

## Universal Health Care Annotated Bibliography

1. Costs could derail Massachusetts health reforms. *Lancet*. 2006;367:1291.
2. EURO-MED-STAT: monitoring expenditure and utilization of medicinal products in the European Union countries: a public health approach. *Eur J Public Health*. 2003;13:95-100.  
Notes: CORPORATE NAME: EURO-MED STAT Group.  
Abstract: BACKGROUND: There is uncertainty about the level of utilization and expenditure for medicines in the European Union (EU), making assessment of their impact on public health difficult. Our aim is to develop indicators to monitor price, expenditure and utilization of medicinal products in the EU, so as to facilitate comparisons. METHODS: There are four major tasks. Task 1: To catalogue data sources and available data in each EU Member State. Task 2: To assess the reliability and comparability of data among the EU Member States by ATC/DDD on country coverage, reimbursement, prescriptions, price category (e.g. wholesale, hospital, retail) and private versus public spending. Task 3: To develop Standard Operating Procedures for data management and to define clearly the proposed indicators in terms of objective, definition, description, rationale, and data collection. Task 4: To pool, compare and report the validated data according to the established indicators, using cardiovascular medicines as an example. RESULTS: Preliminary results from Tasks 1 and 2 are available and demonstrate the methodological difficulties in comparing data from different countries. Multiple data sources must be used. These cover different populations, and refer to different prices or costs. Nevertheless, useful data can be derived, illustrated by the example of lipid lowering medicines. The data shows that only five products are commonly available in all countries. Even when a medicine is available in all countries, there may be substantial differences in packages, which can hinder comparison. Data on utilization of statins shows high usage in Scandinavian countries and least in Italy. CONCLUSION: The preliminary results of EURO-MED-STAT show wide differences in availability, and use of medicines across Europe that may have substantial implications for public health.
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Abstract: In France, public health insurance is universal but incomplete, with private payments accounting for roughly 25% of all spending. As a result, most people have supplemental private health insurance. We investigate the effects of such insurance on the utilization of physician services using data from the 1998 Enquete sur la sante et la protection sociale, a nationally representative survey of the non-institutionalized French population. Our results indicate that insurance has a strong and significant effect on the utilization of physician services. Individuals with supplemental coverage have substantially more physician visits than those without. While French patients have greater freedom than patients in other countries to choose to see a specialist rather than a general practitioner, we find no evidence that supplemental insurance affects this decision.
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Abstract: The publicly funded health system in Canada, almost since inception, has been the focus of numerous critiques, matched only by the solutions offered, and the secondary problems generated. One of the proposed solutions is the use of medical savings accounts (MSAs). It is reasoned that MSAs will make Canadians more accountable for the health services they utilize, yield cost containment, and potential savings. However, before a nation-wide, public MSA can be considered

further, there is need to reconcile the following: (a) empirical evidence in support of MSAs that is not as compelling as some of its proponents argue; (b) the scale and complexity of a MSA if integrated into a publicly funded, nation-wide health system in a country the size of Canada; (c) whether the cost to formulate, implement, and operate a nation-wide Canadian MSA would yield the net gains to warrant such an expenditure; (d) the fact that implementation of a nation-wide MSA potentially may contravene the Canada Health Act.

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Abstract: In the absence of an ambitious federal effort to reduce the number of Americans without health care insurance—45 million and climbing—states around the country are considering their own solutions. The details and scope of these proposals vary widely, and in all cases, the implications for hospitals are enormous.
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Abstract: The healthcare continuum can be divided into stages that move from cause to effect. Each stage is a potential place to focus on improving the management of our healthcare system. The key is to make proactive care profitable for providers without making it too expensive for all other affected stakeholders.
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Abstract: States are leading the search for solutions to the uninsured problem, exploring various paths to universal coverage. In Massachusetts, which recently passed a near-universal plan, it took months to lay the groundwork, and comments were sought from a wide variety of groups. "You can't just look at the most recent accomplishment without understanding what brought us to this point," says Michael Miller, left.
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Abstract: OBJECTIVES: Interest in the composition of the health care menu has grown. Its outwardly comprehensive nature is as rhetorical as the slogans of universal access and affordability. This paper summarizes the international part of a report to the Swiss government, in which we explored the basic package of services covered by social health insurance in France, Germany, Israel, Luxembourg, The Netherlands and Switzerland. The aim of the initial report was to check the

appropriateness of the Swiss catalogue, with special attention to the risk of unequal access to health care by rationing of effective services. In this paper, we highlight the major differences in service coverage between the countries and address the possible factors explaining those differences. METHODS: The contents of the basic packages of the six countries were compared using data from government ministries and sickness funds. RESULTS: Coverage is most comprehensive in Germany and Switzerland; these are also the countries with the greatest total health expenditure. Three countries separated nursing care from other types of health care by creating an independent insurance scheme. Some health care benefits are also covered under the heading of social care. High out-of-pocket payments are increasingly used as hidden rationing instruments. CONCLUSIONS: The present comparison highlights the multi-factorial character of the choices made in six countries in order to keep their health care menu within the possibilities offered by available resources.

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 Abstract: This paper provides a critical analysis of the use of legal claims to assert rights to access health care. Using Canada's system of public health insurance as an example, the paper discusses two significant Supreme Court of Canada cases in which claimants use legal mechanisms to influence health care reform. While one case seeks to expand the range of services covered by public health insurance, the other challenges the government "monopoly" over health care and advocates an expanded role for private health care. These legal claims play out in an adversarial setting where the focus is on the rights claims advanced by individual litigants. Yet, the outcomes of these cases involve broad implications regarding allocation of scarce health care resources and the very structure of the health care system. This paper discusses the benefits and limits of using legal claims in this context and also considers the role of courts in making decisions that may have the effect of constraining policy options available to government decision-makers.
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 Abstract: OBJECTIVE: To examine across five countries inequities in access to health care and quality of care experiences associated with income, and to determine whether these inequities persist after controlling for the effect of insurance coverage, minority and immigration status, health and other important co-factors. DESIGN: Multivariate analysis of a cross-sectional 2001 random survey of 1400 adults in five countries: Australia, Canada, New Zealand, United Kingdom, and United States. MAIN OUTCOME MEASURES: Access difficulties and waiting times, cost-related access problems, and ratings of physicians and quality of care. RESULTS: The study finds wide and significant disparities in access and care experience between US adults with above and below-average incomes that persist after controlling for insurance coverage, race/ethnicity, immigration status, and other important factors. In contrast, differences in UK by income were rare. There were also few significant access differences by income in Australia; yet, compared to UK, Australians were more likely to report out of pocket costs. New Zealand and Canada results fell in the mid-range of the five nations, with income gaps most pronounced on services less well covered by national systems. In the four countries with universal coverage, adults with above-average income were more likely to have private supplemental insurance. Having private insurance in Australia, Canada, and New Zealand protects adults from cost-related access problems. In contrast, in UK having supplemental coverage makes little significant difference for access measures. Being uninsured in US has significant negative consequences for access and quality ratings. CONCLUSIONS: For policy leaders, the five-nation survey demonstrates that some health systems are better able to minimize among low income adults financial barriers to access and quality care. However, the reliance on private coverage to supplement public coverage in Australia, Canada, and New Zealand can result in access inequities even within health systems that provide basic health coverage for all. If private insurance can circumvent queues or waiting times, low income adults may also be at

higher risks for non-financial barriers since they are less likely to have supplemental coverage. Furthermore, greater inequality in care experiences by income is associated with more divided public views of the need for system reform. This finding was particularly striking in Canada where an increased incidence of disparities by income in 2001 compared to a 1998 survey was associated with diverging views in 2001.

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Abstract: France has provided universal health care through employment-based health insurance funds. As its governments have increasingly used tax revenues to supplement payroll levies, they have assumed a larger role. Faced with widening deficits in the funds' accounts, the National Assembly adopted in August 2004 legislation designed to decrease health expenses, increase revenues to the funds, and improve quality of care. The apparent impacts of the so-called Douste-Blazy law are to reaffirm social solidarity and equality of access; to reinforce central control rather than relying more on decentralized and market forces; to give the now-unified funds a stronger director, shielded not only from labor and business but also, possibly, from the central government; to allow French private physicians to retain their unrivaled freedom of prescription; and to continue France's reliance on taxes as well as payroll levies to finance its health care.
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Notes: without health care coverage, but the solution remains elusive
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Abstract: BACKGROUND: Gender disparities in the treatment of coronary artery disease (CAD) have been extensively documented in studies from the United States. However, they have been less well studied in other countries and, to our knowledge, have not been investigated at the more disaggregated spatial level of cities. OBJECTIVE: This study tests the hypothesis that there is a common international pattern of gender disparity in the treatment of CAD in persons aged > or =65 years by analyzing data from the United States, France, and England and from their largest cities--New York City and its outer boroughs, Paris and its First Ring, and Greater London. METHODS: This was an ecological study based on a retrospective analysis of comparable administrative data from government health databases for the 9 spatial units of analysis: the 3 countries, their 3 largest cities, and the urban cores of these 3 cities. A simple index was used to assess the relationship between treatment rates and a measure of CAD prevalence by gender among age-adjusted cohorts of patients. Differences in rates were examined by univariate analysis using the Student t test for statistical differences in mean values. RESULTS: Despite differences in health system characteristics, including health insurance coverage, availability of medical resources, and medical culture, we found consistent gender differences in rates of percutaneous transluminal coronary angioplasty and coronary artery bypass grafting across the 9 spatial units. The rate of interventional treatment in women with CAD was less than half that in men. This difference persisted after adjustment for the prevalence of heart disease. CONCLUSIONS: A consistent pattern of gender disparity in the interventional treatment of CAD was seen across 3 national health systems with known differences in patterns of medical practice. This finding is consistent with the results of

clinical studies suggesting that gender disparities in the treatment of CAD are due at least in part to the underdiagnosis of CAD in women.

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