PRIVATIZED SYSTEMS IN OTHER COUNTRIES pdf

1: More Countries Turn to Faltering U.S. Prison Privatisation Model | Inter Press Service

The United States is currently engaged in a national discussion about whether to make personal accounts a part of Social Security. To date, 31 other countries have implemented some type of individual, or personal, account as part of their mandatory retirement income systems.

Health care in wealthy countries All industrialized nations, with the exception of the United States, implement some form of universal health care. Universal health care in all wealthy countries except US The main ways universal health care is achieved in wealthy nations include: Government run tax funded systems, e. With the worsening global financial crisis hitting America hard, more are likely to lose medical insurance which is often associated with a job. The US does, however, through Federal law provide public access to emergency services, regardless of ability to pay. However, the emergency services system has sometimes felt strain due to patients being unable to pay for emergency services and many who cannot afford regular health care either use emergency services for treatment, or let otherwise preventable conditions get worse, requiring emergency treatment. The New York Times reports that life expectancy disparities are mirroring the widening incoming inequality in recent decades. Other health issues that are pronounced in the US, such as obesity, high cost of medical drugs, lack of access for large numbers of people, have been concerns for many years. The US has not seen health as a human right, but as a privilege. However, President Barack Obama has tried to challenge this view, with proposed reforms to provide universal health care through health insurance for all. This has been met with wrath from the right wing, even thoughâ€"as the charts above showâ€"the US spends the most per person in the world on health care, yet does not get the best for all that money; most other industrialized nations get better, faster and cheaper health care. In the previous link, author and former Washington Post reporter, T. Reid, looks at 5 myths that many Americans have about health care around the world and concludes: In many ways, foreign health-care models are not really foreign to America, because our crazy-quilt health-care system uses elements of all of them. The government provides health care, funding it through general taxes, and patients get no bills. Premiums are split between workers and employers, and private insurance plans pay private doctors and hospitals. Everyone pays premiums for an insurance plan run by the government, and the public plan pays private doctors and hospitals according to a set fee schedule. This fragmentation is another reason that we spend more than anybody else and still leave millions without coverage. Which, in turn, punctures the most persistent myth of all: In terms of results, almost all advanced countries have better national health statistics than the United States does. In terms of finance, we force , Americans into bankruptcy each year because of medical bills. In France, the number of medical bankruptcies is zero. Large pharmaceutical companies are known to have enormous influence in the US. They have also had a lot of influence on various international trade policies such as those on intellectual property, sometimes to the detriment of poorer countries facing health crises as described in the global health overview page on this web site. In the US, high drug prices have been an issue for many years, with some people even going across the border to Canada to get more affordable medicines. While that sounds like a large amount, according to investigative reporter Greg Palast, it is actually an agreement that drug companies will reduce the amount by which they increase their drug costs over the next 10 years, locking in a doubling of costs. Inter Press Service , who adds that the media has given little or no information about the demographics of the polls being conducted, and whether respondents include the estimated one in three citizens who lacked health insurance at some point in While tax-funded and government run, it provides access to all citizens and is mostly free at point of use. The British system includes free primary care paying doctors and running hospitals through decentralized trusts. Almost all treatment is free. For working age citizens, prescriptions are obtained with a flat fee with pharmacists often telling patients if the same drug is cheaper over the counter than through prescription. Dentist and optician visits typically have some fee associated with them, with dentistry having been increasingly privatized for many, many years. There is a parallel private health option but is used by a small percentage of the population usually the wealthy, by definition. Over the years, the NHS has changed in various ways, but even the parties traditionally hostile to big government the Conservative party typically state

at least publicly support for the institution. There have been a number of problems within the NHS, which the right wing in the US are keen to expose even if it includes exaggerating or bending the truth about NHS problems. There are also concerns that under the guise of necessary reforms due to the effects of the global financial crisis , a privatization agenda is being pushed onto the NHS. SpinWatch, for example, claims that private healthcare companies have built a dense and largely opaque network of political contacts in the UK with one aim â€" to influence policy in their interests and get the reforms they want: Web of private healthcare influence Private Healthcare Network Map , March Click for larger version Using favorable terms such as freedom and choice , some of the reform plans have been intensely criticized, such as giving GPs General Practitioners â€" also known as Family Doctors more control over their budgets. At first glance this sounds ideal: However, GPs themselves are worried about this because they have not been consulted on this plan as it would not just meant they have to also become accountants â€" without extra budgets to do this â€" but that they would end up having to ration limited resources and some people may not be able to get treatment as needed, while diluting the power of the NHS as a universal system throughout the country. For an overview of health systems in various other countries, try the following:

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2: The Most Efficient Health Care Systems In The World (INFOGRAPHICS) | HuffPost

The Brazilian health system is composed of a large, public, government managed system, the SUS (Sistema Ãšnico de SaÃºde), which serves the majority of the population completely free of charge or any form of fee, and a private sector, managed by health insurance funds and private entrepreneurs.

In the private sector, where firms are disciplined by market competition, it is usually assumed that resources are used effectively because firms would otherwise fail to profit. Inefficiency leads to higher costs and higher pricesâ€”practically an invitation to competitors to lure away customers. But the relative lack of competition in the K education sector tends to dull the incentives to improve quality and restrain costs. Moreover, in the public system, the ability of parents and students to ensure that they receive a high-quality education is constrained by the enormous obstacles to leaving a bad school. If resources are to be used effectively, policies must create incentives that encourage school personnel to behave in ways that do not necessarily further their own interests. For instance, without the right incentives, teachers may avoid using the most promising teaching strategies, preferring to use the techniques they find most convenient. In terms of policy, one might speculate that if a nation assesses the performance of students with some sort of national exam and uses this information to monitor teachers, teachers will put aside their other interests and focus mainly on raising student achievement. International Evidence This study asks two basic questions: Do policy and institutional variation help to explain variation in student performance? If so, which policies and institutions are most conducive to student performance? To answer these questions, I turn to the international evidence on student achievement. This is because the institutions within a country do not vary enough to test how different institutions affect student achievement. Only the international evidence, which encompasses many education systems with a wide variety of institutional structures, has the potential to show which institutions heavily affect student performance. My working hypothesis is that differences in educational institutions explain more of the international variation in student performance than differences in the resources nations devote to schooling. A large body of empirical evidence on the effects of resources on student achievement already exists. It overwhelmingly shows that, at given spending levels, an increase in resources does not generally raise educational performance. Studies summarized by Eric Hanushek of the Hoover Institution have shown the lack of a strong, systematic relationship between resources and performance within the United States, within developing countries, and among countries. Likewise, studies by Erich Gundlach and myself at the Kiel Institute of World Economics have found no systematic relationship between resources and performance across time within most countries in the Organization for Economic Cooperation and Development OECD and within some countries in East Asia. Data from the Third International Mathematics and Science Study TIMSS again show that differences from country to country in per-pupil spending do not help in understanding differences in educational performance. This means that school productivity, the ratio of educational performance to the level of spending, differs widely across schooling systems. There is no consensus on the lack of a strong positive relationship between educational resources and performance, however. Still others point to controlled and quasi-controlled empirical experiments that have shown that more resources can lead to higher achievement. Notwithstanding this debate, the international variation in student performance levels in mathematics and science is a fact, and it is generally accepted that differences in the amount of resources given to the education sector do not fully explain why performance levels vary. Data This study uses data from 39 countries to analyze how various institutions affect educational performance at the student level. TIMSS is the latest, largest, and most extensive international student achievement test ever conducted. In , representative samples of students in more than 40 countries were tested for various reasons, data files were available for only 39 countries for this study. Countries participating in the study were required to administer tests to students in the middle-school years, but could choose whether or not to participate in the primary and final school years. This paper focuses on the middle-school years, where students enrolled in the two adjacent grades containing the largest proportion of year-old students 7th- and 8th-graders in most countries were tested. This data set includes data on more than , individual students, who form a representative sample of a

population of more than 30 million students in the 39 countries. TIMSS contains student-level data on achievement and family background and various institutional data: Further country-level data on institutional features of the education systemâ€”mainly concerning the distribution of decision-making powers and the size of the private-schooling marketâ€”come from the OECD educational indicators. I performed the analysis at the level of the individual student not the class, school, district, or country because this directly links student performance to the teaching environment. Previous international studies have used country-level data to analyze what influences student performance. The trouble with performing the analysis at the individual level is that there are no independent, individual observations for many variables. Individual students who attend the same school may share some characteristics that are not captured by survey data; the individual observations are not wholly independent of one another. For instance, in comparing students in countries with centralized exams with those with no centralized exams, there were only 39 independent observations the number of countries in the TIMSS sample. Unless the econometric method is adjusted to account for the lack of variation in some of the independent variables, the findings will appear more robust than they are. I use a statistical method known as robust linear regression with countries as strata and schools or countries where appropriate as the primary sampling unit to calculate appropriate standard errors for my findings and to adjust for this potential bias. Before we can test hypotheses, we must control for the effects of family background and the level of resources devoted to education. Students of parents who completed secondary school or higher achieved considerably more than students of parents who finished only primary school. The perform-ance of students increases steadily as you go from students having fewer than 10 books at home to those having more than books. Students scored 54 points better in math and 57 in science on a range with an international average of and an international standard deviation of when they had more than books at home compared with students who had fewer than Just how big are these effects? Consider that the average test-score difference between 7th- and 8th- graders is 40 points in math and 47 in science. The results for school spending are consistent with the literature: When other factors are taken into account, higher spending and smaller class sizes seem to correspond to inferior mathematics and science results, though the overall effect is relatively small. Nevertheless, providing schools with the proper instructional materials and supplies seems to have a positive effect on performance. Students in schools whose principals reported that they do not suffer from inadequate instructional materials scored 7 points higher in math and science relative to students in schools whose principals reported that they were somewhat limited by inadequate materials. Students in schools with a great shortage of materials scored 6 points worse in math and 12 in science. Both of these findings should be interpreted with care, however: This may reflect the positive effects of having more-experienced teachers combined with the negative effects of large age differences between teachers and students. Aging teachers may not understand a younger generation as well as younger teachers, and their motivation levels may be in decline as well. Altogether, the relationship between school resources and student perform-ance is ambiguous. Per-pupil spending and smaller class size do not have positive effects, while having decent instructional materials and experienced, well-educated teachers do show positive effects. Of the 39 countries in this study, 15 have some kind of centralized exams, in the sense that an administrative body beyond the schooling level writes and administers the exams to all students. This can profoundly alter the incentive structure within the educational system by measuring student performance against an external standard, making performance comparable across classes and schools. In other words, centralized exams make it obvious whether it is the student or the teacher who is to blame. It makes the whole system transparent: Centralized exams also alter the incentive structure for students by making their performance more transparent to employers and advanced educational institutions. Their rewards for learning thus should grow and become more visible. Without external assessments, students in a class looking to maximize their joint welfare will encourage one another not to study very hard. Centralized exams render this strategy futile. All in all, given this analysis, we should expect centralized exams to boost student performance. And they seem to. All things being equal, students in countries with centralized exams scored 16 points higher in math and 11 points higher in science, although the science finding is not statistically significant due to the small number of countries in the sample see Figure 3 for results. Furthermore, students in schools where external exams or standardized tests heavily influence the

curriculum scored 4 points higher in math, though there appears to be no effect in science. This suggests that science tests may lend themselves less readily to standardization. Decision-making between schools and their governing bodies. Other school systems are highly decentralized; most decisions are made at the local level. For instance, schools have a high degree of autonomy in the Netherlands, where 73 percent of decisions are made at the local level, according to the OECD. By contrast, Greece, Norway, and Portugal allow local school personnel to make fewer than 25 percent of the decisions. Here the question is, What is the division of decision-making powers between schools and the government in a country, and how do these divisions affect student achievement? The effects of granting more autonomy to schools are hard to predict. On the one hand, schools need a high degree of autonomy in order to respond to the demands of parentsâ€”a prerequisite for competition. Also, the educators within a school should have more knowledge of effective teaching strategies for their students than central administrators. Likewise, individual teachers should know what are the best textbooks and supplies for their students. Heads of schools should also have more knowledge than central administrators about which teachers to hire and who deserves promotion or a raise in salary. On the other hand, enhanced autonomy makes it easier for school personnel to reduce their workload, unless they are subject to external monitoring and evaluation. The more flexibility a school has, the more important it is to have external standards and assessments. Putting decisions on the size of the school budget in the hands of school personnel might also harm performance; it is clearly in their interest to garner additional funds for themselves or resources that lighten their workload. We should expect, then, that giving schools the power to set their own budgets, performance goals, and standards of what to teach will have an adverse impact on student achievement. Such powers are probably best left to central authorities. By contrast, decisions on how to meet the goals and standards, such as the choice of teaching techniques and the purchase of supplies, are best left to schools, as long as an effective monitoring and assessment program is in place. The first variable I analyze is whether having a centrally designed curriculum and a centralized list of approved textbooks is conducive to student performance. These are essentially decisions about what schools are expected to cover. Students in countries with centralized curricula scored 11 points better in math, 6 in science. Students in countries with centralized textbook approval scored 10 points better in math, 6 in science. These findings are not statistically significant due to the small number of independent observations, but they are nonetheless suggestive. Students in schools that had primary responsibility for setting the school budget scored 6 points worse in math and 3 in science the science effect, however, is statistically insignificant. By contrast, giving schools autonomy in purchasing their supplies goes hand in hand with superior achievement. This is also true for decisions on hiring teachers. Students in schools that hire their own teachers scored 13 points higher in math, 5 in science. Students in schools that determine their own teacher salaries scored 11 points higher in math, 15 in science. Centralized decision-making on curriculum issues seems to prevent schools from seeking to reduce their workload and thus raises student achievement. Conversely, local control of teacher recruitment and compensation may allow schools to retain a more effective staff. The influence of teachers. Within schools, the incentives that teachers face and their ability to influence the process also affect student achievement. Since they cannot be easily monitored, they also have a great deal of freedom to pursue their teaching in whatever way they wish. Often they face conflicting interests.

3: Health systems by country - Wikipedia

Mexico is the other country. It is a bit misleading however to suggest that the system of health care in the U.S. is solely private when you consider that percent of earnings up to a pre-determined amount goes to fund Medicare.

Senior specialists are full-time or nearly full-time salaried, assisted by junior salaried staff who in teaching hospitals are studying to receive specialty credentials. Office doctors who treat patients in the community do not treat them as inpatients, and they regain control after the patients are discharged. In the past, hospital staffs never treated Krankenkassen members except as inpatients, but ambulatory clinics have recently been opened, to enable the hospital staffs to see the inpatients just before and just after hospitalization. The purposes are to reduce the costs from duplicating pre-hospitalization laboratory tests and to discourage excessive length of stay. Teaching hospitals have ambulatory clinics and private offices, where senior specialists can treat privately insured and self-paying patients. The medical staffs of their own private hospitals can treat patients before, during, and after inpatient hospitalization. Each sickness fund pays each hospital for the care of its members. Every German hospital fills out a line-item form every year listing its operating costs last year, its operating costs so far this year, the budget it requests for next year, and utilization statistics. Negotiations then take place between: Backed up with statistics about the operating costs and personnel of similar hospitals throughout the province and throughout the country. Supplied by the statistical staffs of the provincial and national headquarters of the associations. Assisted by representatives of the provincial hospital association. Backed up by statistics from the provincial and national hospital associations. Until recently, the two sides then settled on a per diem rate pflegesatz for the next year: Deadlocks were arbitrated privately to settle on a prospective budget and a per diem binding on both the sickness funds and the hospital. The carriers would not pay more. The hospital could not extra-bill the patients. The traditional per diem rate was long criticized throughout Europe as a perverse incentive to avoid difficult expensive patients and to extend length of stay unnecessarily during convalescence. Germany long had an unusually long average length of stay. All sickness funds and the Ersatzkassen pay according to identical principles. The advantages are simplicity, predictability, and harmony, in contrast to the cost-shifting, secretiveness, and recriminations of American hospital finance. Every hospital has a unique budget and in the past a unique per diem rate. Capital grants to hospitals come from provincial governments, which vary in their priorities and policies. Once German hospitals were inexpensive, largely because their nursing staffs were small, overworked, and underpaid, particularly in the religious hospitals. Then followed a thirty-year struggle to limit hospitals costs and protect the finances of national health insurance. Every step required legislation from the national and provincial Parliaments, the interest groups associations of hospitals, doctors, sickness funds, businessmen, labor, etc. At first, it was assumed that the sickness funds would drive hard bargains with the hospitals in order to avoid deficits and avoid increases in the payroll taxes, but these expectations were disappointed. Next, guidelines about affordable annual increases in all hospital budgets were set by a standing conference of providers and payers, sponsored by the national government the Konzertierte Aktion im Gesundheitswesen , but aggregate hospital spending increased anyway. But the law had so many exceptions, many hospitals could claim special needs, and local implementation depended on the provincial politicians, so that hospital spending and bills sent to sickness funds grew excessively. Finally, at the time of writing, the national Parliament has imposed an entirely new approach to hospital finance: Germany has always been a path-breaker in technology, invented by free individuals. Much of the apparently uncontrollable spending in the hospital and physician sectors has been due to the introduction and spread of new methods. Policymakers have now begun to search for ways to evaluate the adoption of new technology and to plan its spread, a completely new approach for Germany. Doctors have existed in Germany for centuries. After many years of conflict among sickness funds, their panel doctors, and other office doctors excluded from the panels, the current system was finally devised. There is one in each province. It is governed by its members. In Germany, the negotiations take place between a joint bargaining committee of the sickness funds and the association representing the office doctors in social insurance practice: Between all the national associations of sickness funds and the KBV. A long-running

contract, not a law. Also done in the rest of Europe, but not in the United States. Fee schedule, an itemized list of relative values. A long-term document, constantly updated by a standing joint committee. Standard method throughout Europe, but not in the United States. Bilateral negotiations conducted every year in each province between the provincial associations of sickness funds and the KV. Something like this is standard throughout European health insurance, but not in the United States. Sickness funds together grant a lump sum every year to the KV. Doctors bill the KVâ€”not the sickness fundsâ€”according to the fee schedule. If utilization exceeds predictions and the money is in danger of running out, the KV prorates the fees downward during the final quarter. No other country with health insurance uses an expenditure cap and degressive fees in paying doctors, but some Canadian provinces enforce their global budgets in a similar manner. The KV staff monitors the bills. If any doctor submits fraudulent or an excessive number of bills, the KV staff can investigate, rebuke him, refuse full payment, and even suspend him from participation in the KV. Doctors earn the standard fees for treating all patients from the sickness funds. Standard throughout Europe, but not in the United States. Some Ersatzkassen try to offer higher fees in orders to buy preferential care for their subscribersâ€”an important attraction for membership. Associations and trade unions representing hospital doctors and civil servants negotiate salary scales, not with the sickness funds but with the governments and nonprofit associations that own the hospitals. Each chief of service negotiates a personal contract with each hospital; it contains special concessions to him. The numbers of doctors increased and the universities resisted limiting the enrollments in medical schools a numerus clausus. Recent reforms authorize the Konzertierte Aktion to recommend expenditure targets for ambulatory services, and the sickness funds are expected to increase the Kopfpauschale only by the annual increase in their own collective revenue, but these financial rules apply to fees and do not cover utilization. Doctors are licensed to practice in localities and, if limits are reached, new doctors will not be authorized to practice there. Utilization, prices, and costs have exploded in all countries, including Germany, the home of some of the principal manufacturers. While some countries have tried to protect the health insurance accounts and consumers by regulating drug prices directly, Germany never did until recently. The drug industry contributed too much to the German economy, has subsidized several political parties, and has always successfully resisted direct controls. Policymakers have long deadlocked over remedies and merely enacted forms of advice and information, to persuade doctors to prescribe less wastefully. The traditional German method of making decisions and controlling costs consists of face-to-face negotiations between providers and payers with only framework laws by government, but the multinational drug industry has never been collectively organized to play such roles. The first method was to discourage expensive and wasteful prescribing by imposing cost-sharing on the patientsâ€”a device common in other countries but unprecedented in Germany. However, to attract subscribers, commercial insurance companies and the Ersatzkassen offer to cover more than the reference prices. The next reform targeted the prescribing doctors directly. Part of the Kopfpauschale paid to each KV by the sickness funds was earmarked for pharmaceutical drug costs: During the late nineteenth and early twentieth centuries, trade unions and the political parties of the Left grew in Germany and in all other countries. Social protection of the working class was a principal aim. During the decades after the war, national health insurance in Germany and elsewhere expanded in coverage and in benefits, services improved, and funding was generous. The third political party representing the business class FDP , complained about the tax burden on enterprises and preferred expansion of private health insurance, but it was never more than the junior partner in coalition governments. Markets were lost to American and Japanese firms, with their lower prices and lower labor costs. Inflation and unemployment rose throughout Germany and Europe. The criticisms of businessmen and the conservative parties seemed more plausible: German labor costs were too high, due largely to high social security taxes, uncontrolled health care costs, and worker absenteeism. If social taxes on business could be reduced and public deficits controlledâ€”in both the social funds and the general governmentâ€”enterprises could sell more in world markets and unemployment could be reduced. Then followed decades of struggle to limit health insurance costs and reduce taxes, made difficult because of the negotiations and deadlocks described on previous pages. Unemployment and export problems were still not diminishing. West Germany annexed East Germany and incurred large unexpected costs and a large budget deficit. The Maastricht Treaty on European

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Unionâ€”inspired largely by conservative German economic strategistsâ€”required the rapid reduction of deficits by all member governments and counted social insurance heretofore off-budget as part of the public budgets. The German national government then uncharacteristically took the initiative and introduced the several structural and cost-control reforms described on previous pages. As in Germany and the rest of Europe, craftsmen and workers had many mutual aid funds. They provided cash benefits during unemployment, illness, and retirement. Some maintained health centers and employed doctors, but most reimbursed subscribers after visits by independent physicians. During the political compromises permitting enactment of national health insurance assurance maladie in , the mutual aid funds were retained as carriers. But they were too small and poorly managed to be efficient. A war aim of the Resistance was creation of expanded and efficient social security in all forms. When statutory health insurance is designed and enacted in all countries, a common problem is the resistance of the medical profession. Doctors perceive themselves as autonomous professionals and scientific specialists; they protest at any hint that they might be subject to scrutiny and control by lay bureaucrats and politicians in government. In particular, the doctors of France have been individualist and secretive. A struggle between the health insurance system and the medical profession has been constant throughout the history of French national health insurance. Since the comprehensive legislation of the postwar government in , nearly the entire population has been covered, is obligated to join a sickness fund, and is obliged to pay percentage-of-earning payroll taxes. In Germany and Holland, the managers and self-employed have been able to remain outside in the private sector. But the French mood after the wartime trauma was social solidarity and universal participation. The compromise in France was creation of special regimes for the self-employed and farmers, with their own rules about taxes and benefits. The best-paid managers have always been covered, once paying taxes on only part of their salaries but now to yield revenue paying the standard rates on their total salaries. The elderly, disabled, and unemployed remain with full coverage and normal benefits.

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4: Privatization - Wikipedia

With the oldest universal health care system in the world, 90% of Germans happily use the public system offered there, and just 10% of the population voluntarily uses the private system. Moving.

Here are the top 6 Updated February 8, at 1: JPG Despite its financial troubles, the U. Keating, Foreign Policy Neither snow, nor rain, nor heat, nor gloom of night may stay the American mail carrier, but pretty soon, the weekend will. With demand for snail mail and paper billing falling and the payments of employee benefits piling up, the venerable USPS is anxiously looking for ways to cut costs, having twice defaulted on its required payments to the federal government. In late , Oxford Strategic Consulting , a British firm, released a report ranking the postal services of the G countries based on three metrics: The United States already lags behind other countries in 12th place on "provision of access" -- which measures the number of citizens per post office -- and would likely worsen if the USPS follows through on its retrenchment plans. The biggest obstacle to a more efficient post office may be the U. Congress, which has failed to approve reform efforts such as setting up retail outlets in post offices, raising prices, shuttering less-used offices, and ending six-day delivery. And in case you American declinists were wondering, China ranks last on the survey. And unlike most countries, it has actually increased the number of post offices in recent years. Despite its popularity with customers, the fate of Japan Post has been one of the most contentious issues in Japanese politics over the last decade. Prime Minister Junichiro Koizumi pushed through a bill ordering the privatization of Japan Post in as the centerpiece of a broad economic reform agenda, despite fierce opposition that nearly brought down his government. The plan was scaled back after the opposition Democratic Party took over in , but the hope is still to eventually spin the financial services division off into a private bank that can subsidize the cost of mail delivery. Japan Post took a major blow in the tsunami, with as many as post offices destroyed or suffering major damages. It lists all customer complaints individually on its website for the public to see. In recent years, Korea Post has been following Japan into the financial services market , providing savings accounts, insurance products, and credit cards aimed at low-income customers. In some remote areas, post offices even provide services like train and airline bookings as well. But Australia Post has been a pioneer in finding innovative ways to raise revenue and maintain services in remote regions. These include allowing privately owned post offices in small towns that operate like franchises, with owners purchasing a license to provide official postal services. These retail outlets also sell other items, including souvenirs, books, office supplies, and coffee and tea -- making them more like general stores that provide postal services than traditional post offices. Australia Post has also partnered with banks to provide financial services at rural locations. Thanks to these initiatives, Australia Post raked in a profit of more than U. Canada Post With only 1, citizens per post office -- compared with 8, and more than 24, in China -- Canada ranks highest in the world for access to postal services. But like its neighbor to the south, Canada has been hit by rising costs and decreased demands for its services. Unions have objected to new rules requiring letter carriers to carry two bundles instead of one, and have also expressed concerns that the investment in new technology is a prelude to large-scale layoffs. Canada Post denies this, but does plan to reduce its workforce through attrition. Though it is still required by law to deliver nationwide six days a week, Deutsche Post has jettisoned almost all of its infrastructure since it was privatized in , eliminating , positions and all but 24 of its physical buildings. German post offices are now, for the most part, within other business like banks, grocery stores, and -- in some rural areas -- private homes.

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5: do any countries have completely privatized education system? Â« Economics Job Market Rumors

3 INTERNATIONAL GROWTH TRENDS IN PRISON PRIVATIZATION Although each of the above countries allows private companies to manage and operate prison facilities, prison privatization can vary by whether it is achieved.

This article has been cited by other articles in PMC. Abstract The purpose of this research paper is to compare health care systems in three highly advanced industrialized countries: The first part of the research paper will focus on the description of health care systems in the above-mentioned countries while the second part will analyze, evaluate and compare the three systems regarding equity and efficiency. Finally, an overview of recent changes and proposed future reforms in these countries will be provided as well. We start by providing a general description and comparison of the structure of health care systems in Canada, Germany and the United States. Health insurance coverage is universal. General taxes finance NHI through a single payer system only one third-party payer is responsible for paying health care providers for medical services. Consumer co-payments are negligible and physician choice is unlimited. Production of health care services is private; physicians receive payments on a negotiated fee for service and hospitals receive global budget payments Method used by third party payers to control medical care costs by establishing total expenditure limits for medical services over a specified period of time. Most of the population lives within miles of the United States border. From the American point of view, Canada provides a good comparison and contrast in terms of the structure of its health care systems. The Canadian health care system began to take on its current form when the province of Saskatchewan set up a hospitalization plan immediately after WWII. The rural, lowâ€”income province was plagued by shortages of both hospital beds and medical practitioners. The main feature of this plan was the creation of the regional system of hospitals: In , the federal parliament enacted the Hospital and Diagnostic Services Act laying the groundwork for a nationwide system of hospital insurance. By all ten provinces and the two territories had hospital insurance plans of their own with the federal government paying one half of the costs. Since the health care system has moved in different directions. While Canada has had publicly funded national health insurance, the United States has relied largely on private financing and delivery. During this period, spending in the United States has grown much more rapidly despite large groups that either uninsured or minimally insured. The provisions of the Canada Health Act define the health care delivery system as it currently operates. Under the Act, each provincial health plan is administered at the provincial level and provides comprehensive first dollar coverage of all medically necessary services. With minor exceptions, health coverage is available to all residents with no out of pocket charges. Most physicians are paid on a fee for service basis and enjoy a great deal of practice autonomy. Private health insurance for covered services is illegal. Most Canadians have supplemental private insurance for uncovered services, such as prescription drugs and dental services. As a result, virtually all physicians are forced to participate and each health plan effectively serves all residents in the province Henderson Patients do not participate in the reimbursement process, and reimbursement exclusively takes place between the public insurer the government and the health care provider. The monetary exchange is practically non-existent between patient and health care provider. The ministry of health in each province is responsible for controlling medical costs. Cost control is attempted primarily through fixed global budgets and predetermined fees for physicians. Specifically, the operating budgets of hospitals are approved and funded entirely by the ministry in each province and an annual global budget is negotiated between the ministry and each individual hospital. Capital expenditures must also be approved by the ministry, which funds the bulk of the spending. Physician fees are determined by periodic negotiations between the ministry and provincial medical associations the Canadian version of the American Medical Association. With the passage of the Canada Health Act of , the right to extra billing was removed in all provinces. Extra billing or balance billing refers to a situation in which the physician bills the patient some dollar amount above the predominated fee set by third party payer. For the profession as a whole, negotiated fee increases are implemented in steps, conditional on the rate of increase in the volume of services. If volume per physician arises faster than a predetermined percentage, subsequent fee increases are scaled down or eliminated to cap gross billings â€” the product of the fee and the

volume of each service â€” at some predetermined target. The possible scaling down of fee increases is supposed to create an incentive for a more judicious use of resources. Physicians enjoy nearly complete autonomy in treating patients e. In spite of the differences it is fair to say that each provincial plan is a public â€” sector monopsony, serving as a single buyer of medical services within the province and holding down medical care prices below market rates. The key element in the Canadian strategy to control overall spending is the regionalization of high â€” tech services. Government regulators make resource allocation decisions. This control extends to capital investment in hospitals, specialty mix of medical practitioners, location of recent medical graduates, and the diffusion of high tech diagnostic and surgical equipment. Access to open heart surgery and organ transplantation is also restricted. That same year the CT scanners in Canada meant one for every , citizens. Recent studies found Canadian deficits in several areas including angioplasty, cardiac catheterization and intensive care. Waiting lists for certain surgical and diagnostic procedures are common in Canada. Nationwide, the average wait for treatment is If care required diagnostic imaging, waiting times are even longer. Canadians are sacrificing access to modern medical technology for first dollar coverage for primary care. Treatment delays are causing problems for certain vulnerable segments of the Canadian population, particularly the elderly who cannot get reasonable access to the medical care they demand, including hip replacement, cataract surgery and cardiovascular surgery. Several lessons can be learned from the Canadian experience. Products provided at zero price are treated as if they have zero resource cost. Resource allocation decisions become more inefficient over time and government is forced either to raise more revenue or curb services. A second lesson from the Canadian experience is that everything has a cost. The Canadian system delegates this authority to the government. Resource allocation is practiced, not through the price mechanism, but by setting limits on the investment in medical technology. Proponents will argue that using waiting lists as a rationing measure is reasonable and fair. Opponents find the lists unacceptable and an unwelcome encroachment on individual decision-making in the medical sector. Proponents of the single payer alternative must deal with the fact that Canadians face waiting lists for some medical services especially for high â€” tech specialty care. To avoid delays in treatment, many Canadians travel south to the United States for more advanced treatment. Critics of the Canadian system must deal with the fact that most Canadians support their version of Medicare. The single most important defense of medical care delivery in Canada is that it works relatively well. The German system of social benefits is based on the concept of social insurance as embodied in the principle of social solidarity. This principle is a firmly held belief that government is obliged to provide a wide range of social benefits to all citizens, including medical care, old age pensions, unemployment insurance, disability payments, maternity benefits and other forms of social welfare. Bismarck saw the working class movement of that time as a threat. This concern led him to advocate the expansion of the existing sickness benefit societies to cover workers in all low wage occupations. In , the Sickness Insurance Act was passed, representing the first social insurance program organized on a national level. The German Democratic Republic East Germany was under the influence of the former Soviet Union and adapted the socialist form of government. The Federal Republic of Germany West Germany maintained its connections with the West and continued to utilize the preâ€”war economic system including the health care delivery system. East and West Germany were reunited in and since that time the former East Germany has been subjected to most West German laws including legislation relating to the medical insurance system. With the combined population of 82 million people, Germany is divided into 16 provinces Laender , each with a great deal of independence in determining matters related to health care. Over the past years the system has grown to the point where virtually all of the population is provided access to medical care. All individuals are required by law to have health insurance. Sickness funds are private, not â€” for â€” profit insurance companies that collect premiums from employees and employers. Those earning more than this limit may choose private health insurance instead. One of every 10 Germans covered by sickness fund insurance also purchases private supplementary insurance to cover co-payments and other amenities. Individual health insurance premiums for workers are calculated on the basis of income and not age or the number of dependents. Premiums are collected through a payroll tax deduction; the average contribution was The social insurance component is organized around some localized sickness funds. The sickness funds are independent

and self â€" regulating. They pay providers directly for services provided to their members at rates that they negotiate with individual hospitals. The sickness funds are required by law to provide a comprehensive set of benefits. These include physician ambulatory care provided by physicians in private practice, hospital care, home nursing care, a wide range of preventive services and even visits to health spas. Patient cost sharing is minimal. The funds, like disability insurance also provide additional cash payments to those who are unemployed as a result of illness. The system is weak in several areas. In particular, public health services and psychiatric services are minimal. As for reimbursement, ambulatory providers are paid on a fee for service basis, hospitals on a prospective basis. Both public and private including for profit hospitals exist, though the public hospitals account for about half the beds. Hospitals tend to use salaried physicians, and unlike the United States physicians in private practice generally do not have admitting privileges. Thus, many doctors have invested in elaborately equipped clinics to compete with hospitals by being able to perform a wide range of procedures. The German experience is especially relevant to the United States. Coverage is provided through a large number of relatively small and independent plans. In this sense, the delivery of health care is similar to that found in the United States where, for the most part, large numbers of employee groups, independent insurers, and providers reach agreements without direct government intervention. Many Americans propose mandated coverage for the working uninsured. Germany relies on a mandated approach where coverage for certain conditions is required by law. Germany also introduced cost controls similar in principle to prospective payment under the U. Government Role and Involvement In the German health care system, each level of government has specific responsibilities.

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The United States is unlike every other country because it maintains so many separate systems for separate classes of people. All the other countries have settled on one model for everybody.

According to a Gallup Poll, citizens of the United States, Canada and Britain describe their healthcare programs as being excellent as good. In the United States, 52 percent of the population felt that their insurance was excellent and in Canada, the number was 53 percent. United States The United States is one of 2 countries that offer health insurance programs to their citizens using a privatized business model. Mexico is the other country. It is a bit misleading however to suggest that the system of health care in the U. Medicare is a program available to seniors age 65 or older. It is a program that is based on the Canadian style health insurance program. The majority of health insurance in the United States is provided through employer-sponsored group health insurance. This accounts for the largest delivery of health insurance and access to health care in the country. Those individuals who are unemployed or who work for an employer that does not provide health insurance can gain access by purchasing a private plan or becoming eligible for public assistance. Canada Canadians participate in the National Health Care system. The system is funded with tax dollars. Canada spends, as a percentage of its gross domestic product GDP , In comparison, the United States spends Most services provided to Canadians under their system are provided through the private sector. Doctors and other medical practitioners that treat Canadian citizens are not employed by the Canadian government, they are private companies. The Canadian health system produces excellent results. The life expectancy is England and the United Kingdom The system in the United Kingdom, which includes England, uses a mixture of private and publicly funded health insurance programs. The National Health Service program in England uses cost controls and negotiated rates in order to hold down healthcare spending. The National Health Service program is funded by tax dollars.

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7: 3 Countries with Excellent Private Health Insurance - Financial Web

Privatization may mean the government sells state-owned businesses to private interests, but it may also be discussed in the context of the privatization of services or government functions, where private entities are tasked with the implementation of government programs or performance of government services.

Health in Algeria When Algeria gained its independence from France in , there were only around doctors across the whole country and no proper system of healthcare. Over the next few decades, great progress was made in building up the health sector, with the training of doctors and the creation of many health facilities. Today, Algeria has an established network of hospitals including university hospitals , clinics, medical centres and small health units or dispensaries. While equipment and medicines may not always be the latest available, staffing levels are high and the country has one of the best healthcare systems in Africa. Access to health care is enhanced by the requirement that doctors and dentists work in public health for at least five years. The government provides universal health care. Health in Cape Verde Medical facilities in Cape Verde are limited, and some medicines are in short supply or unavailable. There are hospitals in Praia and Mindelo , with smaller medical facilities in other places. Brava also has limited inter-island ferry service. Researchers at the Overseas Development Institute have identified the high prioritisation of health and education both within the government and amongst Eritreans at home and abroad. Innovative multi-sectoral approaches to health were also identified with the success. Health care and welfare resources generally are believed to be poor, although reliable information about conditions is often difficult to obtain. In , the most recent year for which figures are available, the Eritrean government spent 5. The two-year war with Ethiopia , coming on the heels of a year struggle for independence, negatively affected the health sector and the general welfare. In the decade since , impressive results have been achieved in lowering maternal and child mortality rates and in immunizing children against childhood diseases. In average life expectancy was slightly less than 63 years, according to the WHO. Immunisation and child nutrition has been tackled by working closely with schools in a multi-sectoral approach; the number of children vaccinated against measles almost doubled in seven years, from This has helped to some small extent even out rural-urban and rich-poor inequity in health. Health in Ethiopia Throughout the s, the government, as part of its reconstruction program, devoted ever-increasing amounts of funding to the social and health sectors, which brought corresponding improvements in school enrollments, adult literacy , and infant mortality rates. These expenditures stagnated or declined during the â€" war with Eritrea , but in the years since, outlays for health have grown steadily. In the country counted one hospital bed per 4, population and more than 27, people per primary health care facility. The physician to population ratio was 1: Overall, there were 20 trained health providers per , inhabitants. These ratios have since shown some improvement. Health care is disproportionately available in urban centers; in rural areas where the vast majority of the population resides, access to health care varies from limited to nonexistent. As of the end of , the United Nations UN reported that 4. Malnutrition is widespread, especially among children, as is food insecurity. Because of growing population pressure on agricultural and pastoral land, soil degradation, and severe droughts that have occurred each decade since the s, per capita food production is declining. According to the UN and the World Bank , Ethiopia at present suffers from a structural food deficit such that even in the most productive years, at least 5 million Ethiopians require food relief. A polio vaccination campaign for 14 million children has been carried out, and a program to resettle some 2 million subsistence farmers is underway. In November , the government launched a five-year program to expand primary health care. In January , it began distributing antiretroviral drugs , hoping to reach up to 30, HIV-infected adults. Health in Ghana In Ghana , most health care is provided by the government, but hospitals and clinics run by religious groups also play an important role. Health care is very variable through the country. The major urban centres are well served, but rural areas often have no modern health care. Patients in these areas either rely on traditional medicine or travel great distances for care. In , Ghana spent 6. In only 62â€"65 percent of the population was estimated to have access to safe drinking water and only 69 percent to sanitation services of some kind; only 8 percent was estimated to have access to modern sanitation facilities.

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In general government expenditures on health constituted 6. Medical facilities in Mali are very limited, especially outside of Bamako , and medicines are in short supply. There were only 5 physicians per , inhabitants in the s and 24 hospital beds per , in In only 36 percent of Malians were estimated to have access to health services within a five-kilometer radius. Health in Morocco According to the United States government, Morocco has inadequate numbers of physicians 0. The health care system includes hospitals, 2, health centers, and 4 university clinics, but they are poorly maintained and lack adequate capacity to meet the demand for medical care. Only 24, beds are available for 6 million patients seeking care each year, including 3 million emergency cases. The health budget corresponds to 1. Health in Niger Health care system of Niger suffers from a chronic lack of resources and a small number of health providers relative to population. Some medicines are in short supply or unavailable. Government hospitals, as well as public health programmes, fall under the control of the Nigerien Ministry of Health. There were Physicians in Niger in , a ratio of 0. Health in Nigeria Health care provision in Nigeria is a concurrent responsibility of the three tiers of government in the country. Historically, health insurance in Nigeria can be applied to a few instances: In May , the government created the National Health Insurance Scheme, the scheme encompasses government employees, the organized private sector and the informal sector. Legislative wise, the scheme also covers children under five, permanently disabled persons and prison inmates. In , the administration of Obasanjo further gave more legislative powers to the scheme with positive amendments to the original legislative act. Health in Senegal The health budget in Senegal has tripled between and , leading to the Senegalese people leading healthier and longer lives â€” the life expectancy at birth is approximately The public system serves the vast majority of the population, but is chronically underfunded and understaffed. This division in substantial ways perpetuates racial inequalities created in the pre-apartheid segregation era and apartheid era of the 20th century. In , South Africa spent 8. Health in Sudan Outside urban areas, little health care is available in Sudan , helping account for a relatively low average life expectancy of 57 years and an infant mortality rate of 69 deaths per 1, live births, low by standards in Middle Eastern but not African countries. For most of the period since independence in , Sudan has experienced civil war , which has diverted resources to military use that otherwise might have gone into health care and training of professionals, many of whom have migrated in search of more gainful employment. In the World Health Organization estimated that there were only 9 doctors per , people, most of them in regions other than the South. Substantial percentages of the population lack access to safe water and sanitary facilities. Malnutrition is widespread outside the central Nile corridor because of population displacement from war and from recurrent droughts; these same factors together with a scarcity of medicines make diseases difficult to control. Child immunization against most major childhood diseases, however, had risen to approximately 60 percent by the late s from very low rates in earlier decades. Spending on health care is quite low â€” only 1 percent of gross domestic product GDP in latest data. The United Nations suggested, however, that the rate could be as high as 7. Between , and 1. As of late , some 4 million persons in the South had been internally displaced and more than 2 million had died or been killed as a result of two decades of war. Comparable figures for Darfur were 1. Health in Zimbabwe Zimbabwe now has one of the lowest life expectancies on Earth â€” 44 for men and 43 for women, [18] down from 60 in Infant mortality has risen from 59 per thousand in the late s to per by

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8: Comparisons of Health Care Systems in the United States, Germany and Canada

Other school systems are highly decentralized; most decisions are made at the local level. For instance, schools have a high degree of autonomy in the Netherlands, where 73 percent of decisions are made at the local level, according to the OECD.

Preth century[edit] The history of privatization dates from Ancient Greece , when governments contracted out almost everything to the private sector. However, the Roman Empire also created state-owned enterprises â€"for example, much of the grain was eventually produced on estates owned by the Emperor. During the Renaissance , most of Europe was still by and large following the feudal economic model. By contrast, the Ming dynasty in China began once more to practice privatization, especially with regards to their manufacturing industries. This was a reversal of the earlier Song dynasty policies, which had themselves overturned earlier policies in favor of more rigorous state control. Significant privatizations of this nature occurred from to , preceding the industrial revolution in that country. The firms belonged to a wide range of sectors: In addition to this, delivery of some public services produced by public administrations prior to the s, especially social services and services related to work, was transferred to the private sector, mainly to several organizations within the Nazi Party. After , council house tenants in the UK were given the right to buy their homes at a heavily discounted rate. One million purchased their residences by British Rail had been formed by prior nationalization of private rail companies. The privatization was controversial, and the its impact is still debated today , as doubling of passenger numbers and investment was balanced by an increase in rail subsidy. Companies providing public services such as water management , transportation, and telecommunication were rapidly sold off to the private sector. Agency for International Development, the German Treuhand , and other governmental and nongovernmental organizations. Ongoing privatization of Japan Post relates to that of the national postal service and one of the largest banks in the world. After years of debate, the privatization of Japan Post spearheaded by Junichiro Koizumi finally started in The privatization process is expected[by whom? It was also said to be the largest holder of personal savings in the world. Criticisms against Japan Post were that it served as a channel of corruption and was inefficient. After the Upper House rejected privatization, Koizumi scheduled nationwide elections for September 11, He declared the election to be a referendum on postal privatization. Koizumi subsequently won the election, gaining the necessary supermajority and a mandate for reform, and in October , the bill was passed to privatize Japan Post in Large privatization of the Soviet economy occurred over the next few years as the country dissolved. Other Eastern Bloc countries followed suit after the Revolutions of introduced non-communist governments. The privatization received very mixed views from the public and the parliament. Even former Conservative prime minister Harold Macmillan was critical of the policy, likening it to "selling the family silver". By the time of her resignation in , there were more than 10 million shareholders in Britain. Egypt undertook widespread privatization under Hosni Mubarak. He was later overthrown in the revolution , the public called for re-nationalization as the privatized firms were accused of practicing crony capitalism with the old regime. Private sector involvement in Medicare and Medicaid is not limited to MCOs; private doctors, hospitals, nursing homes provide medical care; reimbursement claims are processed by private intermediaries; and peer review organizations, utilization review committees and accreditation organizations like JCAHO are staffed by private medical personnel. Welfare services that are often privatized include workforce development, job training and job placement are often privatized. EMOs are usually for-profit and manage charter schools and sometimes traditional public schools as well. Private prison In the US in , private prison facilities housed Contracts for these private prisons regulate prison conditions and operation, but the nature of running a prison requires a substantial exercise of discretion. Private prisons are more exposed to liability than state run prisons. Many of the military interrogators at Abu Ghraib prison were provided by a private contractor and lacked formal military training; this was subsequently identified as a contributing factor to detainee abuse at the prison by the Fay report. US Constitution[edit] The United States Constitution only constrains state action and, with few exceptions, "erects no shield against merely private conduct, however discriminatory or

wrongful". Adequately guarding against abuse of public power requires application of constitutional principles to every exercise of state authority, regardless of the formal public or private status of the actor involved: Tort law might be another avenue of protection, and some may argue that this protection could be even more effective as public agencies and employees usually enjoy some degree of immunity from civil liability. Please help improve this article by adding citations to reliable sources. Unsourced material may be challenged and removed.

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9: 7 Countries That Show Us How Health Care Should Be Done

The Australian system is basically two-tiered: a public insurance-and-delivery system, and another based on private health insurance, each of which cover roughly half the population.

It is publicly run and funded mostly from taxation. Some services require variable co-pays, while other services like emergency medicine and a general doctor are free. Like the UK, there is a small parallel private health care system, especially in the field of Dental Medicine and Ophthalmology. It is is funded by mandatory contributions of employers and the workforce, and by government subsidies for insuring jobseekers, the poor, and for financing medical infrastructure. The nation also has mandatory public long-term care insurance. Healthcare in the Netherlands The Netherlands has a dual-level system. All primary and curative care family doctors, hospitals, and clinics is financed from private compulsory insurance. Long term care for the elderly, the dying, the long term mentally ill etc. They must do this at a fixed price for all. People pay the same premium whether young or old, healthy or sick. It is illegal in The Netherlands for insurers to refuse an application for health insurance, to impose special conditions e. The regulator has sight of the claims made by policyholders and therefore can redistribute the funds its holds on the basis of relative claims made by policy holders. Thus insurers with high payouts receive more from the regulator than those with low payouts. Insurance companies have no incentive to deter high cost individuals from taking insurance and are compensated if they have to pay out more than might be expected. The competition regulator is charged with checking for abuse of dominant market positions and the creation of cartels that act against the consumer interests. An insurance regulator ensures that all basic policies have identical coverage rules so that no person is medically disadvantaged by his or her choice of insurer. Hospitals in the Netherlands are also regulated and inspected but are mostly privately run and not for profit, as are many of the insurance companies. Patients can choose where they want to be treated, and have access to information on the internet about the performance and waiting times at each hospital. Patients dissatisfied with their insurer and choice of hospital can cancel at any time, but must make a new agreement with another insurer. Insurance companies can offer additional services at extra cost over and above the universal system laid down by the regulator, e. Persons on low incomes can get assistance from the government if they cannot afford these payments. Healthcare in Norway Norway has a universal public health system paid largely from taxation in the same way as other Scandinavian countries. The Norwegian health care system is government-funded and heavily decentralized. The health care system in Norway is financed primarily through taxes levied by county councils and municipalities. Dental care is included for children until 18 years old, and is covered for adults for some ailments. Healthcare in Romania According to Article 34 of the Constitution of Romania , the state is obliged "to guarantee the protection of healthcare". Romania has a fully universal health care system, which covers up medical check-ups, any surgical interventions, and any post-operator medical care, as well as free or subsidized medicine for a range of diseases. The state is also obliged to fund public hospitals and clinics. Dental care is not funded by the state, although there are public dental clinics in some hospitals, which treat patients free of charge. However, due to inadequate funding and corruption, it is estimated that a third of medical expenses are, in some cases, supported by the patient. Russia and Soviet Union[edit] Main article: Healthcare in Russia In the Soviet Union, the preferred term was "socialist medicine"; the Russian language has no term to distinguish between "socialist" and "socialized" other than "public", Rus: Initially successful at combating infectious diseases, the effectiveness of the socialized model declined with underinvestment. Despite a doubling in the number of hospital beds and doctors per capita between and , the quality of care began to decline by the early s and medical care and health outcomes were below western standards. The new mixed economy Russia has switched to a mixed model of health care with private financing and provision running alongside state financing and provision. The OECD reported that unfortunately, none of this has worked out as planned and the reforms have in many respects made the system worse. The resulting system is overly complex and very inefficient. It has little in common with the model envisaged by the reformers. Although there are more than private insurers and numerous public ones in the market, real competition for patients is

rare leaving most patients with little or no effective choice of insurer, and in many places, no choice of health care provider either. The insurance companies have failed to develop as active, informed purchasers of health care services. Most are passive intermediaries, making money by simply channelling funds from regional OMS funds to healthcare providers. A purchaser-provider split help facilitate the restructuring of care, as resources would migrate to where there was greatest demand, reduce the excess capacity in the hospital sector and stimulate the development of primary care. Healthcare in Serbia The Constitution of the Republic of Serbia states that it is a right of every citizen to seek medical assistance free of charge. The amount of contribution depends on the amount of money the person is making. In the recent years, however, that has changed and the Serbian government has invested heavily in new medical infrastructure, completely remodeling existing hospitals and building two new hospitals in Novi Sad and Kragujevac. Healthcare in Spain Spain enjoys a public universal health care system for all citizens and, under certain conditions, also non-citizens. The system is essentially free except for small, often symbolic co-payments in some products and services; it is mostly paid from the Social Security budget. All services are provided in the extensive and readily available network of public and chartered facilities, so private care bills will not be paid. Adult dental care is not covered but for basic extractions or problems that could result in serious stomatological conditions. Irrespective of the nationality and insurance situation of the patient, the public system always treats medical emergencies until achieving the best possible outcome. If not covered by the Spanish Social Security i. If actually unable to pay, it is covered by the Social Security on humanitarian grounds unless the patient purposely traveled to Spain to get free healthcare. Obvious unexpected emergencies like accidental injuries or sudden illness are customarily covered, but those that could be reasonably expected e. Private health insurance is available for those who prefer it, and recommended for visitors not covered by the Spanish Social Security or a foreign public or private insurer with overseas coverage. Healthcare in Sweden Sweden has a universal public health system paid largely from taxation in the same way as other Scandinavian countries. The Swedish public health system is funded through taxes levied by the county councils , but partly run by private companies. Government-paid dental care for those under 21 years old is included in the system. Dental care above a fixed amount is also subsidised. Sweden also has a smaller private health care sector, mainly in larger cities or as centers for preventive health care financed by employers. Sweden regularly comes in top in worldwide healthcare rankings. Basic health insurance is mandatory for all persons residing in Switzerland within three months of taking up residence or being born in the country. Insurers are required to offer insurance to everyone, regardless of age or medical condition. They are not allowed to make a profit off this basic insurance, but can on supplemental plans. Healthcare in the United Kingdom Each of the Countries of the United Kingdom has a National Health Service that provides public healthcare to all UK permanent residents that was originally designed to be free at the point of need and paid for from general taxation; but changes included introducing charging for prescription medicines and dentistry those below 16 and those on certain benefits may still get free treatment. However, since Health is now a devolved matter , considerable differences are developing between the systems in each of the countries as for example Scotland and Wales abolished prescription charges.

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