, and the private insurance sector contributes to 4.4 percent of the total health expenditures. Although public insurance guarantees services and procedures with no deductibles, co-payments, or premiums, the public health facilities are riddled with insufficient resources and underfunding, as a result of which most of the population opt for costier, private health facilities, where 65 percent of the total payments are out-of-pocket expenditures[41]. Although services covered under insurance depend on the scheme, the Central Government Health Insurance Scheme and Employees' State Insurance Scheme cover all types of care for the respective populations.

Quality of Care:

[37] A. Karan, W. Yip, and A. Mahal, "Extending Health Insurance to the Poor in India: An Impact Evaluation of Rashtriya Swasthya Bima Yojana on Out of Pocket Spending for Healthcare," Social Science & Medicine 181 (2017):83-92.
[38] Ministry of Health and Family Welfare, "Fund Allocation for National Health Protection Scheme".
[39] "Central Government Health Scheme", Ministry of Health and Family Welfare, accessed June 9, 2020, https://cghs.nic.in/dashboard/dashboardnew.jsp.
[40] "Employees' State Insurance Corporation: Coverage", Ministry of Labour and Employment, accessed June 9, 2020, https://www.esic.nic.in/coverage.
[41] Ministry of Health and Family Welfare, "National Health Accounts: Estimates for India".

Currently, there does not exist any single entity to monitor the quality of care within the healthcare system or make recommendations for improvements. Such functions are mainly carried out through legal and policy measures implemented by the Central and State Governments. In 2017, a centralised tracking system for district hospitals was released, along with a ranking of all the hospitals[42], although this system was based only on the two parameters of resource availability and patient satisfaction.

Over the past decade, numerous bodies have sprung up in order to monitor arenas adjacent to patient care. The Medical Council of India ensures structural quality within the healthcare system. India also has a well-developed accreditation system, with the National Accreditation Board for Hospitals and Healthcare Providers being responsible for accreditation for all types of health facilities. This body is a member of the International Society for Quality in Health Care, and the accreditation criteria are on the basis of best international standards and practices as dictated by the fellow member nations. In terms of patient care, a number of systems and criteria have been established to monitor efficiency and quality. The National Health Systems Resource Centre, created by the Ministry of Health and Family Welfare, provides certifications for most health facilities within India.[43]

In collaboration with the state governments, the Ministry of Health and Family Welfare have created a comprehensive quality assurance framework which serves to reform public health centres and facilities to be more patient-centric, based on four criteria[44]:

- Instituting an organizational framework for quality improvement.
- Defining standards of service delivery and patient care.
- Continually assessing services against set standards.
- Improving quality by closing gaps and implementing opportunities for improvement.

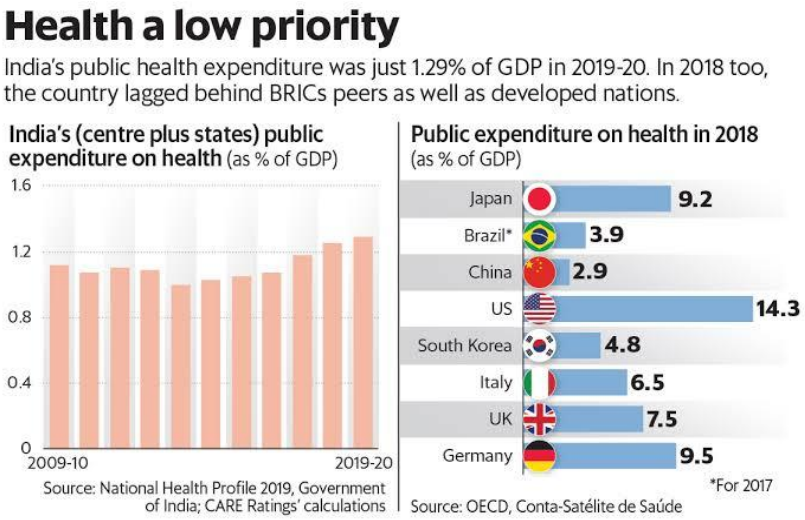
Cost Containment:

Underfunding is one of the largest problems that plagues the healthcare sector in India, which has its roots in the cost containment measures as well. These mechanisms include annual hospital budgets, as well as fixing prices for health care services, pharmaceutical drugs, and other consumables by the Central and State Governments. Given the administrative and technological shortcomings of the Indian healthcare infrastructure, more comprehensive and efficient cost containment plans have failed to be introduced.

In order to improve the accessibility and affordability of essential medical drugs and selected commonly used medical devices, the National Pharmaceutical Pricing Authority has implemented price ceilings on all such commodities[45], ensuring that retailers and pharmacies cannot legally sell them above the maximum price. This is done keeping in mind the interests of the economically weaker sections of society in mind. To increase the supply of medical commodities and prevent illegal commerce of adulterated pharmaceuticals, the Department of Pharmaceuticals also increased the production of name-brand drugs through the Pradhan

[42] "The Health of Our Hospitals: Tracking the Performance of District Hospitals", Niti Aayog, accessed June 9, 2020, https://niti.gov.in/content/tracking-performance-district-hospitals-health-our-hospitals.
[43] Indrani Gupta, "India", The Commonwealth Fund, June 5, 2020.
[44] "Quality Improvement," National Health Systems Resource Centre, http://nhsrcindia.org/quality-improvement.
[45] N. R. Verghese et al., "Government Pharmaceutical Pricing Strategies in the Asia-Pacific Region: An Overview," Journal of Market Access and Health Policy 7 (2019):160.

Mantri Bhartiya Jan Aushadhi Pariyojana Kendra scheme. Under this programme, the name-brand quality-assured drugs were sold through authorised, specialised centers called kendras at affordable prices.



Source: "India's economy needs big dose of health spending", Livemint.

The annual Indian health expenditure in 2020 is only 1.15 percent of its total GDP, ranked a low 184 out of all the nations in the world[46]. Although cutting down prices of goods for increased accessibility to the poorer sections of society is advised, it is imperative to increase the healthcare expenditure for the country, especially taken into account the weak and inefficient infrastructure that is currently in place within the public healthcare sector.

Health Disparities:

Due to the vast population of India being scattered through various regions in the nation, the diversities and cultural complexities naturally give rise to a number of social, health and income inequalities. These are most common among women in rural and tribal areas, where there is vast evidence of unmet access to public health[47]. Lack of access to neonatal care, family planning, and reproductive health resources often lead to the poor health statistics among these populations. With the inefficiency of the public health sector, the economically weaker sections of society are left behind with poor healthcare, as they are unable to afford the exorbitant prices of private hospitals and facilities.

While vulnerable populations have gradually come to the attention of the Central Government under the National Health Protection Scheme, a number of initiatives have also sprung up over the years to assist poor households. The Janani Suraksha Yojana aims to reduce neonatal and maternal mortality by encouraging institutional deliveries among poor pregnant women. It is one of the largest conditional cash transfer programmes in the world[48]. Rashtriya Arogya Nidhi provides financial assistance to those poverty-stricken individuals suffering from deadly diseases. Although some form of action has been taken by the

[46] Ministry of Health and Family Welfare, "National Health Accounts: Estimates for India".
[47] T.S. Ravindran and U.S. Mishra, "Unmet Need for Reproductive Health in India," Reproductive Health Matters 9 (2001): 105–13.
[48] "The State of Social Safety Nets", World Bank, accessed June 9, 2020, https://openknowledge.worldbank.org/bitstream/handle/10986/29115/9781464812545.pdf?sequence=5&isAllowed=y.

Government, there is still a long way to go in terms of healthcare infrastructure for mental health, and providing assistance to individuals in remote and tribal areas and of lower castes and economic statuses.

2.3 The Netherlands

The Netherlands is one among only three other nations in the world (Israel, Liechtenstein, Switzerland), to have universal social health insurance implemented in the form of private insurance. While all residents are legally required to sign up to an insurance scheme provided by private insurers, funding for healthcare and insurance is still largely public, through government grants, tax revenues, and premiums. In 2015, the Netherlands managed to top the annual Euro health consumer index, a study and comparison of the healthcare systems of European nations[49]. Since 2005, the Netherlands has appeared in the top three of the index in every annual report.

Health Insurance:

The first national health insurance programme in the Netherlands was introduced in 1941, based on the German Bismarck model[50] of private and public health insurers. Under this original system, around 63% of the population was covered under public health insurance, while the higher socio-economic classes would often opt for private insurance. However, the Bismarck model of insurance soon came under criticism due to its long wait times and inefficiencies, leading the conversation to a more market-oriented reform based on the suggestions of the American economist, Alain C Enthoven[51]. As such, the Health Insurance Act passed in 2006 merged the public and private health insurance sectors, resulting in the establishment of a singular universal social health insurance programme, characterised by private insurance and mandatory coverage.

The Netherlands health insurance sector functions on a dual level: all primary and curative care is funded by mandatory private insurance, while long-term care for the elderly and mentally ill is funded by social health insurance. Under the statutory private insurance, all residents of the Netherlands as well as non-residents who pay Dutch income tax are required to sign up for the insurance scheme, provided by a number of non-profit private insurers. The uninsured are fined, and their premiums are directly drawn from the income itself. Insurers are legally obligated to accept every single health insurance application that is sent in, and are required to provide the same premiums for all beneficiaires, regardless of their age, underlying health conditions, or income. Moreover, they are also not permitted to impose certain special conditions, such as payments of deductibles and coinsurance, on the insurance schemes.

The normal problems found in traditional health insurance structures are eradicated in the Netherlands system through the processes of increased regulation and an insurance equalisation pool. In order to do away with the problem of moral hazard, insurance

[49] "Outcomes in EHCI 2015", Health Consumer Powerhouse, accessed June 10, 2020, https://web.archive.org/web/20170606082345/http://www.healthpowerhouse.com/files/EHCI_2015/EHCI_2015_report.pdf.
[50] M. Chung, "Health Care Reform: Learning from Other Major Health Care Systems," Princeton Public Health Review (2017).
[51] A. C. Enthoven, "The History and Principles of Managed Competition," Health Affairs 12, (1993): 24–48.

companies are required to provide at least one policy which meets the government standard of minimum coverage, which in turn all adult residents of the Netherlands are legally obligated to purchase. The funding for this insurance and the mandated coverage is derived from the equalisation pool controlled by a regulator. 50% of the pool is financed by a payroll tax collected from employers, 45% consists of the premiums directly paid by the individuals themselves, while the remaining 5% is contributed by the government[52]. The health insurance and financial aid for each individual within a company is drawn from this pool: high-risk individuals get more funding from the pool, while the healthcare of low-income persons and children under the age of 18 are paid for entirely, and hence insurance companies have no deterrent to accepting high-risk individuals, doing away with the problem of adverse selection.

The regulator has the responsibility of overseeing the claims made by the policyholders and prioritise them on their relative urgency. The presence of a regulating force controlling the distribution of funds from the equalisation pool further instils the spirit of competition within the insurance sector. Insurance companies compete with each other for a higher share of the 45% premiums, and are hence incentivised to negotiate with hospitals for lower costs and higher quality of care.

Apart from the mandated insurance, 84% of the population[53] has also signed up for supplementary voluntary insurance for services not covered originally, such as dentistry. In supplementary insurance, premiums are not regulated, and the insurers are permitted to screen the applicants for risk factors and reject them at will. Nearly all the insured purchase their supplementary insurance from their statutory insurance providers.

Quality of Care:

In November, 2007, a survey was conducted in Netherlands, Germany, and five other English-speaking nations in order to assess the adult healthcare experience within the nations. The survey, entitled “Toward Higher-Performance Health Systems”, revealed that the Dutch healthcare system yielded overwhelmingly positive views. 59% of surveyed Dutch adults claimed that they were confident of receiving high quality and safe healthcare, as opposed to only 35% of Americans in the same survey.

Quality of care is maintained through the spirit of competition implemented by the presence of a regulating force. Private, statutory insurers are expected to engage in strategic purchasing, while contracted insurers compete for quality of care and costs. At the national level, quality of care is maintained through legislation which governs professional performance, quality of health facilities, availability of health technologies, and so on. The Dutch Health Care Inspectorate is responsible for monitoring quality and safety, and in 2014, the National Health Institute was established to assist the Inspectorate and accelerate the process of quality improvement. Within the National Health Institute, the National Quality Institute promotes transparency of quality measures. Most of such operations are carried out by the providers themselves, although in close conjunction with insurers, organisations, and patients.

[52] Joost Wammes, Niek Stadhouders, and Gert Westert, “Netherlands”, The Commonwealth Fund, June 5, 2020.
[53] “Netherlands”, The Commonwealth Fund.

Different methods and mechanisms are in place to ensure proper quality of care for individual providers, as well as larger bodies such as hospitals, health facilities, and clinics. The following are the measures in place to promote better quality by individual providers[54]:

- Doctors and medical professionals are required to obtain a government-based national registry certificate, every five years.
- Medical professionals are to be regularly assessed by peers and professional bodies.
- Professional guidelines have also been kept in place by legislatures and monitoring bodies.

Meanwhile, hospitals, nursing homes, and other healthcare institutions have a different set of measures in place:

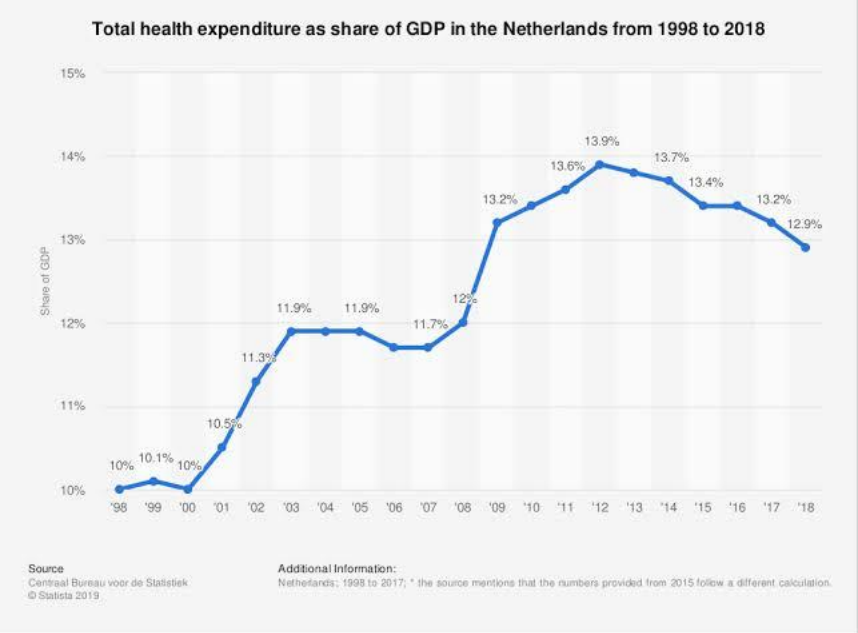
- Accreditation and certification granted by independent organisations.
- Compulsory and voluntary performance assessment based on several parameters.
- National quality-improvement programmes.

The principle of selective contracting is also implemented to ensure quality of care. For example, insurers should only enter into contracts with providers and health facilities that have met minimum standards for volume of procedures performed.

Cost Containment:

While the healthcare system in the Netherlands is of a better quality and more efficient than many other Western nations, it cannot be considered the most cost-effective[55]. Costs are usually high due to an overuse of in-patient care, institutionalised psychiatric care, and elderly care. Due to the privatised insurance system in place, the main approach to controlling costs lies in relying on the market forces of the economy while regulating competition and improving the quality of care. Additionally, payment for providers has also been reformed, shifting from a budget-oriented approach to a performance and result-driven approach. Hence, a subsequent decrease in the health expenditure was also ensured over the years.

[54] "Netherlands", The Commonwealth Fund.
[55] Boston Consulting Group, "Zorg voor Waarde".



Source: Central Bureau of Statistics, Netherlands.

In 2011, the Dutch Ministry of Health signed an agreement with all healthcare providers and insurers, implementing a voluntary ceiling for the annual growth of spending on medical and hospital care. If this ceiling was ever crossed, the government had the power to intervene in the financial matters of the healthcare sector and implement more traditional budget-cuts in an attempt to contain unnecessary costs. The agreement allowed an extra 1-1.5% growth in the annual budget of primary care practices in 2014, so long as they could prove that they were a viable substitute to hospital services. [56]

It is the pharmaceutical sector that is most heavily credited with the decrease of costs and spending within Dutch healthcare. With the establishment of reimbursement caps on the lowest-priced generic drugs, the average spending on pharmaceuticals and prescribed drugs decreased in 2014. There is great debate about whether or not similar reimbursement caps should be implemented on higher priced drugs: while it would certainly reduce the costs within the sector, the reform also runs the risk of reducing the supply and availability of the more expensive drugs to the general populace.

Health Disparities:

A majority of health disparities in the Netherlands exist across socio-economic groups, with there being as much as a difference of 7 years between the life expectancies of the poverty-stricken majority and the higher echelons. These disparities are monitored and assessed by the National Institute for Public Health and the Environment, under the Ministry of Health. Every four years, the Institute measures and publishes variations in health accessibility in the Dutch Health Care Performance Reports, focusing on differences such as ethnicity and

[56] "Outline of Specialist Medical Care Agreement for 2019–2022",Rijksoverheid, accessed June 10, 2020, https://www.rijksoverheid.nl/actueel/nieuws/2018/06/04/hoofdlijnenakkoord-medisch-specialistische-zorg-2019-2022-ondertekend.

education, while geographic and regional variation are mostly left unanalysed[57]. Although these disparities are recognised and monitored by the Dutch Government and other institutions, there are no specific policies in place to overcome them. The government has only implemented some statutory benefit packages, such as the programme in 2014 to cover weight loss and smoking cessation advice[58].

2.4 Sierra Leone

Healthcare in Sierra Leone is rated extremely poorly, with some of the highest infant and maternal mortality rates in the world[59]. Although the Ministry of Health and Sanitation is still largely responsible for the administration of the healthcare system, a more decentralised approach was taken after the Sierra Leone Civil War (1991-2002), as a result of which healthcare is now operated by a mixture of governmental, private, and non-governmental organisations. There are more than a 100 NGOs operating in Sierra Leone in the pursuit of better healthcare, especially in the wake of the 2014 Ebola crisis[60]. Currently, the healthcare system is divided into 13 districts within the nation, each district having its own health management team, around 50 peripheral health units (PHUs) and more than 100 technical staff. The management teams are responsible for organising health programmes and provisions, as well as for the supply of pharmaceutical drugs and medical devices to the healthcare facilities.

Health Insurance:

Until 2010, Sierra Leone had no health insurance setup at all. It was only in April of 2010 that it launched the Free Healthcare Medical Insurance programme, at providing financial aid to pregnant and breast-feeding mothers and children under the age of 5. In response to the insurance plans, healthcare workers soon went on strike, protesting the extra hours of work they would have to put in due to the increased demand for healthcare with the insurance schemes. In order to pacify the protesters, the government agreed to provide pay rises of 200-500 percent[61]. The set-up cost of the scheme was 19 million USD, largely funded by the United Nations and the United Kingdom, who paid for the setting up of hospital facilities and the provision of proper medicinal substances and devices.

It was only with the outbreak of the Ebola crisis in 2014 that the government of Sierra Leone recognised the need for a social health insurance scheme that covered the entire population at large. With this hope was launched the Sierra Leone Social Health Insurance Scheme (SLeSHI) in 2015. It was an initiative launched by the Directorate of Policy, Planning and Information of the Ministry of Health and Sanitation, in collaboration with the International Growth Center, which assisted in evaluation design and survey assessment of the package as

[57] G.P Westert et al., "Dutch Health Care Performance Report 2010", Rijksinstituut voor Volksgezondheid en Milieu RIVM (2010).
[58] Zorginstituut Nederland (Netherlands Healthcare Institute), https://www.zorginstituutnederland.nl/Verzekerde+zorg/g/gecombineerde-leefstijlinterventie-gli-zvw.
[59] "Sierra Leone Country Profile", BBC News, accessed June 11, 2020, https://www.bbc.com/news/world-africa-14094194.
[60] "The Primary Health Care Hand Book Policing", Ministry of Health & Sanitation, accessed June 11, 2020, https://web.archive.org/web/20080217052144/http://www.health.sl/drwebsite/publish/healthcare.shtml.
[61] "Sierra Leone starts free care for mothers and children", BBC News, accessed June 11, 2020, http://news.bbc.co.uk/2/hi/africa/8645968.stm.

a whole[62]. Beneficiaries of the previous healthcare system as well as patients of Malaria, Tuberculosis and HIV/AIDS would be exempt from paying any premiums. The scheme is designed like a typical social health insurance programme, where members of the population are expected to contribute either a percentage fee or a flat rate of 15000 SLL Le (1.53 USD) per month[63]. The wait time is expected to be around 3 months for average procedures.

Quality of Care:

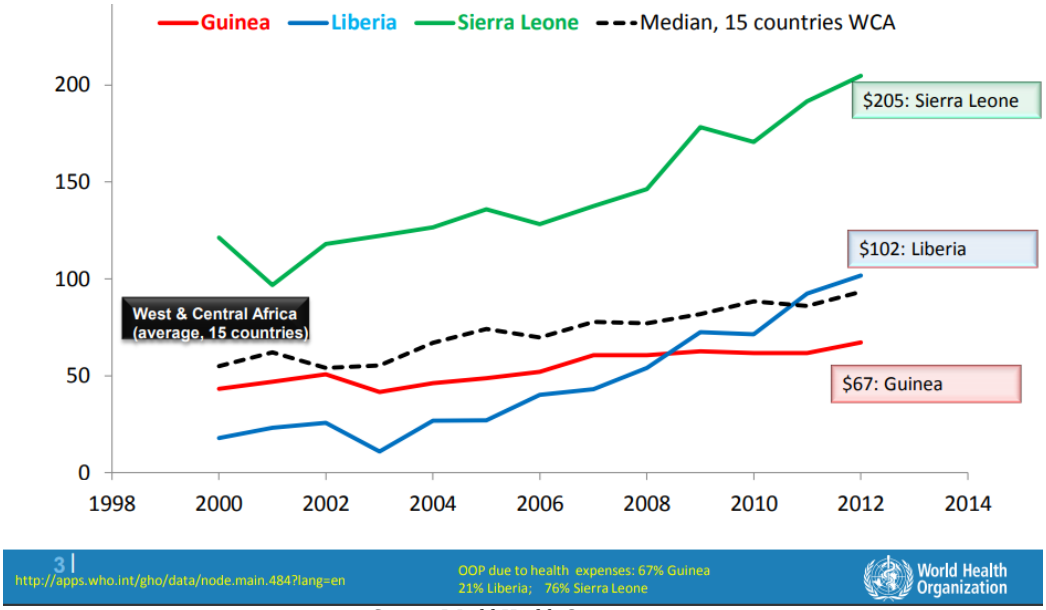
The lack of proper monitoring and accountability within the Sierra Leone healthcare system is the main reason for the poor quality of care. Drugs and other essential medical supplies are often not found in the healthcare facilities or pharmacies, or are sold at exorbitant prices when in reality, they should be offered at minimal or no cost. This is due to the leakage of drugs and supplies out of the free healthcare system, being rerouted illegally for their sale at higher prices. Additionally, the system for the procurement and management of these supplies is complex and often poorly managed.

In examining why these problems persist, it is clear that the lack of a centralised authority for monitory and accountability is the main culprit. Although the problems are broadly known by healthcare officials, the lack of an effective monitoring system means it is difficult to identify specific instances of problems. The unknown scale and nature of the problem further contribute to this issue. Further, the absence of functioning accountability measures means that even if instances are somehow identified, there are no adequate deterrents to prevent repetitions of such crimes. Amnesty International has called upon Sierra Leone in the past to establish proper monitoring and accountability systems in order to cater to the needs of the larger population, especially women and children, and provide effective remedies in light of the violation of their human rights.

Cost Containment:

The World Health Organisation conducted a survey in 2013 regarding the per capita health expenditures of Sierra Leone and other African countries: at 205 USD, it stands far higher than any of the other nations, with a total healthcare expenditure of 560.2 million USD.
However, in spite of the high expenditures, leakages within the healthcare system and exorbitant prices being levied for medicinal goods and supplies results in a lesser efficiency and cost-effectiveness, driving the government to even further poverty.

[62] "Health Insurance Engagement in Sierra Leone", International Growth Centre, accessed June 11, 2020, https://www.theigc.org/wp-content/uploads/2016/02/Glennerster-et-al-2015-Project-memo.pdf.
[63] "An Update on the Sierra Leone Social Health Insurance", The Schramm Connection, accessed June 11, 2020, https://theschrammconnection.com/2015/06/03/an-update-on-the-sierra-leone-social-health-insurance/.



Source: World Health Organisation

Health Disparities:

The main problems of health disparities in Sierra Leone occur among the poverty-stricken sections of society. With the lack of financial resources, the poor are forced to reside in squalid areas with limited protective infrastructure and services. The marginalised minorities usually suffer from health problems due to their pathetic living conditions.

Although data on the health and social conditions of all populations are meagre in Sierra Leone, nearly no attention is paid to the lower socio-economic groups[64]. The lack of health statistics and definite information on the conditions of the slum settlements prevents a qualitative comprehension and analysis of the problem, and hence identifying the necessary policy measures and initiatives to be undertaken is also hindered. Along with the disparities among the poor populations, women and girls are also often unavailable to access the proper medicinal supplies required.

2.5 South Korea

The South Korean healthcare system is considered to be one of the highest ranking structures in the world[65], with the entire population having access to universal healthcare safety net through a single-payer system, as well as the availability of private health insurance in order to cover the additional uncovered expenses. With the end of the Korean War (1950-1953), the medical infrastructure and healthcare of the nation needed to be catered to. In order to assist the national government with their endeavours, the University of Minnesota embarked on a joint collaboration known as the Minnesota Project in 1955[66]. The Minnesota Project resulted in a complete revamping of South Koren healthcare by training medical professionals, dividing hospitals into respective departments, and reorganising the system as a whole. It is

[64] "Sierra Leone", Future Health Systems, accessed June 11, 2020, http://www.futurehealthsystems.org/sierra-leone.
[65] "Health at a Glance 2015", OECD Indicators, accessed June 12, 2020, https://read.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2015_health_glance-2015-en#page28.
[66] Gao Vang, "Paying It Forward: Lessons From the Minnesota Project", University of Minnesota, November 1, 2019.

this project that is largely responsible for the success of South Korea in the healthcare sector even today.

Health Insurance:

In 1963, South Korea established its very first health insurance programme known as the Medical Insurance Act, under which employers were free to provide voluntary health insurance to their workers[67]. It was only in 1977 that the same programme was made mandatory for all businesses and employment organisations with a workforce of more than 500 employees, subsequently resulting in the establishment of a number of health insurance societies. In 1979, the Medical Insurance Act and all subsidiary insurance bodies were required to provide mandatory insurance to businesses with more than 300 employees, public workers, and private school employees, while rural self-employed citizens were included in the Act in 1988. 1989 is often considered the most important year in South Korean healthcare as the Medical Insurance Act was extended to cover the urban self-employed as well, making the insurance wholly universal[68]. A major healthcare financing reform resulted in the merging of all medical societies into the National Health Insurance Service (NHIS) in 2000, which eventually became a single-payer system in 2004. Insurance in South Korea takes three main forms: the National Health Insurance Service, the Medical Aid Programme, and the Long-term Care Insurance Program.

All people in South Korea are eligible for the NHIS, with over 96.3 percent of the total population being covered under the insurance scheme[69]. All contributors and beneficiaries are divided into two categories: employee insured and self-employed insured. Insured employees pay around 5.08 percent of their annual salary. Companies and employers are expected to pay 50 percent of their employer's premiums as well[70]. The contribution rates for self-employed individuals vary based on their income, living conditions, property, and level of participation in economic activities. Apart from contributions, the NHIS is funded by government expenditures which provides 14 percent of the total annual projected revenue, and surcharges on tobacco, which contributes 6 percent of the total annual projected revenue[71]. The insured individual is expected to pay a certain portion of the medical expenses in the form of co-payments, which differ according to the level and type of medical institution. If an individual crosses the co-payment threshold of 3 million KRW (2400 USD) within a period of six consecutive months, they are exempted from paying any of the additional co-payments incurred.

In order to provide financial assistance for low-income households, the Medical Aid Programme was established in 1979, after the promulgation of the Medical Aid Act in 1977. The remaining 3.7 percent of the population are covered under this programme, for whom the government pays all medical expenses[72]. In 2004, it was extended to individuals suffering from rare and chronic disorders, as well as children under the age of 18. Initially funded by

[67] Song, Young Joo, "The South Korean Health Care System", International Medical Community 52(3), (2009): 206–209.
[68] Lee, Jong-Chan, "Health Care Reform in South Korea: Success or Failure?" American Journal of Public Health. 93 (1), (2003): 48–51.
[69] Song, Young Joo, "The South Korean Health Care System".
[70] Song, Young Joo, "The South Korean Health Care System".
[71] Song, Young Joo, "The South Korean Health Care System".
[72] Lee, Jong-Chan, "Health Care Reform in South Korea: Success or Failure?".

the central and local governments, it was soon jointly funded by the NHIS as well, due to the budgetary restrictions and difficulties faced by the governments.

Addressing the problem of old age in South Korea, the government launched the Long-term Care Insurance Programme in several locations around the country as a pilot implementation scheme, covering around 3.8 percent of the aged population[73]. The programme covers not only the aged population above 65 years, but also individuals under 65 years who suffer from age-related disorders such as Parkinson's or Alzheimer's. Efforts are currently underway to extend the programme for the elderly with less serious disorders as well. It is funded by contributions made by the beneficiaries and government subsidies. The government finances 20 percent of long-term care insurance, while the beneficiaries pay 15 percent of the expenses for in-home services, and 20 percent of the expenses for institution services.

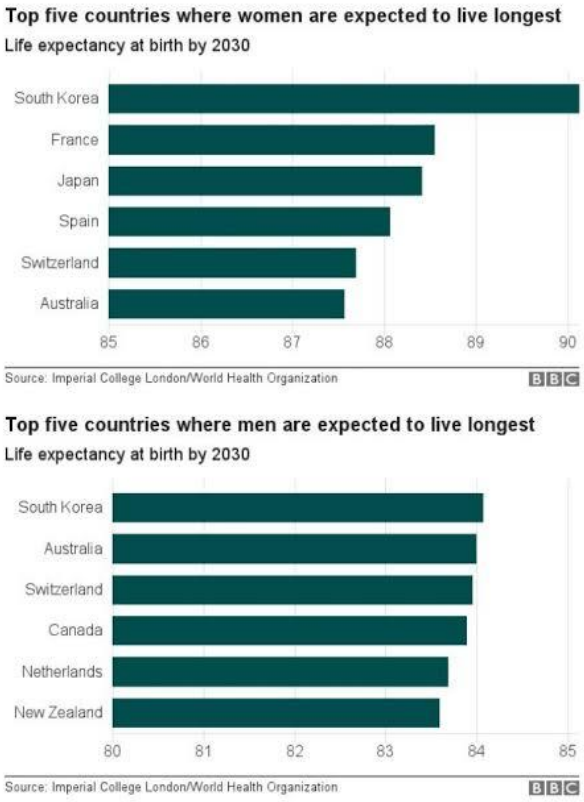
While the single-payer health insurance system is universal in its coverage, an NHIS survey revealed that around 77 percent of the population also possess a secondary private health insurance. This is in order to cover the excess medical charges, as most public insurance schemes cover only upto 60 percent of the total expenses.

Quality of Care:

South Korea is one of the top-ranking nations in the world for the quality of its care. It is ranked 12th in the world for its life expectancy of 82.4 years, has one of the lowest incidences of HIV/AIDS, as well as obesity and cardiovascular disease[74]. The quality of the lives of the Korean people has been generally increasing since the Minnesota Project of 1955, due to the advancements in technology and medical services.

In South Korea, only authorised medical practitioners are allowed to provide health services. The Medical Law states that individuals are required to procure a license from the Ministry of Health, Welfare and Family Affairs in order to be a legally recognised medical practitioner. South Koreans also get a wide range of choice within their delivery system, as they are free to choose the hospital, clinic, or medical facility to utilise. It has the Organisation for Economic Co-operation and Development's second highest number of hospital beds per 1000 people at 9.56 beds, while the usual range was around 2-3 beds for most nations[75]. However, the NHIS has often come under fire for its inefficient handling of financial affairs and costs, which hence adversely affect the quality of care as well.

[73] Lee, Jong-Chan, "Health Care Reform in South Korea: Success or Failure?".
[74] "World Health Statistics 2016: Monitoring health for the SDGs", World Health Organisation, accessed June 12, 2020, http://www.who.int/gho/publications/world_health_statistics/2016/Annex_B/en/.
[75] "Health at a Glance 2015", OECD Indicators, accessed June 12, 2020, https://read.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2015_health_glance-2015-en#page28.



Source: Imperial College, London

Cost Containment:

Healthcare expenditures for South Korea stands at around 8.1 percent of the total GDP; however, since the economic crisis that prevailed throughout south-east Asia in 1997, South Korea was forced to enter into fiscal deficits. At the end of 1997, despite Korean resistance, the International Monetary Fund interfered in South Korea's financial affairs, resulting in even greater deficits from 2002, which somewhat linger even today[76].

The NHIS has been criticised for being unable to efficiently control the costs of healthcare. The Korean government has taken complete and exclusive autonomy over the financial aspects of the system, without involving the medical professionals themselves in the policymaking process. Korean physicians blame the government for the fact that only 65 percent of customary medical care costs are reimbursed by the existing health insurance schemes, claiming that the government has developed a universal healthcare system at the expense of their incomes and autonomy[77]. Conversely, there is no proper monitoring and accountability system in place for the physicians themselves, who have complete autonomy within their professional workplace. This laissez-faire system results in gross misuse of scarce economic resources and finances, in the form of overuse of pharmaceutical drugs and inefficient usage of hospital budgetary fundings. Although regulation of costs has begun to be undertaken by the South Korean government, a lack of monitoring of physicians still remains a major issue. This unbalanced approach by the government may result in ineffective and even harmful healthcare practices being administered to the people.

[76] Lee, Jong-Chan, "Health Care Reform in South Korea: Success or Failure?".
[77] "Profile of Healthcare in South Korea", The Borgen Project, accessed June 12, 2020, https://borgenproject.org/health-care-in-south-korea/.

The increase in the aging population is also posing a financial problem due to the increasing medical expenses. As South Korea is becoming an aging country faster than any other nation, there is an automatic increase in the demand for and hence cost of treatment for chronic and degenerative diseases for the elderly. A more recent problem that has come up is in the provision of healthcare to foreign visitors and tourists. There have been various instances of foreign nationals returning to their home country after availing treatment from South Korea without paying, informally termed within the healthcare sector as "healthcare dine and dash"[78]. Policy changes now require foreigners to sign up for the NHIS within the first six months of residing in South Korea and receive an Alien Registration Card, in order to avail any healthcare benefits and private insurance.

Health Disparities:

The most prevalent health disparity found in South Korea is the divide between the urban-rural populations. Due to medical profit maximisation strategies, nearly 92.1 percent of all Korean physicians practice in urban areas, whereas 79 percent of the population resides in the urban areas[79]. As a result, the remaining population in the rural areas are left with a lesser number of physicians to cater to their own health needs. Around 25 percent of all elderly individuals of South Korea reside in the rural areas, where they are at a high risk of suffering deadly and dangerous injuries[80]. The problem of disproportionate distribution of physicians is only compounded by the fact that most young physicians are also choosing to practice in the cities.

The increasing elderly population and decreasing death rates are changing the family dynamics in South Korea, resulting in large disparities in the healthcare provided to the aged. Since they pose large financial pressures on the healthcare infrastructures, their needs are often ignored. It is only recently with the Long-term Care Insurance Programme that the government has attempted to reduce age disparities, although the programme is still extremely limited and exclusive.

2.6 United Kingdom (England)

Within the United Kingdom, healthcare is a devolved matter, with England, Scotland, Wales and Northern Ireland having their own healthcare systems operated by the respective government bodies, as well as smaller private sector and voluntary organisations. However, the National Health Service (NHS) across the United Kingdom can be used for making any international comparisons[81]. The United Kingdom has been ranked the best healthcare system numerous times by the Commonwealth Fund, in 2007, 2010, 2014, and 2017. The main reason for this is the prevalence of free public healthcare to all normal English residents, with its reputed success in the safety and efficiency of the care process, and equity.

Health Insurance:

[78] "Profile of Healthcare in South Korea", The Borgen Project, accessed June 12, 2020, https://borgenproject.org/health-care-in-south-korea/.
[79] Lee, Jong-Chan, "Health Care Reform in South Korea: Success or Failure?".
[80] Song, Young Joo, "The South Korean Health Care System".
[81] "NHS now four different systems", BBC News, accessed June 13, 2020, http://news.bbc.co.uk/1/hi/health/7149423.stm.

In 1946, a report was submitted to the British Parliament by Sir William Beveridge, detailing the importance of a comprehensive healthcare system in removing social evils such as illiteracy, poverty, and unemployment. It was due to the Beveridge Report that the National Health Service was set up in 1948, providing universal health coverage to the United Kingdom. All those "ordinarily resident" in England are entitled to the usage of NHS services which are mostly free at the point of use, except for additional services such as dentistry, vision care, etc. The NHS cannot strictly be considered an insurance scheme as there are no premiums collected, patients are not expected to pay the costs, and costs are not collected from a prepaid pool. However, it succeeds in the same objective as a typical insurance scheme, which is to reduce the financial risk normally incurred in the pursuit of quality healthcare.

The NHS is a publicly-funded programme, funded directly through general taxation. Additionally, a smaller proportion of funding is derived from national insurance, which is a form of payroll tax paid by employees and employers. The NHS also receives income through copayments, as well as through the payments of patients using the NHS as a private service. From a management perspective, the NHS is divided into two main parts which cater to primary and secondary care, which are further divided into trusts entrusted with healthcare delivery. There are two types of trusts found within the NHS: commissioning trusts, which analyse the local healthcare needs and negotiate with the providers (NHS bodies or private entities) to provide healthcare to the local population, and provider trusts, which contain the NHS organisations and private institutions delivering healthcare services. These trusts reflect the roles of the purchaser and the provider within the healthcare system.[82]

The majority of healthcare for most patients is delivered in the form of primary care. The NHS offers free medical services including hospital, physician, and mental healthcare. The responsibility for health legislation and general policy-making lies with the British Parliament, the Secretary of State for Health, and the Department of Health. The government additionally owns the hospitals, healthcare facilities, and other providers within the nation known as NHS trusts. The day-to-day functioning of the NHS is carried out by a government-funded body known as NHS England, responsible for tasks such as managing the budget, commissioning certain types of care, and working towards fulfilling the mandate prescribed by the Secretary of State for Health.

While 100 percent of the English population have healthcare coverage to the public NHS, less than 11 percent of the population also use private sector insurance, usually funded by employers of larger companies, although private insurers market policies directly to the public as well[83]. The main usage of this additional private insurance is as a top-up to the already existing NHS, since it offers more rapid access to care, choice of specialists, and better amenities. However, most private insurances also exclude several services such as mental health and emergency care.

The private sector is often frowned upon both by the public as well as the government. In 2009, the British Medical Association expressed its concerns about the growing health

[82] Royal College of General Practitioners, "The Structure of the NHS".
[83] "Health Cover UK Market Report: Twelfth Edition", LaingBuisson, accessed June 13, 2020, http://www.laingbuisson.com/wp-content/uploads/2016/06/Health_Cover_12ed_Bro_WEB.pdf.

insurance market within the United Kingdom[84]. Along the same vein, the Care Quality Commission in 2018 warned that informality in private insurance processes meant that efficient and robust safety precautions were not in place. In spite of public opposition, unused private sector capacity has often been used to increase the capacity of the NHS[85]. The NHS has also worked with the private sector on a sub-contracted basis, allowing patients to make use of the NHS services through their private insurer. New capital programmes have also been financed through private healthcare initiatives. There are a number of safety nets in place for people of low income, children, elderly, and pregnant mothers, including drug cost-sharing exemptions, and no co-pays required for dentistry and visual care.

Quality of Care:

The Care Quality Commission is responsible for the monitoring and regulation of all healthcare in England[86]. All providers, including individual practitioners, must be registered under the Commission, which regulates quality care according to nationally established parameters and standards. It has the right to investigate any practitioner for whom concerns have been raised by patients, and can permanently shut down poor-performing facilities and clinics. The National Institute for Health and Care Excellence is responsible for developing national standards and guidelines for healthcare, including mental health, physicians, community care, and emergency services, spanning primary, secondary, and tertiary care. National registries have been set up by the Institute for a number of diseases, and maximum wait-times have been established for dangerous and fatal illnesses as well, such as cancer treatment, as well as several elective procedures. Patients can easily access clinical guidelines through resources found online. However, one of the main problems found with the NHS is the long wait-times, deterring people from receiving the healthcare they require.

Source: National Health Service, England.

In order to provide financial incentives to general practitioners for improving the quality of care and system of monitoring, the Quality and Outcomes Framework was established in

[84] "BMA policies", British Medical Association, accessed June 13, 2020, http://web2.bma.org.uk/bmapolicies.nsf/searchresults?OpenForm&Q=FIELD+Subject+contains+Private+Healthcare+AND+FIELD+DatePolicy+contains+2009~8~50~Y.

[85] "Survey of the general public's views on NHS system reform in England", British Medical Association, accessed June 13, 2020, https://web.archive.org/web/20080227150902/http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFnhssystreform2007/%24FILE/48751Surveynhsreform.pdf,

[86] Ruth Thorlby, "England", The Commonwealth Fund, June 5, 2020.

conjunction with the Commissioning for Quality and Innovation Initiative[87]. Under this system, general practices are awarded points for following the guidelines mentioned in the framework, such as maintaining a disease registry of all patients. The remuneration received by the practice is then determined by the number of points accumulated. For hospitals, 2.5 percent of the contract value is determined by the achievement of a certain number of set goals.

Healthwatch England is an organisation that serves to promote the national interests of patients within a community. Patients are able to lodge complaints to the organisation, who then investigate into the matter and may request the Care Quality Commission to take action. Similar duties are performed by local NHS bodies such as general practices and hospital trusts. Additionally, in order to ensure safe and proper care, all doctors, as well as other professionals working in the healthcare sector, are required to obtain a license from the General Medical Council, which must be revalidated every five years.

Cost Containment:

In recent years, the NHS has come under financial strain due to a deterioration in the quality of care, especially in the area of wait-times. Costs in the NHS are contained on the basis of a national healthcare budget which cannot be crossed, as opposed to a patient cost-sharing basis or direct restrictions on supply. Clinical Commissioning Groups (CCGs) are allocated funds by NHS England, and are closely monitored by them to prevent overspending. Since 2010, the rate of growth of healthcare expenditure has considerably slowed down in comparison to that in the past. Historically, the healthcare expenditure grew by around 4 percent in real terms per annum from 1950-2010, which suffered a sharp drop to 1.2 percent from 2011-2020[88]. Currently, the healthcare expenditure stands at around 9.8 percent of the total GDP. However, while the rate of growth of expenditure has decelerated, the demand for and cost of healthcare has been rising a considerable amount. This mismatch between the funding, demand for healthcare, and cost of providing services has resulted in a great budget deficit for the NHS of nearly 4.3 billion GBP (6.1 billion USD)[89].

Cost containment strategies implemented by the government include freezing staff pay increases, and promoting the usage of generic drugs. In 2016, NHS Improvement launched an initiative to encourage hospitals and healthcare facilities to make more efficient use of their staff and resources in a bid to cut down on unnecessary costs. The initiative is projected to save around 5 billion GBP (7.1 billion USD) by the end of 2020[90]. Costs for prescription drugs are maintained through a voluntary partnership between the United Kingdom Government and several pharmaceutical agencies, whereby a cap is placed on the prices of various drugs. Additionally, the National Institute for Health and Care Excellence appraises cost-effective drugs.

Health Disparities:

[87] Ruth Thorlby, "England", The Commonwealth Fund, June 5, 2020.
[88] Nuffield Trust, Health Foundation, and King's Fund, "Budget 2018, What It Means for Health and Social Care".
[89] "NHS Funding Boost: The Need to Manage Expectations", Nuffield Trust, https://www.nuffieldtrust.org.uk/news-item/nhs-funding-boost-the-need-to-manage-expectations.
[90] Lord Carter of Coles, "Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted Variation — An Independent Report for the Department of Health".

In a 2017 report by the Commonwealth Fund, the healthcare system of the United Kingdom was ranked number one in the world in terms of equity[91]. According to the NHS Constitution, the Secretary of State for Health and the NHS have a legal duty to "have regard" for the necessity of reducing health disparities within the nation. NHS England publishes an annual report regarding their efforts in reducing disparities due to gender, disability, age, and ethnicity. However, in recent years, reports have shown that health disparities and class gaps have actually grown wider between the rich and the poor[92].

A number of NHS strategies have been put in place to ensure equitable healthcare within the nation:

- Financially incentivising reductions in health disparities.
- Providing CCGs with the necessary funding and resources to tackle existing disparities.
- Measuring progress towards reducing disparities using risk stratification tools.

Public Health England is another organisation which also attempts to tackle disparities within the healthcare system. It publishes extensives guidelines for local authorities to be more inclusive in their functioning, and also publishes data on equity distribution across hospitals and healthcare facilities

2.7 United States of America

The United States of America is one of the only developed nations to lack a universal healthcare system, with nearly 8.5 percent of the total population remaining uninsured with no access to healthcare[93]. It is a mix of public and private, for-profit and nonprofit organisations and healthcare providers, and as such, there does not exist any singular framework for a unified health insurance scheme within the nation. Public and private insurers determine their own benefit packages and cost-sharing structures, as per the federal and state regulations.

Health Insurance:

The United States healthcare system relies heavily on private healthcare, which remains the main source of insurance for a majority of the population. The Center for Disease Control and Prevention found that 69 percent of American adults have private health insurance, usually sponsored by their employers. Employer-sponsored health insurance was first introduced in the US in the 1920s, picking up popularity after the Second World War (1939-1945) when benefits of health insurance included tax exemptions. Usually, both employers and employees contribute to premiums, while in a few cases, the employer alone covers the entire cost of premiums. Individuals also purchase private insurance from for-profit and nonprofit providers.

[91] Eric C. Schneider et al., "Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care", The Commonwealth Fund.
[92] Owen Dyer, "Disparities in health widen between rich and poor in England", British Medical Journal (2005): 419.
[93] Edward R. Berchick et al., "Health Insurance Coverage in the United States: 2018", US Census Bureau (2019).

Public health insurance was only introduced to the US in 1965 with the Medicare and Medicaid Programmes, implemented through the Social Security Act. Medicare ensures a universal right to healthcare for elderly persons aged 65 years and older. Gradually, the eligibility requirements have become less stricter, allowing even individuals under 65 with long-term disabilities or end-stage renal disorders to be covered under the scheme. Medicare offers hospital insurance as well as medical insurance, and under the newer Medicare Advantage package, individuals can enrol for Medicare under a private organisation. A voluntary out-patient drug coverage scheme is also included for private enrollees. It is funded through general federal taxes, a mandatory payroll tax for hospital insurance, and individual premiums.

Originally, Medicaid was a state-based programme which provided health insurance to individuals of low-income, and disabilities. Eventually, it was extended to include low-income pregnant women and infants, and later for children up to the age of 18. As it is a state-administered programme, eligibility criteria vary across states, and individuals are required to be readministered within the system regularly to check their eligibility across an extended period of time. It covers nearly 17.9 percent of the American population. It is largely tax-funded, with federal taxes covering 63 percent of costs, and state and local taxes covering the remainder.[94]

In 1997, the Children's Health Insurance Programme (CHIP) was introduced for those children in low-income families who earned too much to qualify for Medicaid, but still could not afford private-insurance. It is a state-administered, public programme which operates as an extension of Medicaid in some states, and as a separate programme in some others. It covers nearly 9.6 million American children[95]. It is funded by grants provided to the states by the federal government.

In the late 1990s and early 2000s, health advocacy companies began cropping up in the US to help Americans with the complexities of the healthcare system. The lack of universal healthcare coverage resulted in a large proportion of the population being unable to mitigate their health expenditures: 62 percent of individuals who filed for bankruptcy in 2007 had unpaid medical bills of more than 1000 USD, and in 92 percent of such cases, the bills crossed 5000 USD[96]. In order to address the issue of a required overhaul of the US healthcare system, Barack Obama, President of the United States at the time, passed the Affordable Care Act in 2010, popularly known as ObamaCare. Its major coverage expansions were implemented in 2014, and its components included[97]:

- Requiring most Americans to obtain health insurance or incur a penalty.
- Extending coverage for the youth by allowing them to use their parents' insurance schemes as dependants till the age of 26.
- Providing financial aid and subsidies to low and middle-income families in a bid to extend health insurance coverage.

[94]CM Torio and RM Andrews, "National Inpatient Hospital Costs: The Most Expensive Conditions by Payer".
[95] "Federal Fiscal Year (FFY) 2018 Statistical Enrollment Data System (SEDS) Reporting", Centers for Medicare and Medicaid Services, accessed June 14, 2020, https://www.medicaid.gov/sites/default/files/2019-12/fy-2018-childrens-enrollment-report.pdf.
[96] DU Himmelstein et al., "Medical Bankruptcy in the United States, 2007: Results of a National Study". The American Journal of Medicine, 122 (8), (2009): 741–46.
[97] S. R. Collins, H. K. Bhupal, and M. M. Doty, "Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured".

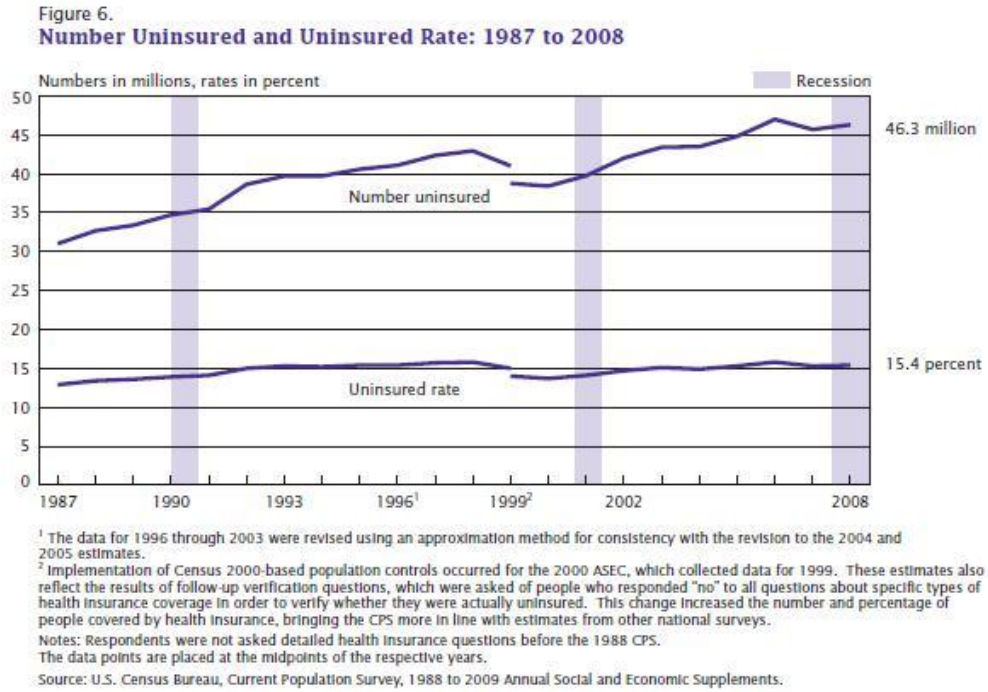
- Extending the coverage and eligibility of Medicaid with the help of federal subsidies.

Health policy experts like David Cutler and Jonathan Gruber argue that such provisions are required in order to provide "guaranteed issue" against unpopular aspects of the existing healthcare scheme. Moreover, the requirement to obtain health insurance would also prevent the occurrence of a death spiral within the American health insurance market.

A number of safety net programmes are also funded through taxes, such as for uninsured, low-income and vulnerable patients. For example, the Affordable Care Act increased funding to health centres which provide primary and preventive care to more than 27 million underserved patients, regardless of their ability to pay[98].

Quality of Care:

The Affordable Care Act required the US Department of Health and Social Services to establish a National Quality Strategy[99]: a set of goals and priorities to guide local, state, and national improvement efforts within the healthcare sector. The strategy would be supported by public and private entities, and be based on annual reporting on a few select criteria.



Source: US Census Bureau

While wait-times are relatively shorter in the US, the high costs incurred in the healthcare system is the main deterrent to purchasing health insurance. As a result, 45000 deaths per year are attributed to the lack of health insurance[100]. As low-income families forego timely health checkups and services, they are forced to wait until their medical condition worsens

[98] "HRSA Fact Sheet FY2018", Health Resources and Services Administration, accessed June 14, 2020, https://data.hrsa.gov/data/fact-sheets.
[99] "What Is the National Quality Strategy?", Robert Wood Johnson Foundation, accessed June 14, 2020, https://www.rwjf.org/en/library/research/2012/01/what-is-the-national-quality-strategy-.html.
[100] David Cecere, "New study finds 45,000 deaths annually linked to lack of health coverage", The Harvard Gazette, September 17, 2009.

and an emergency situation arises, leading to a surcharge and collapse of the emergency services in the nation. Among other developed nations, the US does not place well when efficiency of healthcare is compared, in terms of preventable deaths, value for money, and administrative costs. Moreover, the lack of any single health insurance scheme among the entire population leads to variations and inconsistencies in the quality of care: the treatment given to a patient depends on which healthcare provider they use. As a result, US healthcare delivery system provides uneven quality of care to varying populations.

Cost Containment:

The United States has the highest per capita health expenditures in the world, at 11,172 USD on average in 2018, while the total health expenditure stands at 18 percent of the GDP[101]. Private insurers have attempted to contain costs on the demand-side of the economy, through increased patient cost-sharing, price negotiations, and utilisation controls. On the other hand, the federal government controls costs by setting provider rates for Medicare and the Veterans Health Administration, capping out-of-pocket annual fees for beneficiaries of Medicare and Medicaid, and negotiating drug prices. However, most of these measures have proved to be ineffective since most Americans resort to private insurance, and not public. As a result, state governments have attempted to regulate the private insurance schemes operating within their jurisdiction, which have availed moderate results.

Among public insurance schemes, the Veterans Health Administration and Medicaid are entitled to discounts and lower prices on drugs and pharmaceuticals, through negotiations with the manufacturers. For the VHA, agencies are legally entitled to a minimum 24 percent discount, and are entitled to enter into deeper negotiations[102]. Additionally, prior authorisations encourage the use of lower-cost alternatives. However, Medicare, although the largest buyer of prescription drugs, does not enter into any negotiations with manufacturers, resulting in steep costs and prices which reduce access of low and middle-income families.

Health Disparities:

Within the United States, the largest proportion of health disparities occur across racial and ethnic minority groups. Studies by the Center for Disease Control and Prevention and the Health Resources and Services Administration show the increased vulnerability of African Americans, Asian Americans, Native Americans, and Latinos to health problems. For example, the incidence rate of cancer is 10 percent higher among African Americans than among Caucasians, and the likelihood of developing diabetes is also twice as high[103].

Such disparities are easily visible in the case of the current COVID-19 pandemic as well. A recent CDC report analyses the ethnic and racial rates of 580 hospitalised individuals within a surrounding community. While 59 percent of the actual community was Caucasian, only 45 percent of the hospitalised group was Caucasian. Conversely, African American comprised 18 percent of the outside community, but 33 percent of the hospitalised patients, and while

[101] M. Hartman et al., "National Health Care Spending in 2018: Growth Driven by Accelerations in Medicare and Private Insurance Spending," Health Affairs 39, no.1 (2020): 8–17.
[102] Rice et al., "United States of America: Health System Review".
[103] Ananya Mandal, "What are health disparities?", News Medical, February 26, 2019.

Latinos represented 8 percent of the actual community, 14 percent of those hospitalised was Latino. [104]

In an attempt to reduce the rampant health disparities prevalent in the US, the CDC has released several reports detailing strategies to the same effect, based on the principles of analysis, spreading awareness, and building community partnerships. The strategies involve identifying groups of high-risk youth and support the design and implementation of programmes that help uplift such groups, as well as to analyse the very causes of healthcare disparities and hence attempt to eradicate them from the grassroot level. Apart from the CDC, the Office of Minority Health is tasked with developing policies and programmes to reduce health disparities among racial and ethnic minorities. The Health Resources and Services Administration also provides grants to local and state governments to help in the healthcare of vulnerable populations[105], and federally funded Indian Health Service aims to support 2.6 million American Indians and Alaskan Natives belonging to more than 500 tribes across 37 states. Additionally, through the Internal Revenue Service, the Affordable Care Act made it a legal requirement for non-profit hospitals and healthcare facilities to participate in community health needs assessments along with stakeholders in order to identify and address unmet health needs in different communities.

2.8 Venezuela

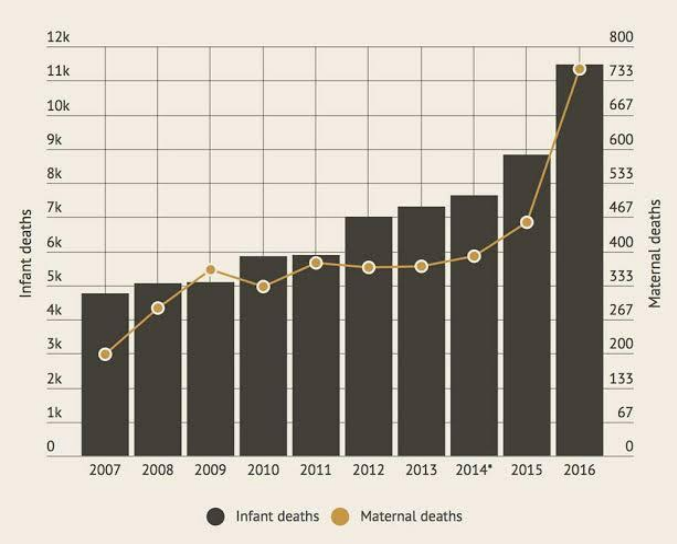
While Venezuela once boasted one of the top healthcare systems in all of South Africa, it has degraded into squalor and deprivation in the wake of the economic crisis in the 21st century. In the 1970s and 1980s, the Venezuelan healthcare system was of a moderate quality, marking the nation's highest sales of medical supplies and pharmaceutical drugs, while also lacking in resources such as hospital beds, and with rampant disparities between the poor and the higher socio-economic classes. National plans were set in place to gradually increase the annual health expenditure through the years, and efforts were focused on increasing the efficiency of hospitals and medical clinics, while paying attention to the needs of the handicapped and those suffering from heart diseases.

The advent of Hugo Chevez's Presidency in Venezuela in 1998, followed by the beginning of the Bolivarian Revolution (1999-present) soon after marked a change of tide for Venezuela, in terms of its socio-economic position as well as its healthcare system. Initially, Chevez's healthcare reforms seemed to do wonders for the nation. As the world's largest crude oil reserve, Venezuela was successful in leveraging its precious resources and fund government expenditure for public healthcare, leading to sharp improvements. A partnership with Cuba meant that in exchange for a certain supply of crude oil, Cuba would supply medical resources, professionals and medical training free of cost to Venezuela[106]. The resultant boost within the healthcare system saw reductions in infant and maternal mortality rates, and an increase in the life expectancy of a nation. In 2010, the government also passed the Insurance Activity Law, which required greater state regulation over private insurance companies[107].

[104] "COVID-19 in Racial and Ethnic Minority Groups", Center for Disease Control and Prevention, accessed June 14, 2020, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html.
[105] "HRSA Fact Sheet FY2018", Health Resources and Services Administration, accessed June 14, 2020, https://data.hrsa.gov/data/fact-sheets.
[106] Tom Phillips, "Venezuela crisis takes deadly toll on buckling health system", The Guardian, January 6, 2019.
[107] "Reformed Venezuelan Insurance Law to Combat Health Insurance Abuses", Venezuela Analysis, accessed June 17, 2020, https://venezuelanalysis.com/news/5609.

The Act served to better address social inclusion in private insurance, better protect the rights of insurance beneficiaires, and ensure that patients requiring emergency care were treated immediately without any wait-times.

With the fall of the oil price in 2008, Venezuela began to enter a state of financial deficit, catapulting the economy into hyper-inflation. Lower demand for oil, sanctions imposed by the US, excessive government spending and inefficient price controls only exacerbated the situation, while Chevez's revolutionary policies resulted in further alienation from foreign support and the cutting of ties with Cuba[108]. Since the period of economic crisis, very little internal data has been published about the healthcare system by the Venezuelan government. State media participate in propaganda by claiming the healthcare system proved to be the epitome of the success achieved by the Bolivarian Revolution.



Source: Americas Society, Council of the Americas

Surveys and studies conducted by external agencies, as well as testimonials by Venzuelan citizens and doctors, speak of a different story. The government has continued to decrease its healthcare expenditure from a high of 9.1 percent of the GDP in 2010, to 5.8 percent in 2014[109]. A 2018 survey by the political opposition to the Bolivarian government revealed that most laboratory services and hospital facilities are open only intermittently or are completely shut down[110]. Infant and maternal mortality rates are at an all-time high. Shortage of basic amenities such as medicines and surgical supplies are rampant in the system, and while 14 percent of intensive care units have been shut down, 79 percent of hospitals and clinical facilities have been reported to have no access to clean water. 53 percent of operating theatres were shut down and 71 percent of emergency rooms failed to provide regular services. Moreover, more than 55 percent of the medical professionals in Venezuela abandoned the country between 2012 and 2017.

The healthcare and economic situation in Venezuela has been deemed one of the greatest humanitarian crises by several intergovernmental panels and organisations. Although

[108] Editorial, "The collapse of the Venezuelan health system", The Lancet, April 7, 2018.
[109] James DeRosa, "A look inside Venezuela's treacherous health care system", Fox Business, February 20, 2019.
[110] Editorial, "The collapse of the Venezuelan health system", The Lancet, April 7, 2018.

multiple nations and the United Nations itself has offered humanitarian aid, the Venezuelan government has declined it, denying the very existence of a crisis in the first place.

Analysis and Interpretation of Case Studies

The ultimate objective of a nation within its healthcare sector is to ensure free and universal healthcare for its population. Different nations have applied different economic, sociological and legislative principles in the pursuit of this goal, to varying results. Through an analysis of the case studies of a number of healthcare systems around the world, as well as by critiquing the results that these systems have had, one can ascertain those principles which work better than some others, and hence come to a definitive result regarding which socio-economic factors would be observed in an "ideal" healthcare system, where access to healthcare is free and universal, quality of care is relatively high especially in regards to infrastructure, resources, and wait-times, costs are contained as far as possible, and where access is equitable with a minimum occurrence of disparities across the population. Contrastingly, studies and reports have determined that there is no gold standard contingent in coming up with a universal healthcare system. Rather, the economic and sociological factors at play within the healthcare sector should be taken in the context of the specific nation and the resources and needs at hand. Country-specific demographic, cultural and institutional factors are imperative when determining the form and details of the prevailing healthcare system. Keeping these contexts in mind, both single-payer and multi-payer healthcare systems pose their own advantages and disadvantages.

Generally, single-payer systems are seen to be more equitable in providing access to healthcare[111]. While most multi-payer systems demand premiums and copayments from their beneficiaries in order to do away with the problem of moral selection, this need does not arise within a single-payer system. Moreover, as a single body is in charge of the entire insurance structure within a single-payer scheme, greater attention can be paid to the needs of the minorities, and hence be efficiently handled with reforms, funding and legislative changes. Additionally, the single-payer system also does a better job in risk-reduction, which is the most primitive function of health insurance in the first place. Such systems distribute the risks across a large risk pool, based on the "law of large numbers", which states that risks that are unpredictable on the individual level become more predictable as the size of the pool grows larger. As single-payer systems deal with the entire population as a whole, it is much more effective at risk-reduction. On the other hand, multi-payer systems apply a more micro-level approach to insurance structures, as a result of which it is difficult to reduce and ascertain risk, leading to the problem of adverse selection and hence a death spiral. Additionally, a single-payer system is better-equipped at cost containment, since the government can easily impose price ceilings and do away with unnecessary expenditures within the sector, while multi-payer systems carry higher administrative costs[112].

However, single-payer systems have often been criticised for its lower quality of care, as well as lack of freedom among the consumers and providers[113]. While bureaucratic authorities are

[111] P. Hussey and G.F. Anderson, "A comparison of single- and multi-payer health insurance systems and options for reform", Health Policy and Management 66 (2003):215-228.
[112] P. Petrou, G. Samoutis and C. Lionis, "Single-payer or a multi payer health system: a systematic literature review", Public Health 163 (2018): 141-152.
[113] Ryan McMaken, "Single-Payer Healthcare Is The Worst Kind Of Universal Healthcare", Centre for Individualism, May 23, 2019.

quick to cut down costs in order to lessen the government expenditures, this can often lead to a detriment in quality, as the more efficient and suitable procedures and medical treatments are inevitably on the costlier side, resulting in price cuts and restrictions being imposed by them. Within a single-payer system, a bottleneck is often created due to the lack of any external agencies supporting the sector, leading to long wait-times. Another factor leading to a lower quality of healthcare is the lack of competition, and hence the lack of any incentives. Within a multi-payer system, private insurance companies compete amongst themselves to get the highest share of the premiums offered by the citizens. The motive of profit-maximisation enhanced by the spirit of competition results in an incentive to improve the quality of care provided in order to attract the high-paying privately insured. Competition is an essential factor within any economy which inculcates entrepreneurship and technological advancement to the benefit of the consumers as well as the producers. The presence of a single power controlling the healthcare sector can also lead to inefficiency due to bureaucratism and red-tapism. Moreover, under a hostile and inefficient government, a single-payer system would be detrimental to the safety of the citizens themselves[114]. As such, a multi-payer system would be more effective, such as in the case of Venezuela. Multi-payer systems also provide greater freedom and choice to the patients, a characteristic that is sacrificed within a single-payer system in the name of savings.

In light of the mixed results yielded by both systems, most nations are interested in retaining aspects of both a single as well as a multi-payer system, in order to produce favourable outcomes across all aspects of healthcare. The most efficient way of doing so would be to modify a single-payer system by increasing the role of private insurance within the hea;th sector[115]. Private insurance in such an economy can take three forms: substitutive, complementary and supplementary. Substitutive private insurance is offered in lieu of the government provided public health insurance, complementary insurance is used in order to cover those additional medical services and treatments that are not covered in the ordinary public insurance plan, and supplementary insurance is used to enhance and improve the coverage of services also covered by the national plans. The Netherlands, Canada and the United Kingdom are all examples of nations who have combined aspects of both single and multi-payer systems to their benefit and attained universal healthcare, as observed in the aforementioned case studies. While supplementary health insurance often creates a two-tiered system which is inaccessible to the lower strata of society, it is complementary private insurance that is best equipped to be combined with a single-payer system to yield the best results[116]. In nations like South Korea and Canada, the government additionally provides subsidies for low-income individuals and families to support their claims to complementary private insurance as well.

It must be noted that ultimately, the system still remains single-payer at heart. In order to smoothen the co-operation and co-existence of the public and private sectors, it is necessary to implement a system of checks and balances. The degree to which the private insurance

[114] P. Hussey and G.F. Anderson, “A comparison of single- and multi-payer health insurance systems and options for reform”, Health Policy and Management 66 (2003):215-228.
[115] P. Hussey and G.F. Anderson, “A comparison of single- and multi-payer health insurance systems and options for reform”, Health Policy and Management 66 (2003):215-228.

[116] P. Petrou, G. Samoutis and C. Lionis, “Single-payer or a multi payer health system: a systematic literature review”, Public Health 163 (2018): 141-152.

detracts from public insurance should be kept limited through increased regulation of the private sector by the government. At the same time, a balance must be struck between cost containment measures and quality of care within the public sector, to ensure that quality is not sacrificed for lower costs and expenditures. This has been ensured in several nations through a dependable system of monitoring and accountability, especially in the United Kingdom, where financial incentives are awarded to providers as well for improvements in quality and efficiency within the healthcare system. Aside from ensuring quality of care within the cost-managed care product, cost containment also gives rise to the problem of maintaining the ethical basis of healthcare[117]. Intervening in costs would essentially undermine the sanctity of the patient-physician relationship that forms the very basis of the principle of healthcare. By forcing physicians to change their treatment methods in pursuit of lesser costs, the patient's trust would be corroded as the physician's interests have shifted from curing the patient to making higher profits. As such, it is instrumental that any cost containment measures should be restricted to reducing prices of pharmaceuticals, reducing budgets of hospitals and facilities as a whole, or in the efficient re-allocation of resources, rather than interfering in the patient-physician trust.

The World Health Organisation recommends that accountability must be implemented by first thoroughly assessing the pre-existing structures within the healthcare sector. After a preliminary assessment, problem areas and appropriate reform strategies must be identifies, on the basis of a number of Key Performance Indicators, which are as follows[118]:

- Increasing transparency and accountability to information to address information asymmetries.
- Establishing reliable rules for accountability relationships between patients, providers, insurance companies, legislations, and financial agencies.
- Effectively monitor and control accountability requirements.
- Implementing legal accountability measures, such as conflict of interest and financial disclosure laws, and citizen participation requirements, necessitating that certain decisions require the input of the public.

Since single-payer systems provide the basic health insurance plans to the entire population in case of universal healthcare, it can be considered to be much more equitable than any other system. However, there still exist various health disparities across populations which remain unaddressed. A community-based, cross-sectional approach to reducing disparities is one that would be the most effective, focusing on the entire healthcare sector as a whole, rather than only the patients. Strengthening a[119]nd diversifying the workforce of health professionals would be the first step to such a change, ensuring the hiring and appointment of minority groups within the healthcare sector as well. There is also a need to expand coverage and affordability of healthcare and insurance schemes for all sections of society, and to increase the transparency and accountability of such structures. From a research perspective, it is important to transform scientific knowledge and innovation by taking a more individual, patient-centric approach, in order to analyse the health needs of individuals across several minorities, rather than the current macro system of research whereby the minorities are often

[117] Vernellia Randall, "Cost Containment Measures".
[118] "Health laws and universal health coverage", World Health Organisation, accessed June 18, 2020, https://www.who.int/health-laws/topics/governance-accountability/en/.
[119] "Strategies to Eliminate Health Disparities", National Conference of State Legislatures, accessed June 18, 2020, https://www.ncsl.org/portals/1/documents/health/HealthDisparitiesDec11.pdf.

left behind and ignored[120]. Financial subsidies implemented by the government and supporting low-income families in signing up to insurance is an essential feature for universal healthcare as well.

Conclusion

Healthcare systems pose an interesting paradigm for governments, policy-makers, economics and sociologists, with its deviations from a traditional market shifting it beyond the purview of a two-pronged consumer and producer setup. The complexities that come up within such systems have been solved in different manners across different nations, some more effective than others, giving rise to the need to perform a detailed case study of various healthcare systems across the world. Health insurance structures, quality of care, cost containment efficacy, and the prevalence of health disparities are the main factors to be taken into consideration when assessing the quality of a healthcare system as a whole.

From this research paper, through an analysis of the aforementioned case studies, it can be concluded that it is a single-payer system with an increased role of private health insurance which may take substitutive, complementary or supplementary forms, that is the most effective healthcare system on a general basis. Such a system could apply to nations all over the world, although some specifications need to be adjusted in the context of the nation and the situation at hand. Quality of care and cost containment measures must be handled carefully: striking the balance between the two is only possible through involving not only the government and the insurers, but also the providers of healthcare and medical professionals, in making all decisions involving cutting down costs and increasing the efficiency of resources. Moreover, it needs to be much more microscopic in order to correctly identify, analyse, and reform health disparities that occur across populations. Each unit of a population must be studied properly to ensure that no one is left behind, in an attempt to reduce and ultimately do away with sociological differences that occur within the healthcare system as health disparities.

[120] "Strategies to Eliminate Health Disparities", National Conference of State Legislatures, accessed June 18, 2020, https://www.ncsl.org/portals/1/documents/health/HealthDisparitiesDec11.pdf.