Anna Donovan

ICELAND

1. **What is covered?**
    a. Inpatient care in public hospitals/treatment centers
    b. Outpatient services (primary care, specialists)
    c. Long term care and mental health

2. **Who is covered (i.e. everyone or some)?**
    a. Residents of Iceland regardless of age, gender, race, ability to pay
        i. Opting out of the system is not an option
        ii. Non residents must have private insurance for the first 6 months of their stay in Iceland

3. **Who pays and how (note mixed systems if appropriate or out of pocket)**
    a. Icelandic Health Insurance Agency (which is paid for using a general tax)
    b. Cost sharing – Ministry of Welfare groups insured individuals into groups (18-66, 67-69, 70 and older, and under 18 who are unemployed)
        1. Each group has co-payment for visits which is regulated by the Ministry of Welfare
        2. Cost sharing applies to: Primary care, hospital outpatient, diagnostic/preventative screenings, etc.
    c. No private insurance needed
        i. Exception: private insurance is necessary during first 6 months as ineligible for national system until then
    d. As of 2011, 9.1% of GDP is spent on health care

4. **Who provides (main points of access – note any special providers/provider organizations)**
    a. Primary care is provided primarily by public system with a few private practices
        i. Primary care provides compensation to providers in a mix of salary and some fee for service
    b. Hospitals are all public
        i. Hospital providers are all paid using global budgets

5. **What are apparent strengths of system**
    a. Safety nets for those who are unable to pay their out of pocket expenses

6. **What are apparent weaknesses**
    a. Access to care – wait times to see providers
7. **Any current/emerging challenges or system changes**
    a. No current system changes, however Iceland does have an aging population and will need to provide the appropriate care for these individuals including care facilities.

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Anna Donovan

Kazakhstan

1. **What is covered?**
    a. Emergency care
    b. Specific outpatient and inpatient services
    c. Outpatient drug benefits (free outpatient medicines)
        i. Free: for children, adolescents and "women of reproductive age"
        ii. Co-payment for all others
2. **Who is covered (i.e. everyone or some)?**
    a. **State Guaranteed Benefits provided by the state for all citizens**

3. **Who pays and how (note mixed systems if appropriate or out of pocket)**
    a. Government budget (includes national and *oblast* level funding)
        i. State Guaranteed Benefit Package (60% of government funding goes to this)
        ii. Most of the remaining goes to covering services outside of the Guaranteed Benefit Package
        iii. 0.17% goes to health promotion
    b. Out of pocket expenses – some of which are informal and cannot be estimated
        i. Out of pocket expenses go to the oblast
            1. Patients pay for all non essential health services
            2. Patients pay for meds and supplies in hospitals,
            3. Meds/supplies and dental care (outpatient)
    c. Voluntary health insurance
        i. Promoted by government and contributions are made by individuals and employers
    d. Outside organizations
        i. USAID, UNICEF, World Bank
    e. 4.5% of GDP in 2009

4. **Who provides (main points of access – note any special providers/provider organizations)**
    a. **Hospitals-accounting for over 50% of health care expenditures**
        i. **Mainly state owned**
    b. **Primary care – 16% of the expenditures**
    c. **Dental & pharmacy**
        i. **Privately owned for profit**

5. What are apparent strengths of system
    a. Willingness to invest in health care & facilities (though it appears this is not well thought out – example building new hospitals but not in areas that are in need of them)
    b. Development of national health information system
    c. Development of capitated payment system
    d. Increased funding for healthy lifestyle programs
    e. Increased focus on shifty to primary care rather than inpatient

6. What are apparent weaknesses

   a. Lack of continuity of care / fragmented services
   b. Reliance on inpatient care rather than outpatient care
7. Any current/emerging challenges or system changes
   a. Care quality
   b. Low life expectancy
   c. Infant/maternal mortality
   d. Chronic diseases
   e. Infectious diseases

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Anna Donovan

Liberia

1. **What is covered?**
    a. National health policy wants to provide a basic package
        i. Communicable disease control, emergency care, maternal/newborn health, mental health

2. **Who is covered (i.e. everyone or some)?**
    a. All Liberian citizens

3. **Who pays and how (note mixed systems if appropriate or out of pocket)**
    a. Government – pays for a percentage (roughly 10% as of 2009)
    b. Donors (NGOs, Aid organizations) – (68%)
    c. Households (20%)
        i. 19.5% of the GDP is spent on health care – this is the highest in the world in 2011

4. **Who provides (main points of access – note any special providers/provider organizations)**
    **a. Care is primarily provided by NGOS and agencies (provides over 90% of health care)**
    **b.** Only 0.01 doctor per 1000 population
    **c.** Only 0.8 beds per 1000 population

5. **What are apparent strengths of system**
    a. Continued efforts to improve their health care system
        i. Increases in life expectancy, etc as examples.
6. **What are apparent weaknesses**
    a. Lack of capacity to care for those in need, especially those in rural areas
    b. Lack of equipment/facilities
    c. Lack of necessary medications
7. **Any current/emerging challenges or system changes**
    **a. HIV/AIDS**
    **b. Malaria**
    **c. Maternal mortality**
    **d. Shortage of health care workers**
    **e. Sustainability**

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## AUSTRALIA

Total Population: 21.168 million

What is Covered?
Either wholly or substantially subsidized by government: Inpatient care, population health, prescription pharmaceuticals, mental health, limited dental, preventive (vaccinations and screenings), long term care and some allied health services. Private can be purchased -> extends coverage to CAM, optometry, ancillary and dental services.

Who is Covered?
Universal coverage under the National Health Services act of 1953 for all residents. Certain workers on temporary visas, overseas students, asylum seekers. Undocumented migrants can apply through NGOs.

Payment Method(s) and Systems
Publicly financed with option to purchase privately. Country spends 9.1% of GDP on healthcare. Public hospital facilities jointly funded by territory and Australian government. Funded mainly through DRG system – a variation called 'efficient national price' new for 2012

Cost-sharing: Medicare reimburses 85-100% for ambulatory services, 75% for inpatient. Unregulated fee schedule but downward pressure -> published Medicare fee schedule. Incentive schemes for bulk billing low income, children and rural residents.

Safety net: Once gap expenses reaches annual threshold of $336, Medicare pays 100%. Once annual out of pocket hits $487 for low income families or $974 for individuals, patient receives 80% of those costs.

Provider Profile
Primary care: 44,600 generalists; most self-employed by multi-provider groups. 8% work for private agencies. Generalists are paid FFS and bulk-bill Medicare.
Outpatient specialists: 29,300 specialists; paid FFS and practice in both public/private sectors and facilities.

Inpatient: Mix of public/private/non-profit hospitals. 735 public acute hospitals; 17 psychiatric hospitals; 303 private day hospitals and 285 private 'other'.

Strengths/Weaknesses
One of the biggest strengths appears to be cost as spending per capita is $3,670 (US $8,233) and spending per discharge rate highly, however out of pocket costs and cost as a barrier to access are issues that need to be addressed.

Current Challenges

- Health disparities/inequity for indigenous people.
- Changes in demography and disease patterns
- Uncertainty of how to best balance the public/private sector funding
- Healthcare workforce supply and distribution
- Quality assurance

## Scotland

Total Population: 5 million

What is Covered?
In practice: preventive services, vaccinations, health screenings, inpatient and ambulatory care, prescription pharmaceuticals, dental, limited eye-care, mental health, palliative care, personal care for elderly, rehabilitation. However no statutes exist explicitly outlining covered services.

Who is Covered?
Universal – all Scottish residents; visitors and illegal immigrants can access ER and infectious disease care.

Payment Method(s) and Systems
Approximately 83% of total health spending under NHS is publicly funded mainly through taxation; another 8.5% through Voluntary Health Insurance(VHI) board. Most care is free at the point of access.

Cost sharing: user charges – until recently prescriptions; dental services patients pay 80% up to a maximum of $962 per course of treatment. Eye diagnostic testing free however other ophthalmic services are not covered.

Provider Profile
Primary care: 4,937 generalists within 1009 practices. Most (87%) independently contact with NHS under nGMS; others contract with local health boards through Personal Medical Service (9%) or are directly managed by the board (4%).

Informal carers (non-health professionals) play a huge role – with 657,300 identified that save an estimated 7.7 billion pounds annually.

Specialty and inpatient: 30 district general hospitals owned/operated by NHS; care provided by salaried consultants, docs in training and allied health professionals. 35 ERs and 59 minor injury clincs. 7 teaching hospitals for complex/rare cases. 37 specialized services commissioned by NSS

Strengths/Weaknesses
Universality of access and high ratings for user experience of the system. Struggles with rural care which amplifies socioeconomic inequities which despite universal access do still exist. Wait times and hospital based infections have been issues but improvement being seen in both those areas. Overall population health is poor, with high obesity rates, tobacco/alcohol use and poor diets. Increased transparency since devolution from English system has been fruitful in terms of improving outcomes/efficiency.

Current Challenges

- Health disparities/inequity for rural and low income residents
- Greater emphasis on preventive care
- Ballooning costs attributable to aging population and the free personal elderly care setup

## Venezuela

Total Population: 29.9 million

What is Covered?
Preventive services, hospitalization, lab services, dental, pharmaceuticals, maternity care, transportation and medical appliances.

Who is Covered?
Universal access – health care is defined as a right in the constitution.

Payment Method(s) and Systems
Total spend: ~2% of GDP spent on healthcare (2010). System funded through a combination of wages (4% private, 2% public), employers payroll tax (9-11% private, 4.75% public) and the government. Out of pockets costs are 90.6% of total private expenditure, well over the global average of 50.6%.

Public and private mix; ~300 public hospitals with only 100 fully functioning. 4,800 ambulatory centers (96% public). Approximately 100 public diagnostic/emergency centers. 315 private for profit care centers; 29 charitable facilities. Right now, approximately 8,000 beds in private hospitals are treating over 50% of the population. Mix of centralized and decentralized services, difficult to ascertain due to complexity and lack of data.

Provider Profile
1.94 physicians per 1,000; .55 dentistry professionals per 1,000 (2001 figures) There are 9 domestic medical schools but the country has residency status agreements with several neighbors (Bolivia, Columbia, Ecuador, Peru) that allow foreign providers to practice as well. Unsure if those providing care at public facilities are salaried or contracted by government.

Strengths/Weaknesses
Depending on the perspective, one strength is the Mission Barrio Adentro – the system of 11,000 neighborhood clinics that have been successful and providing preventive care, pharmaceuticals and eye operations to the poor, but has done so at the expense of the public hospitals from which it has siphoned funding. Transparency in the system is non-existent, making overall analysis of system issues complicated at best.

Current Challenges

- Poorly funded
- Physician migration
- Lack of supplies
- Public health (disease outbreaks)

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# South Africa

**What is Covered?**

Health care in South Africa is provided through a two tiered system of public and private services. Basic primary care is offered for free to all individuals through state-funded public health care model. Individuals can receive comprehensive services through ward-based primary health care and district-based specialty and hospital care. However, the demand for public health care services outpaces the available resources, and access and quality are highly variable. The private sector also provides comprehensive services, including advanced technology and specialist care, but only the minority of individuals who have private insurance can access these services.

The national Department of Health oversees health policy, planning, and service delivery including major health reforms currently underway. Under South Africa's current system reform efforts, primary health care will be at the center of health care delivery. Many of South Africa's community health workers are being retrained to serve as ward-based primary health care agents under this new model. School-based health care and mobile clinics will play a significant role in the delivery of children's health care. District clinical specialist teams will also work to improve health outcomes for mothers, newborns and children.

**Who is Covered?**

About 80 percent of the population of South Africa relies on public health services for medical care. Public programs emphasize maternal and child health and additional services for HIV/AIDS, TB, mental health, and cancer are delivered with support from NGOs. Less than 20 percent of the population is covered by private insurance, and this population is disproportionately White and has higher incomes than those without private insurance coverage.

**Payment Systems**

Health care payment in South Africa is currently split between the public sector and private "medical schemes." There are approximately 97 medical schemes in South Africa serving over 8.5 million beneficiaries. These medical schemes are largely employment based and serve mostly middle and high-income populations. The private sector serves less than 20 percent of the population but accounts for nearly half of health care spending in South Africa. The public sector, in turn, makes up only 49 percent of national healthcare spending and serves about 80 percent of the population.

This division between the parallel public and private health systems has resulted in very disparate access and quality and made it difficult to ensure equity in health care. However, the development of a National Health Insurance (NHI) scheme that would unify health care payments into a unified national insurance fund is currently underway. In this model would implement universal coverage, introduce accreditation and tighter regulation of health care delivery, and work with districts to more clearly delineate the functions of the public purchaser and the providers (both public and private). This new payment system is being piloted in several regions while efforts to improve public infrastructure and develop the health workforce are underway.

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**Service Provision**

Until the end of apartheid government in 1994, South Africa's hospitals were divided by racial groups with most services concentrated with the White population. Since the establishment of the current democratic government, dismantling the previous system and transforming health services has been the focus of the Department of Health. Currently provincial health departments deliver comprehensive public health care services to local districts, with private providers and hospitals operating in parallel. In anticipation of the introduction of the NHI, South Africa is currently investing in infrastructure to support systems changes, including building new and upgraded facilities and investing in the health workforce.

**Strengths**

South Africa's national health policy framework provides a strong basis for transforming the system to better meet the population's health needs. While there is not universal approval of the NHI, there is political will to implement national health care reforms and address issues of equity, quality, and efficiency.

**Weaknesses**

The current two-tiered system is fragmented and provides inequitable access to health care. The poor health outcomes South Africa experiences relative to other middle income countries are evidence of this shortcoming. The inadequate public infrastructure presents a significant challenge; current efforts to address health care workforce shortages and insufficient facilities and equipment, however, are attempting to address these problems.

**Current & Emerging Challenges**

The implementation of the NIH began in 2012 and will be phased in over 14 years. South Africa will need to address many challenges in this transformation to a single health system for a large and diverse country. Additionally, AIDS, TB, and other poverty-related diseases continue to place a large burden on the population and the health care system. Addressing this continuing disease burden and improving the low average life expectancy at birth will likely present unique challenges in the context of major health care transformation efforts.

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# Russian Federation

The legacy of the Soviet Union and the highly centralized Semashko system lead to a Russian health care system that prioritizes universal access to basic services over specialty services and new technologies. Reforms in the early 1990s introduced a new compulsory insurance model, but Russia continues to struggle with decentralization and faces challenges in meeting population demands for volume and quality of health care services.

## What is covered?

State-approved basic health services are covered free of charge for all individuals in Russia. The scope of "basic services" can vary from year to year and region to region based on the state medical benefit package determined by annual decree. This benefits package has two parts: a) the basic compulsory insurance package that covers everyday healthcare needs of the population and b) the budget financed package that covers specialty and high-technology services, prescription costs for special populations, and emergency care. Except for limited "special populations," outpatient prescription drugs are not covered and must be purchased out of pocket.

While health care is nominally free and covers a comprehensive range of benefits, scarcity of resources due to underfunding and inefficiency as well as widespread informal payments undermine the promise of universal access. Individuals who can afford the expense make direct payments for specialist services. Population-level preventive services, social services, and investments in technology and facilities, are largely underfunded, as they depend on budgetary funds that are often diverted to other purposes such as security. Health research is also greatly underfunded.

## Who is covered?

Health care coverage in Russia is universal, free, and guaranteed as a right under the constitution. Certain "vulnerable populations" receive additional support for the purchase of outpatient prescription medication. However, disparities in health outcomes between regions and between men and women indicate that rural populations and men have less access to health care resources than urban populations and women. Also, wealthier individuals in Russia receive more care and are able to make direct, informal payments to receive services.

## Payment Systems

In 1993 Russia adopted a compulsory insurance model, replacing the former model that was entirely funded through the federal budget. This reform allowed Russia to open an additional stream of financing and has protected health services from some of the budget shortages experienced by other social services programs. Under the compulsory insurance model, the mandatory health insurance tariff is set at 3.6 percent of an enterprise's total salary amount. The Mandatory Health Insurance Funds pool contributions and use a weighted capitation formula to distribute them to insurance companies. Insurance companies then contract with providers that are mostly owned by the local and regional governments. Recently insurers have attempted to use selective contracting to encourage competition between providers and increase efficiency.

Additional public funding for health programs comes from the general revenue streams of local, regional, and federal governments, mainly from oil and gas exports. Payments from local and regional authorities are responsible the polyclinics and hospitals in their region, including the

development and maintenance of facilities. Individuals also pay directly for health services through informal payments to providers and payments for prescription medications.

**Service Provision**

The government provides health services at the municipal, regional, and federal levels, with a large network of primary care facilities—a legacy of the Soviet era—serving the entire country. Health care is provided on a regional basis through a hierarchical system, with facilities owned and operated by each level of government and a tiered system of referrals. The dominant regulatory and planning institution in the system is the federal Ministry of Health and Social Development, but reforms focused on decentralization have increased regional and local control of service provision.

District physicians are responsible for the health of the population in their assigned local service area. Providers are employed by the state and are paid a salary based on the unified salary scale. Urban communities are served by "polyclinics" in which primary care internists and pediatricians work alongside a team of narrow specialists. Polyclinics combine secondary and tertiary care with hospital outpatient clinics, and specialist outpatient clinics all housed in one facility, sometimes collocated with inpatient hospitals. Russia's remote rural communities are covered by "feldsher" midwife posts and small village hospitals, though small village hospitals have been closing more recently.

**Strengths**

Russia boasts an exceptionally large workforce of trained health care professionals. This includes general practice providers serving Russia's remote rural communities. Additionally, the extensive network of polyclinics and hospitals provides infrastructure in communities across the geographies of Russia's large country. Both are a legacy of the Soviet era system.

**Weaknesses**

Russia's delivery system is inefficient, incurring greater costs than other countries with comparable health outcomes. Standardized salaries and retrospective reimbursement for services provide little incentive for doctors to focus on improving quality and reducing costs. Resource limitations and pervasive informal payments are increasing disparities in access to care.

**Current & Emerging Challenges**

As Russian health economist Igor Sheiman stated in the *Bulletin of the WHO* "The health financing system of the 1990s can be compared to a beautiful car whose owner forgot to fill its tank with fuel." While reform efforts are attempting large systems improvements, underfunding has significantly limited their impact to date.

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# Peru

**Payment Systems**

Peru has a fragmented insurance-based system made up of public and private payers. Overall, spending on health makes up 4.8% of Peru's GDP, and health spending per capita is generally lower than that of other Latin American and South American countries. The Ministry of Health (MINSA) is the government agency that oversees health planning and the implementation of public programs. In 2001, MINSA's mother-child and school children insurance programs were combined into a new Integrated Health Insurance (SIS) program designed to reimburse public providers for health care services provided to vulnerable populations living in poverty. For wealthier individuals, EsSalud is the Social Security program that provides insurance for employees and their beneficiaries. The Armed Forces and National Police Medical Service each provide insurance to their workers' immediate families. Lastly, private sector institutions provide insurance for the few individuals who are able to pay premiums.

**Who is Covered?**

The SIS program for Peruvians living in poverty covers 33.4 percent of the population, the social security program EsSalud covers 16.5 percent, and private insurers cover 1.7 percent of the population. The remaining 48 percent of Peruvians are without insurance. The lower-middle and low-income populations of Peru are often left uninsured; they are not poor enough to be covered by SIS, are largely self-employed and lack access to EsSalud, and cannot afford to pay private insurance premiums. There are large disparities both in access to health care and health outcomes between income groups as well as between the rural and urban populations of Peru. Many individuals do not receive formal health care, primarily due to lack of money to pay providers' fees, and may instead purchase drugs from pharmacies and self-medicate, use home remedies, or visit a traditional healer.

**What is covered?**

The Essential Plan of Health Insurance is the basic plan that all public and private insurers are required to offer. It includes 140 health conditions with services and interventions organized by stages of life and the health status of the population. It is most explicit about care guaranteed for maternal and infant conditions. For the poor and rural populations MINSA helps deliver basic primary care services through regional health centers. Access to specialist care and care at large hospitals is limited by patient fees, with higher income populations receiving more hospital and specialist care. Additionally, pharmaceutical costs are paid for out of pocket by patients, and medications can make up more than a third of a low-income family's expenses.

Public health programs implemented by MINSA have had a significant impact on improving population health in Peru. Some of the greatest gains in health in Peru in recent decades have come from increases in the standard of living, with more individuals gaining access to clean water and sanitation. Maternal and child health programs have also been successfully implemented in the last decade, helping to reduce the high infant and maternal mortality rates and increase vaccination rates.

**Service Provision**

Like the insurance system, the delivery of health care services in Peru is highly fragmented and segmented. Public and private providers offer services that frequently overlap and lack coordination. MINSA is the primary provider for public health, primary care, and hospitalization for poor and lower income populations. Hospitals remain a private and largely unregulated sector dependent on fees paid by patients. Health workers in Peru often work several jobs in both the public and private sectors. The overall number of health care workers in Peru has increased, but there are disparities between different regions f the country with Lima and the coastal areas having the greatest density of health care workers. Disparities between density of providers in urban and rural areas have decreased recently with the implementation of a national plan to distribute and retain health care workers in rural areas.

**Strengths**

Peru's attention to public health and sanitation programs has begun to move the dial on the poor health outcomes and prevalent infectious diseases that burden the population, especially the poor. In particular, attention to maternal and infant health in the last decade has had a significant impact. Additionally, efforts to implement a national insurance plan have resulted in an increase in insurance coverage in Peru.

**Weaknesses**

The fragmented system still leaves nearly half of the population uninsured and perpetuates disparities in access and outcomes between poor individuals accessing care through MINSA and wealthier individuals who receive care through EsSalud or private entities.

**Current & Emerging Challenges**

Extreme poverty has been declining in rural Peru but increasing in urban centers, creating new challenges for Peru's health system to address with urban populations. Communicable and infectious diseases are leading causes of death, and while improvements have been made, maternal and infant mortality remain a major challenge. The need to address the disparities in access and outcomes between Peru's poor and non-poor populations and improve the fragmented insurance and care delivery systems will continue as a major challenge for the country's health system.

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**Country System Synopsis: Vietnam**

Who is covered?

Vietnam's Social Health Insurance Agency is responsible for managing a pool of social health insurance pool funds, monitoring premiums, paying claims and implementing the Ministry of Health's policies on government supported health insurance programs. People obtain health insurance either through an employer or purchase a policy as an individual. While health insurance is required for public employees, it is elective for those who are self-employed. The annual cost of an individual health insurance policy for someone who is self-employed is estimated at 4.5% of their monthly minimum salary, around USD $55. The government provides health insurance for the poor, elderly and veterans.

Who pays and how?

Vietnam's health system is funded through health insurance premiums. Additionally, the government financially supports the health care system. In 2011, Vietnam spent 6.8% of GDP on health expenditures and the total expenditure on health per capita was $231 USD (World Health Organization, 2013).

A person with health insurance will pay a 20% co-pay for a clinic visit or procedure, while Social Health Insurance will pay the remaining 80% of the cost. A person without health insurance is personally responsible for the cost of the health care visit.

What is covered:

Primary care, including prevention, is provided at no cost at all community health stations. Additionally, the government pays for all health care services, including vaccines, for children under the age of 6.

Who Provides

Community health stations, district hospitals and provincial hospitals are all public. Each province has numerous community health stations, several district hospitals and one provincial hospital. Commune health stations provide basic medical care, while district hospitals are

equipped to treat more complex cases and care for patients over an extended period of time. District hospitals generally offer emergency, surgical, pediatric, internal medicine and obstetrics department as well as a pharmacy. Surgical services are provided at both district hospitals and provincial hospitals.

Village health officers and volunteer public health officers increase access to the health care system throughout the country's vast network of villages and communes. They provide personal support, basic health care services and information on health prevention programs.

Strengths:

Vietnam health care system prioritizes primary health care and prevention. The vast network of community health stations provides access points for people to receive health primary care. According to the Ministry of Health (2009), "To meet primary health-care needs, the Government has built and consolidated a commune health network, in which 99% of all communes have a CHS, 65.9% of all communes have a medical doctor and 84.4% of villages have active village health workers" (p. 14).

Weaknesses:

Vietnam has a shortage of health care professionals. Specifically, there are not enough physicians working in rural areas to serve the health care needs of the population. Per Hinh and Minh (2013), "The number of health workers in Vietnam has increased substantially over the past 10 years, but there are still severe shortages in remote and disadvantaged areas" (p. 7).

Challenges:

Vietnam needs more physicians to meet the health care needs of the population, especially in rural areas. Also, about 25% of the population does not have health insurance. It is likely that the majority of those who are uninsured are self-employed and have an annual income that positions them just beyond the scope of government assistance. This vulnerable sector of the population faces financial risk and diminished health as a result of delaying primary care.

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**Country System Synopsis: Rwanda**

Who and what is Covered?

Community-based health insurance is available to all Rwandans. The average household cost of health insurance is USD $2, plus a 10% co-payment for each episode of illness (Basinga et al., 2012). Community based health insurance covers primary care, prevention and major illnesses. According to Basinga et al. (2012), "the government introduced a community-based health insurance scheme as a long-term strategy to address financial barriers to health care for all, as recommended by the World Health Organization, with special attention to protecting the most vulnerable people – the poor, widows, orphans, and people living with HIV- from catastrophic expenditure" (pg. 52). By 2005, community based health insurance extended coverage to 85% of Rwanda's population (Drobac et al., 2013). The Government of Rwanda provides subsidies for health insurance for households classified as poor, survivors of the 1994 genocide and people living with AIDS (Saksena et al, 2011). Community based health insurance has been credited with expanding health care services throughout the country.

Who pays and how

Rwanda's health care system is a public system, where people access care from public health care centers. The system is funded through the national government, health insurance premiums and external donor aid. According to the World Health Organization, the Government of Rwanda's health expenditures were 10.5% of GDP in 2010.

Who Provides

Rwanda's health system is based off of a district health model. Community health centers are located in each of Rwanda's 30 districts and are staffed by nurses. Each community health center serves around 20,000 people. Health centers provide vaccinations, reproductive and child health services, acute care, and diagnosis and treatment of HIV, tuberculosis and malaria. District hospitals provide more advanced care, including surgical services. District hospitals are staffed by 10-15 general physicians and serve 150,000 to 250,000 people. Additionally, each

district has three community health workers that provide health education, basic preventative and curative services, and family planning. Finally, district health units are responsible for administrative management of the district health system.

Strengths:

The Government of Rwanda implemented the National Decentralization Policy in 2000. Decentralization emphasizes public sector accountability and gives district level public institutions the freedom to design responsive service delivery based on local priorities and needs, and allocate public resources where they are needed.

Introduced in 2001, performance-based pay links a health care worker's pay to accountability and service delivery as a means of encouraging high quality care. According to Basinga et al. (2012), "Payments are linked to services (outputs) delivered with specific coverage and quality of care targets for the following key interventions: antenatal care (at least four visits), facility-based childbirth, postpartum visit, family planning and prevention of mother-to-child transmission of HIV" (pg. 53). As a result, health care workers are compensated based on their performance, rather than a set fee scale.

Weaknesses and Emerging Challenges:

Similar to other countries in sub-Saharan Africa, Rwanda does not have an adequate number of health care workers to serve its current population. While sub-Saharan Africa bears 24% of the global burden of disease, the region is served by only 4% of the global health workforce (World Health Report, 2006). In 2011, Rwanda had .84 physicians, nurses and midwives to per 1,000 people (Binagwaho et al., 2013).

Rwanda's current health care work force cannot meet the needs of the population. A significant increase in the number of trained physicians, nurses and community health care workers is needed.

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**Country System Synopses: Bulgaria**

What is covered?

The Health care system is managed and organized by Bulgaria's Ministry of Health (MoH). The MoH is responsible for providing and funding public health services, emergency care, primary care, tuberculosis treatment and inpatient mental health care. The insurance system covers diagnostic, treatment and rehabilitation services as well as medications for insured individuals (Dimova, Rohova, Moutafova, Atanasova, Koeva, Pantelu, Ginneken, 2012).

Who is covered?

The Health Insurance Act of 1998 reformed the Bulgarian health system into a health insurance system with compulsory and voluntary health insurance. People pay health insurance premiums through their employer into the National Health Insurance Fund. People who are self-employed purchase health insurance and pay all contributions themselves (Anglioinfo, 2010).

Who pays and how?

The MoH sets health policy, manages the operations of the health system and coordinates public health policies. The MoH pays for all public health services.

Bulgaria's health system has a mixed public-private financing. The health system is financed from compulsory health insurance, out-of-pocket payments, taxes, voluntary health insurance premiums, corporate payments, donations and external funders (Dimova et al., 2012).

Informal out-of-pocket payments, including both user fees and direct payments, accounted for about 86% of health expenditures in 2008. User fees are collected for physician visits, dental visits, laboratories and hospital stays ((Dimova et al., 2012).

Who Provides:

Health care providers contract with the National Health Insurance Fund. People who have insurance access health care services from providers who have a contract with the National Health Insurance Fund.

The MoH owns and operates all of the university hospital, national health care centers, specialized hospitals, emergency medical care centers, psychiatric hospitals, centers for transfusion and dialysis, as well as 51% of the capital of regional hospitals (Dimova et al., 2012).

Strengths of the System

Bulgaria's health care system has many specialists and specialty medical centers. However, an individual incurs the cost as the National Health Insurance Fund does not cover specialty medical care.

Weaknesses of the System

Bulgaria does not enough health care workers, specifically physicians and nurses, to meet the needs of the population. Additionally, the geographic distribution of health care workers doesn't represent the needs of the population, as there is a disproportionate amount of the health care workforce in urban areas. Bulgaria's rural areas are underserved.

Challenges

Bulgaria's MoH implemented a series of health care reforms over the last10 years. However, these reforms have not strengthened the system. The health care system has been criticized as being plagued with inequity that is the result from socioeconomic disparity, uneven distribution of the financial burden for health are services, poverty and substantial out-of-pocket payments (Dimova et al., 2012).

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# Synopsis

## ✱ Cuban Health System

Cuba has a population of 11,238,412 habitants, 50.1% are males and 49.7% are females. Cuba has been experiencing a demographic transition. It presents the lowest birth rate of Latin America (1.5 children per women). It also has the lowest mortality rate in the region 7.3 per 1000 and its life expectancy is comparable with developed countries (77 years). How this low income country could achieve this goals?

### Universal Coverage

The Cuban government regulates, finances and provides the health services. Cuba recognizes health as an inalienable human right. Therefore, the state throughout the SNS (National Health System) guarantees access to health care to the entire population. The Ministerio de Salud Publica (Ministry of Public Health) implements the policies of the NHS. The principles of those policies are accessibility, and gratuity of health services, promotion of health habits, prevention of illnesses. The Ministry of health is divided in three sectors: national, provincial, and local. The national level provides complex services (third level of attention), the provincial level provides treatment and recovery (second level of attention) and the local level is responsible for activities of health promotion and prevention of illnesses.

### Who get the benefits

Cuba guarantees the free access to every level of attention to the entire population. The coverage is 100%. This access to health services does not depend on ability to pay, social economic position or type of health insurance. Ideally the health system is equal for everyone.

### How the system is financed

The health system is financed with resources and revenues of the Cuban government. According to WHO (World Health Organization) Cuba spent in 2009 11.9 of its GDP in health. The revenues are managed by the Ministry of Health and redirected to the national, provincial and local level depending on their needs.

### Workforce and infrastructure

The number of health workers in 2009 were 582.538 (8.7% of the workforce). There are 6.7 medical doctors per 1000 people and 7 nurses per 1000 habitants. In 2009 Cuba had 5.9 beds for medical assistance per 1000 habitants (this standard is superior to the one suggested by the WHO 1 bed per 1000 habitants).

### Strengths

- Universal Health Coverage
- Gratuity
- Equality
- Good access to remote geographical areas
- Enough health providers for the population
- Low cost, effective.
- Focus on prevention and promotion of health

### Weaknesses

- Delays in attention
- Lack of advance technology treatment
- Delays in elective surgical procedures

### Challenges

Cuba is facing a demographic transition. The shift from high birth rate and high mortality rate to a lower birth rate with very low mortality rates corresponds to an aging population. This demographic transition represents more cost for the health system. The increment of chronic condition and the lack of advance technology to face this challenges will make the system less effective. Therefore, Cuba has to rethink a way to implement more advance technology for the treatment of chronic conditions in elder populations.

## ✱ Colombia Health System

Colombian Health System can be understood in 4 different levels. The first level is financing. second level is managing, third level is regulatory and fourth level providing health care. The name of Colombian health system is SGSSS (Sistema General de Seguridad Social en Salud) which translated to English means General System of Social Security (GSSS)

### Financing Colombian Health System

There is an institution named Fosyga which manage the revenues of the system. Fosyga has two different divisions: contributors and subsidized and the entire population are integrated two one of these two divisions. The contributors are financed by employees, employers and independent workers. The contributor group provides a premium plan that is equal to anyone who contributes to the system. However, the benefits could be expanded if a contributor has more ability to pay. On the other hand,

the subsidized group has a limited premium plan and it is financed by the contributors, national taxation, petroleum tax and sale taxes. So far, 89% of the population is affiliated to the health system. 47.5% are contributors and 52% are subsidized.

## Managing the Colombian Health System

The administration of the Health system is responsibility of the EPS (Empresas promotoras de Salud, which translated to English means Company that Promotes Health). The EPS manages the system for both division contributor and subsidized. The government gave authority to the EPSs to affiliate individuals, to administrate the revenues of the health services and to guarantee the access to activities of health promotion, prevention, treatment and rehabilitation.

## Regulation

The regulatory functions of the system are responsibility of the Colombian government. These functions are regulated throughout the CRES (Commission of Health Regulation) and the Ministry of Health. The CRES defines the "premium plans", and the medications that these premium plans can include, and the UPC of each division. The Ministry of Health dictates the health policies.

## Providing Health Care

The IPS (Instituciones Prestadoras de Servicio which in English means: Institutions that Provides Health Services) are responsible for providing access to health care to the entire population in every level of attention: primary, secondary and tertiary. The IPS hires health providers (medical doctors and certified nurses). The services that they provide are dictated by the EPS and are previously arranged in the premium plans.

## Strengths

- Provides health coverage to vulnerable populations
- Guarantees access equality disregarding someone's ability to pay

## Weaknesses

- Different premiums regarding people's ability to pay

- Imbalance between contributors and subsidized
- Fewer access in remote geographical areas

### Challenges

Colombia health system present an imbalance in the way it is financed. The contributors to the system are fewer than those who are subsidized. This imbalance make the system economically ineffective and inefficient.

## ✱ Canada Health System

Canada has a predominantly publicly financed health system with approximately 70% of health expenditures financed through the general tax revenues of the federal, provincial and territorial governments. Canada health system is mostly privately delivered but publicly funded.

### Delivery

**Primary care services:** initial point of contact for health services, provides prevention and treatment of common illnesses and injuries, and basic emergency services, and coordinates the movement of patients to other levels of care, such as referrals to specialists and/or hospital admissions.

**Secondary care services:** Specialized medical services like diagnostic testing, prescription drug therapy, rehabilitation services, counseling. **Additional care services:** Services not usually covered by provincial health insurance: Such as prescription drugs, dental care, vision care, and independent living for seniors and those with disabilities.

**Financing:** Mostly Public: What is covered varies by province/territory. Services are mostly financed publicly from province/territory public health insurance plans and federal funds.

### Universal mandatory coverage

Provinces have a lot of power over the private physicians/hospitals: Fee for service mode of payment: physicians are paid a specific fee for a specific service, reimbursed

by the provincial government. Provincial public insurance plans negotiate with provincial physician associations to set prices. Hospitals are usually private, non-profit but provincial governments set and provides the hospital's' budgets and determines the number of provided services.

Canada has mandatory universal health insurance plan. It covers basic medical services and is funded through taxation (provincial and federal). They are very monopolistic. Private health insurance: Not available for basic services covered by public health plans. Used for dental and vision care, medical equipment, and independent living for seniors and the disabled, and out of hospital prescriptions

**Strengths**

- Ensure universal basic coverage for all citizens
- Single Payer: Create common, mandatory standards for billing and claims interactions to save money
- Prioritize necessary and preventive care about elective services to improve timeliness and lower costs

**Weaknesses**

- Since health expenditure has grown more rapidly than the growth in either the economy or public revenues, this has triggered concerns about the fiscal sustainability of public health care.
- One major criticism on the Canadian health care delivery system has been long wait ing times. But this is mainly for elective surgical procedures. To keep costs down, Canada limits the supply of these.

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