

# The US health care reform 2010 in light of European health care regulation - A comparative analysis

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## 1. INTRODUCTION

Health care systems provide security against major life risks on account of high expenditure in the social pillar. Every state has its own methods of organizing health care. European states enjoy the reputation of accomplishing the task of providing health care for their citizens to the fullest extent on an efficient basis with universal coverage. While European countries demonstrate how social policies in the field of health care have been successfully implemented, the United States (US) shows a lack of regulations that grant efficiency in the fields of health care. Missing universal coverage and facing tremendous expenditures (the US has the highest expenditure of all OECD states in the fields of health care), the US health care sector is long overdue for reform. The US health care reform 2010 by Barack Obama embodies a change in the organization of health care with regard to the problems faced. In this respect the idea behind this research is to compare the new system structures of health care in the US to European systems and to answer the question to what extent European patterns of health care can be re-discovered in the US system. Therefore, an analytical comparison between the US and European cases, namely Germany (DE) and the United Kingdom (UK), is conducted to determine the similarities of European and US health care systems prior and post to the Obama administration, which serves the idea to determine to what extent European regulation of social policies can be regarded as the prototype for US health care and its reform.

On the steps of the Capitol in Washington, DC, on January 20<sup>th</sup> 2009, judge John Roberts attested the 44<sup>th</sup> President of the United States of America – a historical and cultural event, which saved its spot in the history books. Two million people of all ethnicities from all over the country traveled to Washington to observe the first black President of the United States of America (USA) taking office – taking over a heritage nobody could be envious about. The post-Bush administration was facing a pile of shards that was coined by the biggest financial crisis the USA ever faced. Nonetheless, Barack Obama moved straight to work, following his principle “Yes we can!”. Besides the difficult task of shutting down the prison ‘Guantanamo Bay’ and to regain control over the financial deficit of the United States, Barack Obama sees it as his task as the President to reshape the social state, knowing that the creation of stable social patterns in society is an important fundament for a satisfied population, which creates a fertile ground to conduct further reforms in different policy fields. Therefore a reform of the American health care system was developed and shall create a relief of the highly damaged economy. Knowing that the reform is the first piece of truly re-distributive reform since the administration of Franklin D. Roosevelt, Obama’s objectives for reform entail follow-up changes rather than a process of many changes. Therefore he pledges two major improvements of the current health care system:

The cost-level of health care contributes to the national debt and also high expenditures are negatively impacting the US economy. Changing these circumstances, one part of the approach is to diminish the cost-level of health care and thus to support the economy. The other target is to offer access to health care to the entire American population and achieve a system of universal coverage.

Signing the *Affordable Care Act* on March 30<sup>th</sup>, 2010, Obama started the new era of American health care. Although the attempts for reform faced strong opposition, the White House estimates the reform’s consequences as being highly valuable.

As one of his aims for foreign affairs he announced to resume the communication with leaders from Europe to improve the transatlantic relations, which had severely suffered among the former Bush administration. “In America, there’s a failure to appreciate Europe’s

leading role in the world” as Obama stated. A true fact, especially when considering that for decades Europe is the leading power in creating a social state environment that periodically underlies reform movements to adapt the system to existing circumstances.

Without any doubt the USA is seen as a role model in many fields, but regarding the social sector and the problems the system of health care is facing (e.g. about 16% of the US population is not covered by any health insurance), the USA can take some lessons from Europe. Europe offers a wide variety of different health care systems, which is mainly caused by the multiple state structures that is pre-existing. Two models of the organization of health care are predominant in this context: the ‘National Health System’ and the ‘Health Insurance System’ (Hassenteufel & Palier, 2007). A reason for Europe’s dominant position in the social sector is – besides a long shared history combined with mutual information exchange in policy sectors – the relatively frequent effort for policy adjustment related to political and public interests. Moreover, this tendency towards policy change through reforms, especially in the health care sector, is still searching for its peers.

The Dutch newspaper ‘de Volkskrant’ termed the reform of the US health care system “European-colored” (Remarque, 2010), which means that many elements of European social policies can be found within this new reform. But is this really true? Can we speak of an adoption of European policies in this new reform? And if this is really the case, to what extent can this reform be characterized as being “European-colored”?

To answer these questions, this research tries to concentrate on the differences and similarities of the European and the American health care systems. The pre-Obama health care regulation and the adopted changes by the Obama reform are examined on the basis of European health care policies. At the same time, it is questioned to what extent the Obama reform involves features of European health care.

In context of the research on the extent of European health care in the Obama reform, chapter two introduces concepts of welfare, health care and reform that help developing a broader understanding of health care systems, which is required to analyze health care in detail. The third chapter of the research provides an understanding of the underlying methodology. The Research Question and strategies for analysis are closer defined, the measurement of the extent of European patterns in the US system is introduced, and in the process of elaborating on the Research Design, the case selection of Germany and the United Kingdom as exemplary cases for this research is reasoned.

Empirical description is the key word of the fourth chapter, which focuses, first, on the two European cases for health care provision, and second, on the organization of US health care and its current reform plans. Each health care system is described based on the political presentation of the system and not on the bills implemented in the legal pillar.

The final chapter is the analysis of the European (United Kingdom and Germany) and US health care systems with regard to the present US reform. Findings on the Europe-US, as well as on the US-US system comparisons (prior and after the reform) sum up to a conclusion on the extent to which the Obama reform can be called European-colored.

## 2. THEORETICAL CONSTRUCT

Health care is the most expensive component of the social sector and underlies the responsibility of higher authorities. Existing theory offers possible viewpoints on the regulation of health care: On the one hand, Esping-Andersen’s welfare state theory provides an understanding of the logic of welfare distribution by classifying states in regime types. On the other hand, Hassenteufel describes the possibilities to regulate health care on the basis of defined key determinants, which create different systems of health care. Furthermore, the

theory on changes of health care system, as well as the complexity and impact of reforms and their meaning within the health care sector are presented.

## 2.1 Theoretical Approaches: Welfare states and health care systems across Europe

### 2.1.1. Welfare State Theory

Health care is connected to welfare in the sense of being part of the welfare program. Esping-Andersen (1990) examines the possibilities of arranging social policies to generate welfare within the state body and defines the underlying criteria for the distribution of welfare within states. He claims that welfare states “involve state responsibility for securing some basic modicum of welfare for its citizens” (Esping-Andersen, 1990, p. 18), which is based on T.H. Marshall’s (1950) discovery that social citizenship is an important component of a welfare state. The concept of social citizenship contains three aspects important for welfare distribution: First, if social rights were granted as an opportunity for citizens these rights would entail a de-commodification of the individual’s status towards the market. Second, citizenship also involves social stratifications, which means that one’s status as a citizen competes with or even replaces one’s class position. And third, the mix of institutions and their activity in social provision needs to be clarified to understand welfare states. The state, market and family are considered as the main institutions (Esping-Andersen, 1990, p. 21).

Re-specifying the welfare state puts focus on the ideas of de-commodification and stratification: The introduction of modern social rights implies a loosening of the pure commodity of citizens. De-commodification means that workers are allowed to maintain a livelihood without the reliance on the market. This enables citizens to freely opt out of work - if necessary - without the potential loss income, or general welfare (Esping-Andersen, 1990, p. 23). Social stratifications, which refer to the arrangement of individuals into divisions of power and wealth within a society, make the welfare state become an active force in the ordering of social relations. (Esping-Andersen, 1990, p. 25). According to the three core ideas related to social citizenship, Esping-Andersen clustered European countries in different welfare regimes with regard to their position towards these core values. He defined three variations of welfare state that can be discovered among states: the *liberal*, *corporatist/conservative* and *social-democratic* model.

The liberal welfare state delivers a modest social backup for its citizens mainly through the market with a provision of benefits for the low-income, which are usually the working classes or state dependants. This offers minimized de-commodification effects, while containing the realm of social rights and erecting an order of stratification, which supports equality among recipients of state-welfare and market-differentiated welfare among the majorities. The class-political dualism is strengthened. The United States is one of the countries that is clustered by such a pattern. (Esping-Andersen, 1990, p. 27) Great Britain is clustered by a variation of the liberal regime, namely the *Beveridge* system. In this case modest universalism is preserved in the state and the market reigns for growing social strata, which demands superior welfare. Dualism is not only between the state and market but also seen in welfare-state transfer. (Esping-Andersen, 1990, p. 26)

The corporatist welfare state, which counts Germany, France and the Netherlands amongst others as representing states, grants social rights to the population and puts emphasis on the preservation of status differentials, which attaches rights to class and status. Upholding stratification therefore makes that state’s redistributive power negligible. The market is displaced as a provider for welfare. The preservation of traditional family hood supports the dominance of the principle of subsidiary, which makes the state support foremost interfere at the last stage possible (Esping-Andersen, 1990, p. 27).

The third regime is the social-democratic model, which extended the principles of universalism and de-commodification of social rights. Social democracy is the dominant force behind social reform and makes the welfare state promote an equality of highest standards, as can be seen especially in the Nordic states. Every citizen benefits, all are dependent and therefore everybody feels an obligation to pay. In contrast to the subsidiarity principle, in social-democratic regimes families are preemptively supported in consideration of social costs, which creates enormous costs to maintain the system so that minimization of social risks and maximized revenue is seen as a precondition (Esping-Andersen, 1990, p. 28).

The debate on welfare regimes provides valuable insights for a comparative analysis in fields of social policies, but cannot be directly applied for health care systems. Esping-Andersen developed his ideas on welfare based on programs, such as pension or unemployment, which concentrate on money transfer, rather than factors that are more important for health care. An ideal-typical method for health care systems requires recourse to dimensions other than those more generally applied to welfare systems (Wendt et al., 2009a). Funding is not as important as the provision of health care hence Esping-Andersen's approach lacks a conceptual framework specifically devised for defining health care systems. His view on welfare is inapplicable to health care since the three key indicators that determine welfare regimes fail to establish an adequate basis for differentiating between key features of health care systems, thus a more specific approach needs to be introduced that concerns social and health care services (Alber, 1995, Moran, 2000; Bambra 2005; Wendt 2009b). In this sense a model towards health care regulation by Hassenteufel and Palier (2007) will be introduced to explain important determinants for health care.

	Social rights & de-commodification	Social stratifications	Institutions involved
Liberal regime	<ul style="list-style-type: none"> <li>• Minimized de-commodification effects</li> <li>• Realm of social rights</li> </ul>	<ul style="list-style-type: none"> <li>• Order of stratification: equality among recipients of state- and market welfare (dualism)</li> </ul>	<ul style="list-style-type: none"> <li>• Strong state ↔ weak market</li> </ul>
Conservative/Corporative Regime	<ul style="list-style-type: none"> <li>• Grants social rights</li> <li>• Rights to class and status → status conscious and social cleavages</li> </ul>	<ul style="list-style-type: none"> <li>• System of considerable social stratifications</li> </ul>	<ul style="list-style-type: none"> <li>• Market is displaced as a provider;</li> <li>• Strong state</li> </ul>
Social-democratic regime	<ul style="list-style-type: none"> <li>• Extended de-commodification of social rights</li> <li>• Social rights most fully realized</li> </ul>	<ul style="list-style-type: none"> <li>• Reduction in class differences</li> </ul>	<ul style="list-style-type: none"> <li>• Dominant state → crowded out all private competition/ market</li> </ul>

Table 1. Esping-Andersen's welfare regimes

### 2.1.2. Health care systems across Europe

Hassenteufel and Palier focused on the creation of ideal-typical models for health care. From a historical perspective it can be stated that health insurance was at the core of the social system. All European countries followed similar health care objectives – they tried to aid the sick on low income and wanted to guarantee a substitute income for salaried workers suffering from illnesses. Especially after WWII access to health care for all citizens was attempted. Later, each state chose different solutions to the universal coverage problem (Hassenteufel & Palier, 2007, p. 576).

Different assumptions on health care regulation among states led to the development of two dominant models of health care organization:

The first one introduced is the *National Health System*, which provides an almost free access to health care for all citizens and guarantees universal cover for illnesses. The supply of health

care mainly takes place by the state and is funded by general taxes. Some systems show a high dependence on centralized organizations, whereas others have decentralized organs of organizations and management.

The second predominant health care system is the *Health Insurance System*, which organizes the supply of health care partially private and partially. Most of the time patients are guaranteed to have a free choice of doctor, as well as the status of the liberal practice of medicine. The expenses of this health care system are covered by different health insurance funds, but also through social contributions. The organizational structure is the same as in the National Health System: sometimes centralized, sometimes decentralized (Hassenteufel & Palier, 2007, p. 576).

In the National Health System, a large degree of equal access to health care and low levels of health spending define the system. Long waiting lists to access specialists are common. Health Insurance System supply is often plentiful, but the high health spending and the inequality of access to health care are negative points.

The central question arises about the operation of both health insurance systems. Hassenteufel's and Palier's research framed four factors as being important in health care regulation: Access to, benefits from, financing, and the organization of both systems (Hassenteufel & Palier, 2007, p. 577).

Referring to the access, the National Health System offers insurance, which is open to all, with the attempt to control the circulation of patients within the system. The Health Insurance System was first intended for employees and their dependants, which was extended to a universal cover. A large liberty of choice of doctor for each patient is available with direct access to specialists (Hassenteufel & Palier, 2007, p. 577).

With regard to the benefits the Health Insurance System covers sick pay and is used to replace income that is lost because of illnesses. Today most expenditure is covering the costs of treatment (70%). In National Health System the difference between public and total health care expenditure is the smallest with a limited co-payment – a generous assumption of the costs of payment is offered.

Whereas the Health Insurance System is financed through the payroll tax, which is the long time favored social contribution charged on salaries, the National Health System takes its financial resources out of taxation (Hassenteufel & Palier, 2007, p. 578).

When it concerns the organization of both systems, it can be stated that the National Health System is more centrally organized, but the extent of supply is far more limited than in Health Insurance Systems. Public authorities mainly regulate the National Health System, a distinct difference to the Health Insurance System in which negotiations between managers of health insurance funds and representatives of the medical professions organize the system (Hassenteufel & Palier, 2007, p. 579).

For the following research it is important to know that Hassenteufel determines the United Kingdom as a representative of the National Health System, which embodies a state regulated approach of health care – Germany shows similarity to the Health Insurance System, which is a more market-based model with supervision and co-provision from the state. The two models for health care regulation include the necessary key determinants to consider health care systems in analytical comparisons since the theory includes factors of provision and access, which is not given by welfare state theory.

The next step is to introduce theory of system reforms to the research, which serves the purpose of understanding the impact of the US health care reform to the current system and its value for the US health care sector. In the background of the US health care reform it is important to see what theory predicts for the impact of health care reform and what type of changes can be expected by the Obama reform. Pierson's viewpoints on reform are therefore introduced in the next section.



	Access to health care	Benefits	Financing	Organization
National Health System	<ul style="list-style-type: none"> <li>Free access to health care for all residents</li> <li>Control circulation of patients in system</li> </ul>	<ul style="list-style-type: none"> <li>High fraction of total expenditure for public</li> <li>Limited co-payment</li> <li>Generous cost-level assumptions</li> </ul>	<ul style="list-style-type: none"> <li>Taxation</li> </ul>	<ul style="list-style-type: none"> <li>Task of public authorities</li> </ul>
Health Insurance System	<ul style="list-style-type: none"> <li>Universal cover for population</li> <li>Free choice of doctor and of status of liberal practice; direct access to specialists</li> </ul>	<ul style="list-style-type: none"> <li>Covers sick pay</li> <li>Replaces income loss through illness</li> </ul>	<ul style="list-style-type: none"> <li>Different health insurance funds</li> <li>Social contributions (payroll tax)</li> </ul>	<ul style="list-style-type: none"> <li>Negotiations between managers of health insurance funds and representatives of medical professions</li> </ul>

Table 2. The models of health care systems

## 2.2 Welfare state and health care reforms

Focusing on the analytical comparison between European and US health care systems, it is important to declare what direction a reform of health care can take, what the overall scope of a reform can be, and how feasible intended changes can be.

Characteristics of health care that shape system structures were already introduced in the previous section. Hassenteufel distinguished four of them: The mode of access to social benefits, the structure of benefits, the financing of programs, and the way of managing these policies (Stiller, 2007, p. 3).

Pierson (1994; 1996) sees constraints on politicians as determinants that shape health care. He identifies three problems: First, prevailing status quo protects against attempts of change. Second, any efforts for radical changes are unpopular in the eyes of electorates, because the system mostly reflects public opinion. Third, a new organized interest, which consists of consumers and providers and defends health care (Stiller, 2007, p. 5).

All three problems that are faced contribute to so-called ‘path-continuity’, which implies that resistance to change manifests itself in organized opposition to reform efforts. This resistance is a big share of efforts to ‘path-dependency’, which entails a policy lock-in, as well as sticky institutions. The combination of all three restraints limits policy-makers option to conduct radical reforms. In fact, just as stated by Hemerijck & Visser (2003), changes are still happening and are not blocked, which might misleadingly be expected by path-dependency. Thus achieved changes mostly occur within the previously chosen path.

Although Pierson sees a likelihood of path-breaking reforms, he sees a persistence of the status quo happening (Stiller, 2007, p. 6).

In the background of health care, reforms in this field follow the same pattern as in any other field in which reforms are conducted and therefore face similar circumstances that impact reform efforts. The tendency towards path continuity in reform movements show that some patterns of the system can enjoy slight modifications, but radical changes do not seem to be a logical result. Reforms are therefore not contrary to the existing system. Further, the idea that the status quo is already prevailing does not allow great range for reforms although changing



circumstances, such as institutional shift, are widening the scope of the reform. Also, in consideration of the reform's feasibility, path continuity has to be broken so that it is likely that changes can be conducted.

The Obama reform, in consideration of this theoretical view, would follow incremental changes of the health care system with a rather redistributive character, instead of critical changes within the social sector. Acquiring the idea behind this theory, the next step is to introduce the methodology of the research by forming the leading questions in light of the overall research question, which is dealing with the extent of European patterns in the prior and post Obama health care system.

### 3. Methodology

In this chapter, the methodology of this research is introduced. First, the research question is stated and sub-questions derived from the theoretical construct are evaluated. Then, the concept of "European-colored" is introduced and it will be explained how it is measured. Further aspects of this chapter are the research design and the underlying strategy, as well as an elaboration on the case selection.

#### 3.1 Research Question and Sub-questions

As indicated, the research is based upon findings in the field of health care, which is part of nations' system of welfare. The main focus is on the reform of the US health care system and the organizational structure of the system in comparison to European cases. The degree of similarities between the European and US systems is underlying, which makes the main research question asking:

*To what extent can the reform of the US health care system be characterized as being European-colored?*

The terminology of 'European-colored', already mentioned in the introductory chapter, is further conceptualized in section 3.2. For the focus of the research question two concepts were introduced: welfare states and health care systems. These two concepts are closely related since they both deal with health care regulation, but while welfare state theory explains the redistribution of wealth in general, the models on health care describe a specific regulation of health care. Nevertheless, both concepts are useful when analyzing health care systems in Europe and the US. Derived from the previous chapter, three sub-questions can be formulated in process of giving an answer on the overall research question.

From the theory on welfare states and health care systems in section 2.1 it is known that according to the theory states are clustered in certain welfare regimes. The UK and the US share similar assumptions on the organization of welfare. Due to the common position both are labeled as being liberal welfare states; Germany on the other hand is a conservative/corporatist welfare state. Although welfare theory misses features of access and health care provision, it is still interesting to see whether states that share similar assumptions on welfare also show a similar organization of health care, inasmuch that the following question about the regulation of health care in states is:

*Q1: Since the US and the UK are both liberal regimes, sharing the same assumptions on welfare organization, can it be expected that similar patterns of health care regulation develop?*

While welfare theory offers a rougher view on health care, the theory on the regulation of health care suggests two specific models that deal with health care: On the one hand there is the National Health System, which puts emphasis on a strong presence of the state and a weaker position of the market in health care regulation. The other model is called Health Insurance System and develops health care from a shared market and state basis. Considering that the market is an important component of the American system, a favored position towards the market-based model of health care seems to be likely, which raises the question:

*Q2: If the US health care system shows similar patterns to European systems, is the US system then more likely to reflect features of the market-based model of health care (Health Insurance System), rather than of the state-control model (National Health System)?*

Theory on system reforms puts emphasis on the idea of path-continuity as a core point of changes in highly institutionalized systems, just as health care is. In this respect, incremental system changes are facilitated and seem to be more conceivable than radical changes. Therefore a third question can be raised towards the overall research question:

*Q3: Given a high institutionalization of health care, is the US health care system thought to change incrementally due to reform?*

In a nutshell, the three leading questions derived from the theory serve as components to answer the overall research question. To determine the degree of European patterns in the US health care reform, the research question will be further conceptualized and the measurement methods will be introduced.

### **3.2 Conceptualization**

With respect to the research question, to determine the extent to which the reform of the US health care system can be characterized as being European-colored, the terminology of the research question needs to be specified and elaborated to create important indicators for the further research. “European-colored” is a word in this respect that needs to be closer defined. Speaking of “European-colored” in the context of health care, it is understood that patterns in the US health care system are discovered that are similar to those in European systems, which means that the US handles aspects of health care just as European peers do. From a conceptual perspective, as described in the theoretical chapter, welfare state theory and health care models, which are defined through basic criteria, are possible theoretical constructs to compare system structures between different health care systems. Using the criteria listed in table 1 and 2, it is useful to choose an ordinal measurement to indicate if patterns can be re-discovered in another system and consequently to what extent the US health care system shows similarities to European systems.

As mentioned in section 2.1.2, Germany and the UK are representing the two models of European health care: the National Health System and the Health Insurance System. Translating this idea into a simplified two-dimensional scale approach for the fraction of pattern-similarity the following model develops:

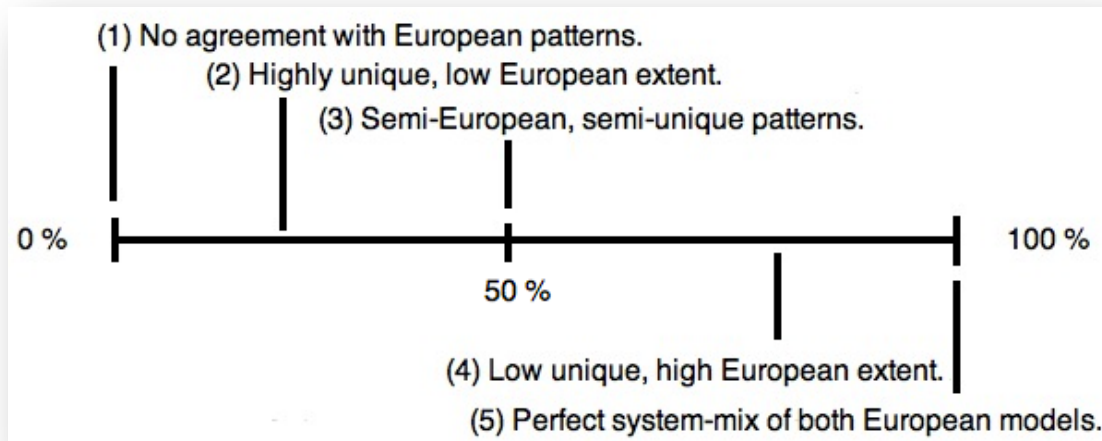


Illustration 1: Scale of European-coloredness in health care systems.

A system comparison is used to determine the position of the US health care system on this scale. Assigning an approximate percentage to the position of the US health care system on this scale helps to express the extent of European patterns in the underlying system. For this purpose a simplified calculation method is used to estimate an approximate value for “European-coloredness”: Each criterion from Hassenteufel’s models on health care regulation (compare table 2) is assigned to a value that describes the similarities to European patterns. “0” means that the criteria shows no agreement with a European system, “0.5” indicates partial agreement with one of the two systems, “1” means complete agreement with one single system. “1.5” means complete agreement with one system and partial agreement with the other. The maximum possible value for one criteria is “2”. The estimated value for each criterion is then summed up and divided by the maximum possible value to determine the percentage for the extent of “European-coloredness”.

It is only logical that the more patterns of different European systems can be discovered in another system, the more we can speak of “being European-colored”. Considering the four criteria of the health care model from section 2.1.2, the more agreement between criteria in European and US health care systems, the higher the percentage of European-coloredness as demonstrated by the illustration above. As indicated, if a system shows no agreement with European patterns, the extent of “European-colored” is 0% (1). If a system is highly unique and to a small part consisting of patterns from European system, the percentile extent of European-coloredness is between 0% and 50% (2). Since the extent of European-coloredness depends on the agreement of criteria for the health care regulation, 50% European-colored according to the scale is prevailing when two out of the four criteria for health care are similar to those in European systems (3). A system is even more European, if a high mix of both European systems exists, whereas the degree of unique structures is low (4). In this case the percentage is between 50% and 100%. In fact, the highest possible extent on this scale is achieved when the system consists of a mix of all European systems (5).

Since both models, the National Health System and the Health Insurance System, represent two different models of health care regulation in Europe and in addition the US health care system embodies a different model too, it is quite useful to introduce a position map for the health care system in respect to the comparative approach in this research. The position map is based on three dimensions, namely the US, the UK and Germany:

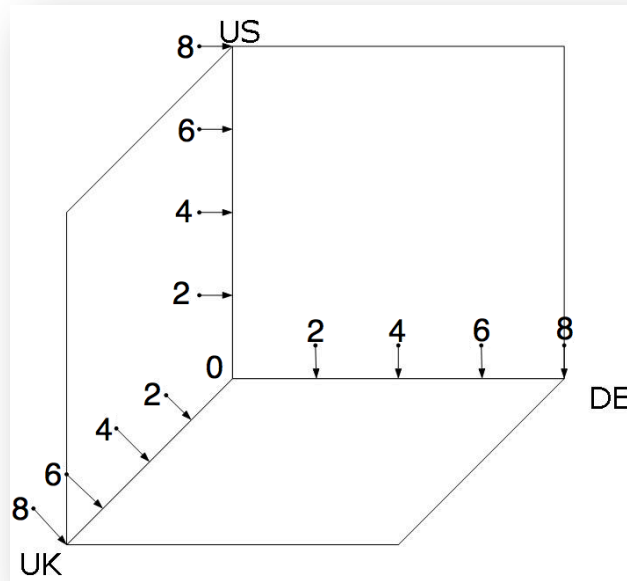


Illustration 2: Three-dimensional position map of health care systems (DE – UK – US).

Illustration 2 demonstrates the position of the health care system with regard to the three underlying systems in Germany, the UK, and the US. Each axis consists of eight units, which represents the maximal possible value a health care system can appeal according to the calculation method introduced in the beginning of this section. After analyzing the criteria of the health care models from section 2.1.2, the US health care system's position after the implementation of the Obama reform can be inserted in this position map. The next step now is to describe the research design and strategy for this research.

### 3.3 Research Design and Strategy

As described in the theoretical approaches, the health care system is part of each nation's program on welfare. This causes that the organization of health care provision differs from country to country on account of the basic criteria their system of welfare is predefining – to say it bluntly, a state implements its own ideas on how to successfully provide health care to its population in accordance with its preferred policy path.

As mentioned in section 3.2 the information that is used to answer the overall research question will be gained from a system comparison. That makes it important to know what kind of data is needed to gain knowledge about the different health care systems. Therefore a two-step method is approached:

The first step is to analyze the health care systems of two European cases and the pre- and post reform system of the United States in the context of the theory on welfare states and of the models of health care organization. As a second step, the findings from step one are compared and retrieved knowledge is used to give an answer on derived sub-questions from the theoretical chapters. As a bottom line, the results received from the system comparison add up to an answer to the research question.

Qualitative data is used in this research to gain data on criteria of welfare states and health care systems; the criteria were already derived from the theory presented in the previous chapter (section 2.1.2).

In this study, nation states serve as the units of analysis. Since there is no unique regulation of health care across Europe, the two different models of health care and respectively the underlying criteria (access, benefits, financing, and organization) are the main basis for the conducted analysis. The goal is to make a system comparison, which on the one hand shows

the similarities between the US and the European health care systems – on the other hand it shall be shown in how far the US health care reform changes the current US system towards European regulation.

In fact the method to retrieve the necessary data was partly mentioned already. The chapter on the theory of welfare states and of health care systems provides criteria for countries that enable to assign states to different types of welfare regimes and models of health care. Those criteria are also fundamental when comparing nations and their systems. For each case used in this research an analysis will be made with respect to the selected criteria.

In addition to the method selection to retrieve data, two methodological choices were made in advance so that the research follows a realizable pattern. Therefore, in consideration of the necessity of qualitative data, the research appeals to conduct a small-n case study. Circumstances of highly individual health care sectors make it too complex to adopt a multiple case study approach, whereas a small-n case study has its focus on two different models of health care system. In this context one example of each model is selected, namely Germany and the United Kingdom (the case selection is further elaborated in the next subsection).

The second methodological choice deals with data restriction to simplify a conduction of the research. First of all, the present form and organization of the health care system is used to rule out the threat of data variation for each case. On this way the comparison of health care systems is as recent as possible and therefore enforces an empirical analysis that is highly accurate. As a second arrangement, reform description only happens in the case of the United States and not in the European examples. This has the reason that the European health care systems' development plays a minor role in contrast to their current organization. Developments are shortly described while mentioning the historical origins of the health care systems, but there is no focus on them. The past US reforms on the other hand are necessary to evaluate the discrepancy of failed reforms in the past towards the enhanced need of changes in the system.

### **3.4 Case Selection**

Governments of European states still enjoy authority when it concerns decision-making in the health care sector. Therefore it is most economic to categorize member states and analyze groups of health care systems. Thus, to conduct a small-n case study seems reasonable. With respect to the highly diverse sector of health care, the two most common models of health care systems across Europe represent the selection criteria for cases in this study. From the pool of states available to be analyzed it is just economic to choose the most prominent representatives of the Health Insurance System and the National Insurance System as cases for the research: Germany and the United Kingdom.

Germany, which has one of the oldest universal health care systems across Europe, embodies the most famous case of the Health Insurance System. The fundament of social principles in connection with the interplay of state and market influences on the German health care sector makes Germany an interesting case. The United Kingdom on the other hand is supposed to represent the same welfare regime as the United States, and as the most prominent representative of the National Insurance System, it is logical to choose the UK as the second case. The strong position of the state makes it differ from the organization of the German system and therefore embodies a completely different model that can be approached.

In addition, both health care systems are similar to the US system with respect to the level of budget spending, which makes it interesting to compare the two states to the US and its health care system.

## 4. Empirical Description

This chapter deals with the empirical description of the cases that are used in this research. The first part introduces the two European cases, Germany and the UK. Health care regulation of both systems is explained in accordance to health care criteria mentioned in section 2.1.2.

### 4.1 The health care Systems in Germany and the UK

#### 4.1.1 Germany

According to Esping-Andersen, Germany represents the Conservative/Corporatist welfare regime. In fact, Germany's health care program (as part of the welfare German citizens enjoy) is one of the oldest universal health care programs in Europe. The so-called statutory health insurance is the basic form of German health insurance regulated by the state. In addition, a private health insurance is offered for those who want to opt-out or those who want to enjoy an extended coverage in health care.

The roots of health care in Germany refer back to Otto von Bismarck, the first German chancellor, who made the proposal for social insurance coverage in the 1880s and created the pillars of German social insurance. The idea behind the proposal was that it offered the possibility to buy political support from workers in exchange for economic protection and material benefits. In the years after the introduction of a social coverage further programs of welfare were established. The first step towards a safety net for people in the working sector was the Health Insurance Act in 1883: a mandatory/*Statutory Health Insurance* (SHI) for blue-collar workers was established, which embodied a primitive form of the current German Health Insurance (Kamke, 1998, p. 172).

Each insurance that is established by legislative procedures underlies the 'insurance principle', which entails that insurances are "characterized by contribution-funding and guarantee the link between the contribution made and benefits received in return" (Kamke, 1998, p. 172). The insurance principle does not only serve as a method to keep the insurance system working, but it also sets regulations: contribution funds are earmarked and cannot be touched by the state, which takes away the danger of deficit spending that cannot be avoided in systems such as the ones based on tax-funding (Kamke, 1998, p. 172).

The most important changes for the SHI came with the health care reform in 2007: For the first time in Germany's history the social sector made health care compulsory, so that every citizen is covered in case of illness (Warns, 2009).

The German state defines its organization of health care coverage as being social. This means that responsibility of health coverage is upon the state's tasks. Nevertheless, this task is divided upon different institutions in the public and the private sector. Even the financing of the health insurance system steps back from a government funded approach and is mainly covered by contributions paid for the SHI and the *Private Health Insurance* (PHI) (Kamke, 1998).

In general, the German health insurance system is offering two different sorts of insurance in its program. A mandatory coverage is the SHI, which guarantees all necessary insurance services to the population. About 90% of the German citizens are insured in the SHI (Internet sources, 1), which consists of different available sickness funds insured persons pay contributions to. These funds are independent in decision-making about the services offered and the contribution rates claimed. Usually the SHI contracts with insurance associations, i.e. hospitals or associations of SHI physicians, to determine the rates and services. In those negotiations the board of directors, consisting of representatives of the insured members and their employers, decides on the sickness funds' contribution rate (Kamke, 1998, p. 173). The state embodies the supervisor in this context, but more important is that potential patients are able to influence the decision-making process and participate actively. On this way collective contracts are negotiated that serve as the basis for health insurance and are uniform to all



patients – irrespective what sickness fund they are insured in (Kamke, 1998, p. 173). As already mentioned, employers and the insured finance the SHI through contributions. The contribution amount depends both on the employee's assessable income up to a certain assessment limit (2010: €45.000 per year), and the contribution rate. A general applicable percentage for the contribution rate is 14%.

Most important in the SHI is that employer and employee each pay half the contributions (Internet sources, 2). If the income assessment line is passed, the insured loses the obligation of being insured in the SHI and can decide if they either stay in the SHI or if they switch to or add a PHI option (Bundesministerium für Gesundheit und Soziale Sicherung, 2005). In any ways, an advantage the SHI brings along is the possibility of free coverage for spouse and children once one working family member is covered through SHI. The principle of solidarity plays an important role in the SHI – the socially resilient take care of the socially weak part of the population.

The other possibility for insurance in Germany is the PHI. Approximately 9% of the population is covered by PHI. In contrast to SHI in which sickness funds are not allowed to deny coverage to any applicant (Leffmann, 2009), the participation in a PHI is either possible if members of the SHI want to add services to their coverage, which serves as a supplementary insurance, or if they exceed the defined income line of €45.000 per year. Hence, the contributions to private sickness funds are more expensive and differ in their calculation: they are determined by the kind of services that are covered, by the health status of the insured, gender and age.

In Germany about 2% of the population falls out of the general insurance scheme. One reason for this is the military covers their staff in their own insurance system.

#### 4.1.2 The United Kingdom

Although the establishment of the UK as a sovereign state can be dated back to the 18<sup>th</sup> century, its history of health care is relatively young. The *National Health Service* (NHS), which is a state-regulated health insurance, was created shortly after World War II. Since its development in 1948 by Aneurin Bevan, the NHS is based on three core principles: it shall meet the needs of everyone, it shall be free at the point of delivery, and it shall be based on clinical need – not the ability to pay. Ever since time passed new minor objectives were added, but these three principles are still at the core of the NHS (Internet sources, 3).

The provision in the NHS is divided into two subsections: the primary and secondary care. Primary care is the first contact of patients with the providing bodies of the health care system, such as *General Practitioners* (GP), dentists, pharmacists and optometrists. Secondary care is also known as acute health and can either be elective care or care in the ambulatory sector. Secondary care mostly follows an appointment after receiving primary care's referral (Internet sources, 4). The overall incentive of the NHS, however, is to provide health care coverage on a universal basis to all residents in the UK. The social principle is the fundament of this idea so that the gap between poor and rich is closed (Internet sources, 5). The direct responsibility of the NHS belongs to the four governments of the United Kingdom (England, Scotland, Wales and Northern Ireland) and is led by the state employees of the NHS-Executive. The department of health (as in the example of England) controls the NHS and has influence on the *Strategic Health Authorities* (SHA), which oversee all the NHS activities in the member of the Kingdom. The SHA on the other hand supervise all trusts in their area (primary and secondary trusts) – a hierarchical structure is established to guarantee an efficient working of the system (Internet sources, 4, 7). In general, the NHS covers 99% of the British population and entitles to free doctor visits and hospital treatment (Grant, n. d.)

Despite being entitled to join the NHS, residents also have the option to participate in a private health insurance, which adds services that are not covered by the NHS.



The funding of the NHS is based on taxation. The UK, in contrast to other European countries, makes the taxpayer contribute to the costs of health care; about 82% is paid by general taxes. The rest costs are covered by co-payments (European Observatory on Health Care Systems, 1999). The NHS accounts for about 86% of the total health expenditure.

As a supplementary coverage in health care, private health insurance serves as a solution for rising needs in the medical sectors for the population. It covers about 12% of the population and in total accounts for 1% of total health care expenditure (Grant, n.d.). Other sources of financing are out-of-pocket payments that cover 90% of the total private expenditure on health (Boyle, 2008).

In the UK efficiency plays a big role in the concerns of health care authorities. The ‘Gershon Efficiency Program’ for instance deals with high-level efficiency targets and monetary gains while it achieves increasing productivity, creating cost-effective deals, reducing costs in the NHS and the central administration and increasing efficiency of social care provision (Boyle, 2008). Especially the factor of cost-efficiency is a circumstance the NHS is famous for.

## 4.2 The Health Care System of the United States

The second part of this chapter describes the case of the US: first a recap of the US history on health care reform is given. Then the current US health care system is explained in accordance to the mentioned criteria from chapter 2. After that the problems of the system are expressed to underline the necessity for reform. Finally, the reform effort of Obama is presented.

### 4.2.1 History of health care reform

The United States is looking back on a history of health care that goes far beyond the times of the two World Wars – a history that is nearly one century old. When discussing health care, it is often mentioned that it is a heritage of many Presidents. In this context Obama stated:

*“I am not the first President to take up this cause, but I am determined to be the last”*

Obama, while being aware of all former Presidents’ work to implement major changes in health care, embodies the seventh administration that is dealing with the Hercules task in the US social sector.

Theodore Roosevelt approached the first effort of health care reform in 1912. His reform movement, which was labeled as the “square deal”, was the first attempt in American politics to establish a plan to provide universal health insurance for all residents of the United States. During his administration, Roosevelt was not able to pass the intended reform and after his defeat in the elections by Woodrow Wilson, the legislation lacked the necessary support in Congress to be implemented.

The second President in the reform process was Roosevelt’s cousin Franklin D. Roosevelt. In 1935, under the “new deal” platform, Roosevelt signed the Social Security Act, which provided a safety net for elderly, sick and disabled people; and the federal government enjoyed the role of the public welfare administration.

Henry Truman and his democratic party, representing the so-called “fair deal” platform, made universal health care coverage part of the party’s incentives. However, in the end of the debates Truman was forced to settle for a modest expansion of social security coverage, which was still highly influential on the program of the Johnson administration, but did not succeed in offer universal coverage.

Lyndon Johnson’s “great society” policy outlined a plan on social security coverage, which had the reputation of being “socialistic” and “un-American”, thus he faced a solid opposition

from the congressional Republicans. Nevertheless, Johnson was still able to pass the legislation for ‘Medicare’ and ‘Medicaid’ (both explained in the next subsection) and to enhance the federal government’s role, however, the plans on universal coverage – originally defined by Truman – were not met.

The next President in the process of health care reform was President Nixon. While expanding the availability of programs provided by the federal government, he took stand for universal health insurance. Negotiations with the democrats in Congress resulted in the “Nixon-Kennedy health care plan of 1974”, which was derailed by the Watergate Scandal. Although the time seemed to have arrived for a focus on health care reform, the economic difficulties the US government was facing in that time put the attention away from health care reforms towards other topics at hand. Moreover, in response to the failure of health care coverage, Jimmy Carter stated later on that economic difficulties made universal coverage of health care politically unfeasible.

The last President that failed to implement universal health care was Bill Clinton. His administration profited from conditions of prosperity hence he proposed a detailed plan to provide universal health care. The negative factor in times of his administration was a strong opposition that successfully vilified his proposal by broadcasting TV counter-campaigns (the famous Harry & Louise campaign). His proposal was finally defeated in Congress and embodied for the time being the last attempt for universal health care in the United States. What became obvious from the history of health care reform was that reform efforts of health care followed a certain cycling process: universal coverage, which is gradually expanding the health care coverage was always countered by the reluctance for rapid change in US politics.

#### 4.2.2 The current US health care system

In the US Health facilities are largely owned and operated by the private sector. The same is true for the availability of coverage: universal coverage is not guaranteed among the population. The most common coverage among US citizens is the private group coverage, which allows the working population to receive health insurance through the employer. This sort of health care system is based on private initiative, thus the employer contracts with a private health insurance or *Health Maintenance Organizations*. Employees are offered to participate in such an insurance, which is mostly covering family members as well – a *Group Health Plan* is established (Fleischhauer, 2007). Financed is this group health plan through contributions from employer and employee and possible extra payments that are due when taking advantage of insurance benefits (Breyer & Buchholz, 2009). Although many employers offer possibilities for insurance, the contributions differ from employer to employer. In addition, employees are running danger of losing coverage in certain cases, such as job change, unemployment or retirement.

The second possibility to retrieve health insurance in the United States is through state-funded insurance programs. Health insurance in the US is formally connected to the workplace, whereas other groups face serious troubles concerning coverage, such as elderly people (65<), unemployed or people with low income. For those people two state-funded programs were created during the Johnson administration to support the mentioned groups.

*Medicare* is intended to support the elderly population (65<) and severely handicapped people. It can be divided into four parts (Fleischhauer, 2007), which offers coverage for different aspects:

- (1) Hospital insurance covers, which is financed through tax-contribution and further contribution by 1.45% of the employee’s salary (Breyer & Buchholz, 2009)
- (2) An optional addition to this health insurance is outpatient coverage. The financial organization of this option is divided into a private contribution of 25% and 75% of the insurance is financed through taxes.

(3) A further addition appeals an alternative coverage with respect to the traditional coverage principal (Klauber, Robra & Schnellschmidt, 2006) According to the principle of managed care respective people are able to receive additional coverage through a *Health Maintenance Organization*.

(4) Medication based on prescription is available to receivers of Medicare, as well. This requires a monthly contribution, but also enforces the state to subsidize.

*Medicaid* embodies a simpler approach of health care than Medicare does. It belongs to a program of welfare and is directed by the federal states (Breyer & Buchholz, 2009), which finance Medicaid through taxes and federal budgets. The categorical preconditions for Medicaid define only certain groups as possible receivers (e.g. pregnant women, children, parents/ persons in custody of children under 19, certain patients of institutes and disabled persons). The financial preconditions are connected to income and assets. The federal government sets the line for income, which determines who is qualified to receive Medicaid. The state government on the other hand can again adjust this income line. Medicaid covers predefined services, but the state government is enabled to expand the offered services.

In addition to the state core programs Medicaid and Medicare there are several other minor departments that are part of state-funded health care, such as the Indian Health Service or the Department of Defense.

#### 4.2.3 *The problems of the current system*

The United States face a situation in which its health insurance system is confronting a large opposition and with respect to the numbers, the US population seems to be more than ready for a health care reform that tackles the problem at its root. The high number of people that are neither insured in the private nor insured in the public sector underlines that universal coverage is a necessary target that needs to be achieved. Forecasts say that in the end of 2010 16% of the entire population (49 million) will not be insured (compare Appendix 1), and the number is rising. This number is even bigger than the number of people that are either receiving Medicare (39 million) or Medicaid (42 million). Despite those numbers, it is still surprising that the US health care system is the most expensive system in the world and the forecast shows a rising expenditure. A further trend in health care is the so-called *Wal-Mart-Style* of health coverage: this means that health care costs are shifting towards employees and workers are increasingly struggling due to payments of higher premiums, deductibles and co-payments. As a matter of fact, Americans that are insured in the private sector face a double-digit increase of costs and they are confronted with higher and more frequent out-of-pocket costs for doctor visits and skyrocketing prices for prescriptions (“What’s wrong with America’s Health Care,” n.d). On the other hand, not only insurances increase pressure on the insured population. Increasing pressure through rising cost levels also takes place on account of employers. Health care costs are shifting to a larger extent onto workers, which results in larger co-payments and deductibles at treatment-time. Besides a suffering wallet, the US population experiences furthermore a lack of quality in health care: it is argued that the system’s lack of comprehensive quality measures and assurance programs contributes to a decreasing degree of quality in health care. The fact that the most successful health insurance program – Medicare - being increasingly under attack is underlining this negative development: the Bush administration followed the attempt of privatization, instead of strengthening and modernizing Medicare, which is in urgent need of reform.

However, probably the most important part of the critique on the US health care lack is that most of the uninsured people in the US belong to the middle class, which puts emphasis on the contradiction that the larger fraction of uninsured people in the US are actually not poor, but still not able to contract an insurance (Scholnick, 2005, p. 9).

#### 4.2.4 Obama's Plan: a health care reform

President Obama, with regard to his policy program, made it his life-task as the President of the United States to create the fundament to solve the problem of health care. In the beginning of 2010 Obama presented his proposal on health care, which follows five aims:

First, he wants to make health care more affordable by providing the largest cut in the middle class tax for health care in history. It is planned to reduce the premium costs for tens of millions of families and small business owners. On this way 32 million uninsured Americans would receive health care and thus makes it affordable for even more. Obama promises that 95% of all American residents will be insured (White House, 2010).

The overall idea of the *Obama Plan* is formulated in his second aim, which is the expansion of health coverage to all Americans. The increasing number of uninsured US citizens shall be offered the possibility to contract insurance. This is to be achieved by ending the discrimination against Americans with pre-existing conditions and by providing an increased program of health insurance. One idea is to expand the Medicaid program, which involves more groups from society (e.g. childless couples). Furthermore, the bottom line for income related subventions shall be adjusted and a compulsory organization of coverage for employees offered by their employers is planned to come into effect – if that is not possible for any reason, employers are obliged to make contributions to an insurance fund to cover costs of health insurances for employees (Davenport, 2009). Small businesses are going to experience a tax-cut so that they are able to provide coverage to their employees.

The third aim of the *Obama Plan* is the decrease in expenditure so that the US health system is more sustainable. In this process the idea is developed to reduce the costs of health care, which shall release the pressure that is currently on the middle class. This shall be achieved through investments in an improved system of infrastructure to increase the system's efficiency. As a result, patients that are in need of expensive treatments are better covered, while costs are reduced at the same time. In addition to that Obama tries to make health insurers more accountable, which is the fourth aim of his plan that he tries to achieve by laying out common-sense rules to keep premiums down and to prevent insurance industry abuses as well as a denial of care (White House, 2010).

The last incentive of the *Obama Plan* is a stabilization of family budgets, the federal budget and of the economy. This part of the plan is passively followed and seen with respect to the long run. Hence, the costs of the reform are about \$1.2 trillion. Future savings of the new system shall cover the major part of this amount (Watzlaweck, 2009). Another source of financial coverage for the reform is a new tax on the rich that is planned to offer support of \$544 million (ZDF Heute, 2009).

As the government is cutting its overspending and reining in waste, fraud and abuse, the White House estimates a reduction of the deficit by more than \$100billion over the next 10 years and over \$1.0 trillion the second decade (White House, 2010).

As all three cases under consideration were presented, the next step is to put the information on the different health care systems into the context of the theory from chapter 2.

## 5. Empirical Analysis

This chapter deals with the analysis of the presented cases: the information from each case delivered in the previous chapter is compared to the criteria that were introduced in chapter 2. Section 5.1 is thought to create the necessary data for the comparison. Section 5.2.a is the comparison of the current US health care system with the two European cases – a statement on question Q1 is given. Section 5.2.b compares first the US health care reform to the two European cases and gives an answer on question Q2. Then a US – US comparison is made to give a statement on Q3.

### 5.1 The European and US health care systems under analysis

The first step in the process of determining the extent of European-coloredness in the US health care reform is to find out what criteria are typical for European states and whether the current US system goes along with the theory in this field. This is achieved by comparing the system structures of each case to the theory described in chapter 2.

#### Germany:

The three defining criteria of welfare state theory - ‘social rights and de-commodification’, ‘social stratifications’ and the ‘mix of institutions’ - are reflected on the German health care system. The reform of 2007 makes health care compulsory, which means that it became a social right. Extending coverage to the entire population de-commodifies to a large extent. People can opt-out of work without being afraid of losing coverage, which is due to prevailing solidarity. Income-related insurance coverage further creates an emphasis on class and status differentials since not every citizen is in the position to afford additional insurance coverage. The result is a system of considerable stratifications within Germany.

Concerning the institutions involved, it can be stated that the state has legislative as well as supervising tasks, whereas the provision of health care belongs to the market. Although the market shows a strong presence in the system, however, the state holds an even stronger position as the controlling body.

	Social rights + de-commodification	Social stratifications	Institutions
Germany	(1) Realm of social rights (2) High de-commodification	1. Status and class differentials prevail	2. Strong state 3. Market providing health care 4. Maintaining family values

Table 3: Germany’s health care under the aspect of welfare theory

From the findings it can be derived, compared to Esping-Andersen’s criteria for welfare states, that German health care fits the conservatist/corporatist regime.

Hassenteufel describes the models of health care systems. Their definition depends on variations in access to, benefits from, financing and organization of the system. Concerning the access to German health care, it is important to see that sickness funds in the compulsory system of SHI are not allowed to deny any applicant. Access to health care is granted to every person, which creates high numbers for SHI coverage (90% of population), and minor numbers for PHI coverage (9% of the population).

The benefits resulting from the German system first include that no income losses can be expected since it covers sick pay. Further, solidarity among the population is a clear benefit for socially weak people, and also the coverage of family members in an insurance system, which was usually created for the working force, is an advantage.

In general, the system is financed by social contributions (payroll tax) that are equally shared by employer and employee. Besides these contributions, additional payments as well as out-of-pocket payments are the pillars of the systems’ funding.

The organization of the system is regulated on the basis of negotiations that take place within the sickness funds. The board of directors decides on important factors for the insurance, such as contribution rates or the service provided. The board of directors consists of many interests groups, which entails that the voice of the public is taken into consideration during negotiations. Furthermore, the state fulfills supervising tasks under this aspect and grants that decisions in negotiations are legal.



	Access	Benefits	Financing	Organization
Germany	2 Access to every applicant 3 Universal coverage	4 Covers sick pay 5 Family members covered	6 Social contributions (payroll tax)	7 State is supervising and legislative body 8 Sickness funds organize provision

Table 4: Germany's health care under the aspects of health care system theory

In sum, comparing the German health care model to Hassenteufel's theoretical construct, the Germany system can be perfectly characterized as being a representative of the *Health Insurance System*.

### United Kingdom:

The system of the UK underlies principles for insurance that grant rights to every citizen. Health care is highly universal – 99% of the population belongs to the NHS, which de-commodifies the population to a high extent.

Dualism is describing the situation of society in which low-income state dependents oppose market welfare recipients. The role of the state in the UK is relatively strong. As the provider of health care for the entire population the state is dominant to the market. The latter is involved as well, but the function of the market underdeveloped. Thus a mix of institution can be detected, whereas there is no equal contribution by the actors.

	Social rights + de-commodification	Social stratifications	Institutions
United Kingdom	1. Coverage is a social right 2. high de-commodification	3. Dualism (low-income state dependents vs. market welfare receivers)	4. Strong state 5. Weak market

Table 5: United Kingdom's health care under the aspect of welfare theory

The findings expose an abnormality to Esping-Andersen's theory on welfare: While confirming the order of stratifications and the institutional involvement, discoveries of social rights and de-commodification do not cope with the UK's theoretical position, but rather show social-democratic patterns that are highly universalized with a large extent of de-commodification.

Concerning the aspects for health care systems, the UK gives every citizen the right to join the NHS – access is therefore granted for the entire population and makes the system highly universal. Each person enjoys therefore a generous supply of health care services and the patient flow within the system is given.

As a benefit of the system it can be stated that the expenditure on NHS is relatively high (86% of total health expenditure), which on the other hand keeps the extra-payments low for the population – it is said that the cost-efficiency level is generous.

The NHS is mainly financed through taxation, which makes the population contribute equally with regard to the tax rate - in addition some extra payments have to be made when obtaining services not covered by the insurance.

The state embodies a central role in the organization of the system. The NHS is under the umbrella of national authorities – the market on the other hand has a supplementary function and is not able to replace or compete with insurances provided by the state.

	Access	Benefits	Financing	Organization
United Kingdom	9 Access for every resident 10 Universal structure	11 High expenditure of health on NHS 12 Low extra-spending	13 Taxation 14 (extra payments)	15 State organized health care supply 16 Market supplementary function

Table 6: United Kingdom's health care under the aspects of health care system theory

Comparing the findings to the theory it can be seen that all four factors that form NHS are identical to those of the National Health System and therefore makes the UK a representative of this system.

### The United States:

According to the social rights and de-commodification, the US shows no system of universal coverage and health insurance is to a large extent connected to employment. The provision of insurance through the employer makes the employee lose coverage when opting-out of work. Inter alia, this shows the dependency on employment and makes workers commodities. From a health care perspective, society consists of market and state dependents, as well as the uninsured people, which determines class position as factor of stratification.

The dominant actor in health care is the market as main provider of health care. The state's tasks are limited and state-funded health care is underdeveloped. Thus, the current situation shows a strong market and a relatively weak state.

	Social rights + de-commodification	Social stratifications	Institutions
United States	2 Social rights (health insurance) are underdeveloped 3 Highly commodified structure	4 Market dependents vs. state dependents vs. uninsured	5 Market is strong 6 State is relatively weak

Table 7: United States' health care under the aspect of welfare theory

Just as the UK, the US also embodies a discrepancy towards Esping-Andersen liberal regime: Minimized de-commodification seems appropriate describing insurance receivers in the US, but the majority of the people is rather commodified, which evolves from the fact that insurance is rather connected to employment instead of being a social right. In addition, stratifications in the liberal regime are described by dualism, which is not the case in the US. Further the institutional set-up in the health care sector contradicts the theory too. In fact, it is reverse to theory: the state is less involved than the market.

The US system of health care also displays a contradiction towards Hassenteufel's theory as the analysis shows:

In the US not every citizen has access to health care, which is illustrated by the 16% of the population who lack insurance coverage. Lack of access also becomes obvious in the limited benefits from the system. Those benefits are clearly not universal, but rather favor certain groups in the population. For instance, coverage of family members when contracting insurances is not guaranteed, but more or less depending on the insurance plans between insurance provider and employer.

The financing of the system is also diverse in the US: market welfare depends on contributions from employer and employee, whereas state-funded programs are partially tax-funded (and through federal budget) and partially supported by social contributions from insurance receivers (e.g. 1.45% of employees salary).



The organization of health care seems to be rather confusing since market-provided standards for services depend on the negotiations between the contractor and the insurer, and also vary from work place to work place. When it concerns the state programs on health care, the federal government sets standards for insurance – state governments are able to adjust those standards if necessary.

	Access	Benefits	Financing	Organization
United States	17 No universal access/provision	18 Some group advantages 19 Family member coverage	20 Social contribution (in market welfare) 21 Tax-funding or budget spending (in state programs)	22 Negotiations between contractor and insurer (in market welfare) 23 State standards (for state programs)

Table 8: United States' health care under the aspects of health care system theory

With regard to the models of health insurance described by Hassenteufel it can be seen that the system in the US is not confirmed by one of the models, but rather shows a lot of different patterns. Although it can already be seen that the system in the US health care system shows aspects of both the National Health System and the Health Insurance System, the analysis of the US health system is done in more detail in the following section.

## 5.2 System comparison

### 5.2.1 A Europe - US system comparison

#### Welfare State comparison:

Esping-Andersen's theory on welfare states defines regimes on the basis of 'social rights and de-commodification', 'social stratification' and 'institutional involvement'. From the theory the following question was derived:

*Q1: Since the US and the UK are both liberal regimes, sharing the same assumptions on welfare organization, can it be expected that similar patterns of health care regulation develop?*

In the previous analysis of health care systems it could be seen that Germany perfectly reflects the corporatist/conservative welfare regime. Contrary the US and the UK both showed irregularities towards the type of welfare state they are labeled as. Having a closer look at both systems, it can be stated that the UK shows partly liberal and partly social-democratic features. The US shows liberal patterns only towards de-commodification – even if it is only to a small extent – but has features of stratification and institutional involvement that cannot be classified by one of Esping-Andersen's welfare regimes.

The analysis showed the lack of applicability of welfare state theory towards both the US and the UK attests a discrepancy between welfare state theory and health care regulation. As stated in section 2.1.1, Esping-Andersen tries to explain the redistribution of wealth, but does not directly refer to the track of health care. Instead he provides underlying principles for welfare regulation, principles that do not play a major role in health care regulation (access to the system and provision of services values are higher valued in health care). In a nutshell, this means the three criteria for the determination of welfare regimes are not appropriate to identify the extent of European patterns within the US health care system since health care

cannot be analyzed under the aspect of welfare theory. Esping-Andersen's theoretical construct towards welfare is not appropriate to determine the extent of European patterns within the US health care system since it does not include provision of health services or access to health care, however, it helps to understand why the US system does not show a high extent of UK patterns within its system. With regard to Q1 it can be said that the UK and US are not expected to share many viewpoints on health care according to the findings on welfare, which means for the research that health care models need to be closer regarded to gain knowledge about similar patterns in European and US health care systems.

### Health care system comparison:

Hassenteufel uses different factors in his theory to describe the regulation of health care within states. These factors help developing general models on health care, namely the National Health System and the Health Insurance System. 'Access', 'benefits', 'financing' and 'organization' are the important determinants that help defining the states health care system according to this theory.

Looking back on the findings from section 5.1 it can be seen that the UK embodies the National Health System and Germany the Health Insurance System. Both European countries can be described by Hassenteufel's theory, which means that those findings can further be used to determine how many aspects of European health care regulation can be re-discovered in the US health care system, since findings from section 5.1 show that the US system cannot completely be described by one of the models. From the theory the following question was derived:

*Q2: If the US health care system shows similar patterns to European systems, is the US system then more likely to reflect features of the market-based model of health care (Health Insurance System), rather than of the state-control model (National Health System)?*

The US health care system does not grant access for every citizen. Exclusion of applicants occurs and is common behavior in the system. Further, health care coverage is not universal. Circumstances of access in the US system cannot be discovered in either models of health care organization.

The benefits of the US system show similarities with Germany hence the US private coverage sometimes includes family members – just as in the SHI in Germany. Although both countries share this feature, the US benefits are more limited. Germany on the other hand offers additional benefits, such as cover for sick pay, and is therefore socially higher developed – hence it cannot be spoken of similarities between the US and Germany in this part of health care. Taking the benefits of the UK's system into consideration, it is obvious that the low spending on health insurance in the UK is contrary to spending in the US, as health insurance has the reputation of being highly expensive.

If comparing the financing structures of all three health care systems, it can be seen that the US system is based on both social contributions and federal budgets, which is supported by tax funding. In any case, both European systems are not congruent to the US system. Germany is mainly based on social contributions, the UK finances health care through a system of taxation. The US health care system unites both European patterns in its system.

The organization of health care follows similar patterns. The private health care organization mainly happens in negotiations between insurer and contractor. Public health is impacted by standards set by the federal and state government. Again those patterns can partly be found in the system of Germany and the UK. Germany is shaped by negotiations of health care

providers, the UK by state decision-making. Table 9 shows the shared features of the current US health care system with those of European.

	Access	Benefits	Financing	Organization
United States	24 No universal access/provision	25 Sometimes family member coverage	26 Social contribution (in market welfare) 27 Tax-funding or budget spending (in state programs)	28 Negotiations between contractor and insurer (in market welfare) 29 State standards (for state programs)
Germany	-----	2 Family members coverage	3 Social contributions	4 Negotiations between independent actors
United Kingdom	-----	-----	3. Taxation	4. State regulation

Table 9: Similarities of the US health care system with Germany and the UK.

As the comparison shows, the US health care system does not confirm one single model on health care completely, nor does it contradict the models described in the theory of Hassenteufel. The structure of the system is unique for access to health care. The benefits of the US health care system – as stated before – are limited, but show similar benefits in family coverage as can be found in the Health Insurance System. Still it cannot be spoken of shared values towards benefits because those of US health insurance are too limited in comparison to Germany’s system. Concerning the financing structure, the US unites features of both European systems, which defines this part of the system as clearly being European. Private health care is funded by social contributions from employee and employer, whereas the state-funded programs retrieve money from taxes and federal budgets. The organizational structure of the insurance system in the US is similar to both the German and the UK system since private health care is negotiated between two independent actors, which is partly true for German circumstances - public health care is under the regulation of the state, which is just as in the UK. The role of the state is still too limited so that the US organizational structure is congruent to either one system, but rather adopts them both partly.

Reflecting these findings on question Q2 the following can be stated: The US system is partly unique, partly similar to the European systems. However, a tendency towards the German system is not obvious. However, the reform entails changes of the system, which might increase the extent of German patterns in the US health care system.

### 5.2.2 The reform changes the system: US (– Europe) – US comparison

Regarding the new organization of the current US health care system, the Obama reform incorporates several structural changes, which shall accomplish the desired goals of the Obama administration. Although the effects of the changes can only be predicted and discussed on a hypothetical basis - because of not being implemented yet - still the results are of importance for the effects on the US health care situation. The aims of the reform concern the accountability and expansion of health care, decreasing expenditures, a higher accountability for insurers and a stabilization of budgets to strengthen the economy.

Regarding the accountability of health care, tax cuts on middle class and reduced premiums shall guarantee that 95% of the US population has access to health care. In combination with

the expansion of health care, which involves the discrimination-stop of patients with preconditions, as well as the extension of state-funded programs and a higher liability of employer, the US health care system is supposed to be highly universal and grants every citizen access to insurance programs. Furthermore, the almost elimination of all uninsured citizens would create dualism within the society – market welfare recipients would be opposed by state welfare recipients. The decrease in expenditure shall be achieved by reducing the costs of health care, which lowers pressure on patients and increases efficiency at the same time. The fact that insurers will be more accountable by introducing common-sense rules for insurances will not only keep premiums down and make insurance more affordable, but also the presence of the state in the organization of welfare increases. Stabilizing budgets and the economy is a positive and desired outcome, but has no direct influence on the structure of the US health care system and is therefore of minor interest for this research.

Comparing the new US health care system to the European systems shows significant changes for the structure of the US system:

Turning towards the theory on health care systems, one major change in access can be discovered: health coverage will be universal, whereas access will be granted to each and every citizen. In this context the US system shows similarities to the Health Insurance System model and thus adopts the structure of the German system: post-reform health care regulation makes it mandatory for employers to guarantee health insurance for their employees. Further structures from the NHS can be discovered since universal access is part of the system in the UK as well, but differs in the sense that in the US health care is still no social right.

Benefits of the system are not changing. While costs are decreasing, it is still hard to imagine that the reduced cost-level will be significant enough to speak of it in terms of benefits.

Finally, the pillars of financing and organization will experience adjustments that especially in matters of organization will create a greater mix of European systems. The state sets common-sense rules for insurers, which will increase the involvement of the state. Comparing this to the German system, it can be seen that the US resembles the German system by having a market provision of welfare with increasing state influence. UK system patterns can be seen in the increasing state presence, whereas it cannot be spoken of a universal organization of the state. Therefore the mix of the German and the UK patterns in the organization pillar of US health care is still given with changes towards an adoption of German structures and a partial adoption of UK patterns.

The financing of the system is not changing that much either. The structure is still the same, which means that social contributions and taxation are the two determinants. Merely the contribution rates get adjusted so that the middle class is less impacted and that employers are more accountable than they were before. Further tax reductions and low premiums keep health care within the limits of funding for the population, but do not change the regulation.

	Access	Benefits	Financing	Organization
United States	30 Universal Access 31 Compulsory for employers to contract health insurance	32 Sometimes family member coverage	33 Social contribution (in market welfare) 34 Tax-funding or budget spending (in state programs)	35 Negotiations between contractor and insurer (in market welfare), state sets common-sense rules 36 State standards (for state programs)
Germany	5 Health care is compulsory	5 Family members coverage	6 Social contributions	7 Negotiations between independent actors, state supervision
United Kingdom	• Universal access	-----	5 Taxation	6 State regulation

Table 10: Similarities of the US health care system (after the reform) with Germany and the UK.

In sum, it can be said that the change in access towards patterns similar to those in the German system creates a greater mix of European patterns within the US health care system in total. Access is similar to the German system, but also entails patterns seen in the UK. Benefits are still unique for the US systems – which means that they are still limited. A mix of systems can be seen in the financing structure, as well as in the organization of health care, but with a complete adoption of the German system and only partial adoption of UK’s system. Reflecting this on question Q2, after incorporating the reform of the health care system the US shows many European characteristics and is especially in the aspects of access, financing and organization identical to Germany. The UK’s system patterns also exist, but only find partial agreement in these criteria. Benefits still show a unique form of the US health care system. In conclusion, this means that the US health care system is more likely to reflect patterns of the Health Insurance System, rather than those of the National Health System.

With respect to the question Q3 about reforms in health care,

*Q3: Given a high institutionalization of health care, is the US health care system thought to change incrementally due to reform?*

A comparison between the current and the new US health care system is necessary. For this the data from table 9 and table 10 is translated into the simplified calculation scheme that was introduced in section 3.2.

	Access	Benefits	Financing	Organization
Current US health care system	0 (Unique)	0 (Unique)	2 (Mix of both systems)	1 (Partly Germany, partly UK)
US health care reform	1.5 (Mix Germany, partly UK)	0 (Unique)	2 (Mix of both systems)	1.5 (Mix Germany, partly UK)

Table 11: Calculation scheme for the extent of European patterns in the current US health care system and in the US health care reform

From table 11 the extent of European patterns in the US health care systems can be calculated. The current US system shows 37.5 % agreement (calculation of values:  $0 + 0 + 2$

+ 1 = 3;  $3/8 = 0.375$ ) with the existing European systems. The new regulation of US health care on the other hand shows an agreement with existing European systems on health care of 62.25 % (calculation:  $1.5 + 0 + 2 + 1.5 = 5$ ;  $5/8 = 0.625$ ).

### US health care 2010

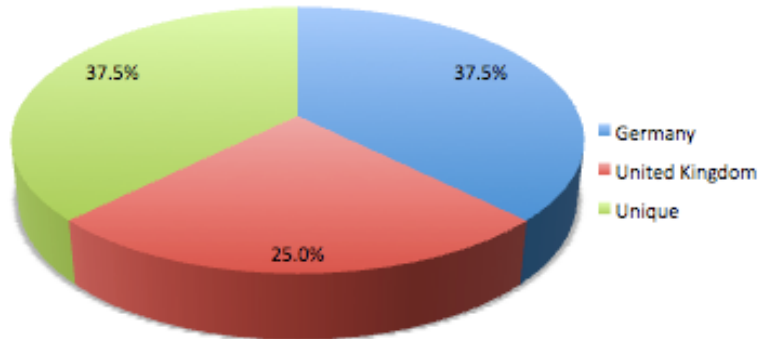


Illustration 3: Share of patterns in the US health care system 2010.

Inferring from those numbers the development of US health care due to reform as described in this section, gives an answer to question Q3 since the reform does not dramatically change the system, but mostly adjustments of the system will drive the US health care system towards a larger extent of European patterns.

Comparing the “new” US health care system to the illustration in section 3.2 it can be seen that the US health care system still shows a mix of European patterns with own characteristics. The increasing mix and the decrease of own characteristics have influence on the overall extent of European patterns in the US health care system. It can be stated that after implementing the US health care reform, the level of European structures in the US health care system is rising, while a tendency towards the Health Insurance System (represented by Germany) is identifiable as can be seen in Illustration 4:

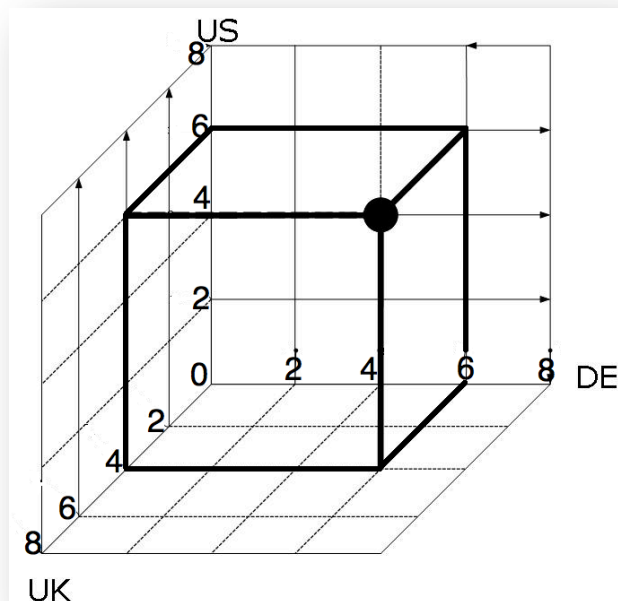


Illustration 4: US health care system in the three-dimensional position map of health care systems.

## 6. Concluding Remarks

When arriving into office, Barack Obama's highest priority was to start the political change from the "inside" so that a fertile ground for further structural changes would be established. Reforming the "problem child" of the US social pillar, the health care sector, means that it is necessary to have a look at the states that are in control of this issue area. Europe shows that a regulation of health care is possible while still following social principles. Therefore it is not unusual that similar patterns can be discovered within the United States and the European health care systems. In order to investigate to what extent European patterns can be discovered within the system, this study evaluated the theories of welfare state and health care systems on the cases of Germany, the United Kingdom and the United States. Providing theoretical basis for this research by expressing underlying principles for the redistribution of wealth, Esping-Andersen's theory on welfare states offers viewpoints that entail aspects of citizenship towards different welfare state regimes. Although sharing liberal views on welfare, the US and the UK differ with respect to the track of health care. Findings from the research discovered that besides sharing same assumptions on the distribution of wealth, Esping-Andersen's welfare theory lacks views on the access and provision of health care services. Therefore theory on health care models was introduced that entailed those missing aspects of health care. Showing more reference to health care itself, Hassenteufel's models on health care are adequate tools to evaluate on health care system structures. Taking 'access', 'benefits', 'financing' and 'organization' as criteria from the models of health care regulation into consideration, it was possible to approach a comparison between the US and European health care systems. Based on this comparison, the extent of European patterns in the US health care system could be determined. The calculations showed that the current US health care system consists of 37.5% shared patterns with European systems. Implementing the reform would raise that fraction to 62.25%. Interesting to see is that the implementation of health care reform changes the share of European patterns from below 50% to above 50%, which indicates that the US health care reform is becoming increasingly European-colored. Surprisingly, besides the congruence of many patterns between the systems, the US health care system shows a particularly large similarity to the German health care system after the implementation of the Obama reform.

Disregarding the advantages and disadvantages of the reform, the theory on reform-changes described that reforms follow paths rather than breaking them. In the case of the US health care reform, the path towards the European system is clearly followed. Although the increase in the extent from 37.5% to 62.25% does not seem to be large, the theory explained that minor changes are likely resulting from reforms, which makes the number of 62.25% appear reasonable. This also underlines the objective of Barack Obama to conduct a redistributive reform of the health care sector, since history of US health care reforms demonstrated that critical changes of the system faced tremendous opposition and resulted in defeats of reform proposals. Therefore incremental changes of the health care system in the US are on the one hand possible method to conduct changes of highly institutionalized systems and on the other hand create effective structures for health care regulation.

Particularly, the development of the system shows that the US health care system is not only developing towards Europe, but also shows a similarity with the German health care system, which indeed provides evidence for the assumption that the extent of being "European-colored" can be determined as being high. To be more accurate, on a scale from 0 % to 100% with 0% equalizing a complete unique health care system and 100% representing a perfect mix of European health care systems, the US health care system has an extent of 62.25% European-coloredness after the implementation of the reform. This number also indicates that the US health care system has a convergence mix of health care policies, since it shows



patterns of both European, as well as of the US health care system with a development towards European-colordness. Respecting that all three cases were regarded from a political presentation of the governments and not from a legal perspective, the findings of the research have to be classified in the political and not the legal pillar of social policies.

Additionally, based on the findings of this research, a new door opens for further studies in other fields of reform properties of health care, such as the information exchange of reform material that provides the US politicians with the required knowledge to adopt “European-colored” reforms. The findings of the research show that present European-colordness in the US health care system inspires a deeper investigation in Europe - US health care relations.

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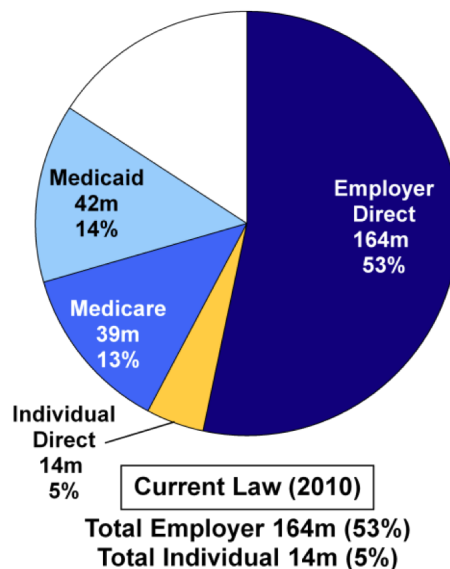
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## 7.3 Appendix

### Distribution of 307 Million People by Primary Source of Coverage Under Current Law (2010)



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