

Single-Payer Health Care Systems:

The Roles and Responsibilities of the Public and Private Sectors

by Jeffrey D. Munn and Lynne Wozniak

Health care systems all over the world are experiencing some change as they look for a new balance between supply and demand. This article provides context for the U.S. health care financing debate by examining the health care systems of five other countries: Canada, the United Kingdom, Australia, China and India. The authors show that, with few exceptions, countries around the world have seen an increase in both government and private health care spending between 1998 and 2002. The authors also demonstrate that employers throughout most of the world are becoming more, rather than less, involved in the funding and delivery of health care to employees and their dependents—even among nations with so-called single-payer health systems.

During the last two decades, all health care systems, regardless of whether public, private, single-payer or multi-payer systems, have faced rising demands and limited resources. A myriad of factors has contributed to this environment, such as advances in the medical technology used to diagnose and treat illnesses and injuries, an increase in risk factors as individuals continue to engage in poor health habits, and a rise in global health concerns like the outbreak of severe acute respiratory syndrome (SARS) and fears over avian flu. The largest driver of increases in cost, however, is the aging population. Older individuals tend to consume three to five times more health services per capita than younger individuals.

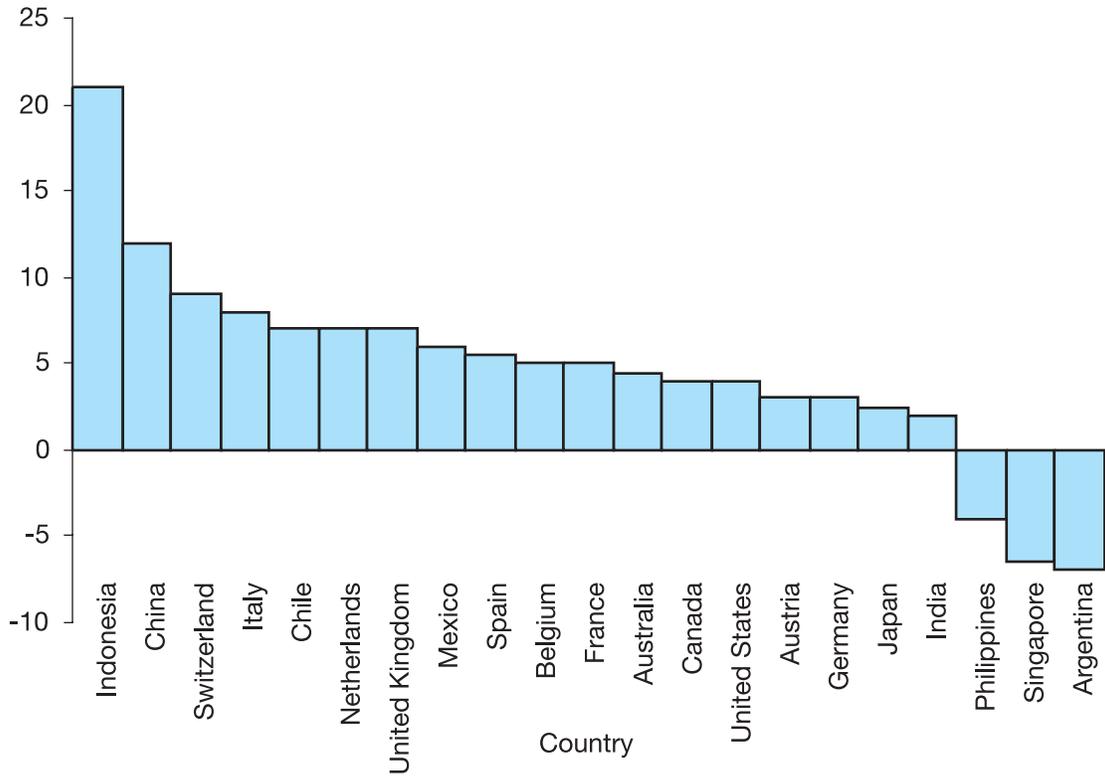
In response, all systems, by design or default, have rationed care. In private or market-driven systems, the provision of care is based on ability to pay. In

public, notably single-payer systems, care has been rationed through waiting lists, schedules for nonessential care and prescription drug formularies that have become more restrictive. No system is perfect. All health care systems are striving to achieve a sustainable equilibrium among accessibility, cost and quality of care.

In this article, the authors examine the similarities and differences in three single-payer systems in advanced economies—Canada, the United Kingdom and Australia—and two emerging market economies—China and India. Like health care systems all over the world, these systems are experiencing some change as they look for a new balance between supply and demand. These changes involve a reexamination of the role the public and private sectors play in the responsibility for care (government, employers and employees) and in coverage (public vs. private insurance). Generally, we find that the term “single-payer health system” is a misnomer. Even in

FIGURE 1

**ANNUAL GROWTH OF GOVERNMENT EXPENDITURE ON HEALTH CARE
RELATIVE TO GENERAL INFLATION (1998-2002)**



Source: World Health Organization.

the most well-known government health care systems, private insurance, especially that provided by employers, plays a significant and, in many cases, growing role.

GLOBAL HEALTH CARE EXPENDITURES

With few exceptions, government expenditures on health care relative to general inflation increased steadily during the period 1998-2002 for a sample of countries in the Americas, Asia and Europe (Figure 1).

Growth in public spending is only marginally correlated with the type of health care system. Government spending tends to decline precipitously in periods of economic crisis. In Argentina, per capita government expenditures on health fell from US\$364 in 2001 to US\$120 in 2002, the year the government was forced to end the peso's peg to the U.S. dollar and allow the currency to float freely. In Singapore and the Philippines, government-imposed austerity pro-

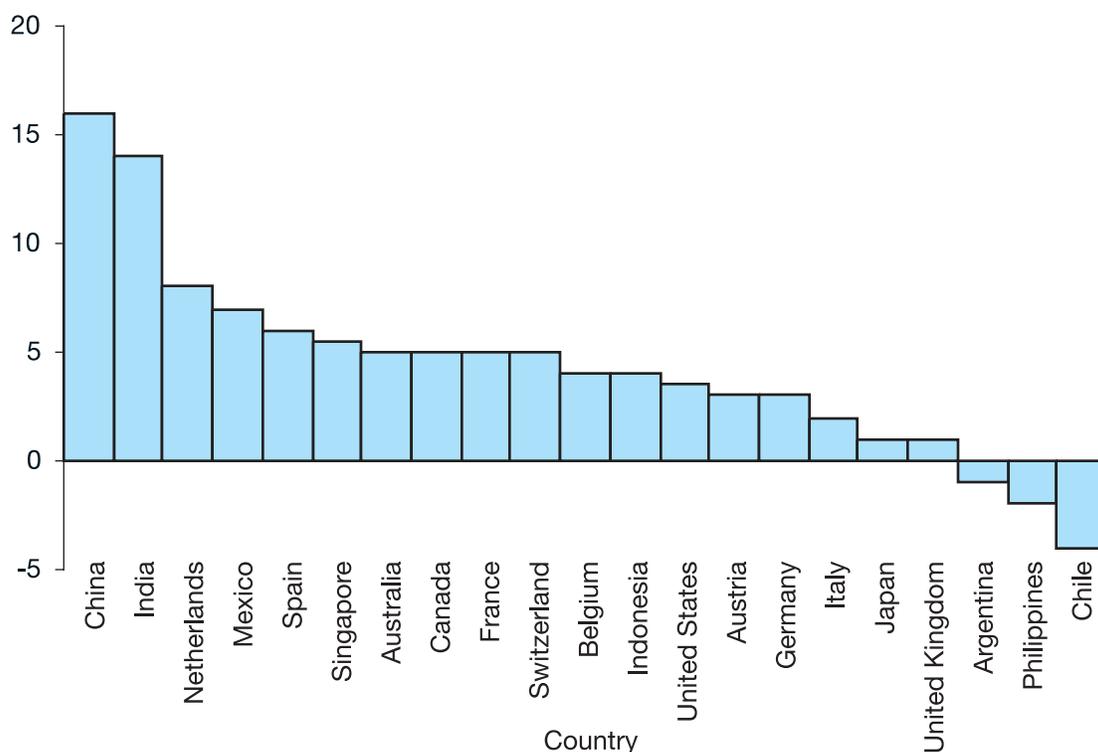
grams designed to pull the respective economies out of the recession created by the regional financial crisis of the late 1990s meant fewer public funds were available for health care.

Public spending for health care rose at a much higher rate in two emerging economies—Indonesia and China. Indonesia recovered rapidly from the regional financial crisis due to its oil revenues; overall public expenditures increased on welfare and education as the government tried to quell popular protest due to political instability. Government spending in China on health care has been facilitated by the country's rapid economic growth.

Similarly, total private expenditures (employer and individual) rose during 1998-2002 (Figure 2). Again, spending increased in countries with public and private systems alike. In China and India, the rate of growth in private expenditures was the highest, due to the increase in disposable income among the burgeoning middle class and the war for talent that employers are waging, particularly as global sourcing intensifies.

FIGURE 2

**ANNUAL GROWTH OF TOTAL PRIVATE EXPENDITURE ON HEALTH CARE
RELATIVE TO GENERAL INFLATION (1998-2002)**



Source: World Health Organization.

During the Argentine economic crisis, as real wages fell to their lowest level in 50 years, individuals simply had less money to spend on health care. In Chile, wages stagnated and unemployment rose as the economy suffered from the contagion effect of the Argentine crisis. Low levels of individual savings precluded individuals in the Philippines from maintaining their usual level of expenditures on health care. In Singapore, on the other hand, private savings and increased company expenditures for health care sustained spending.

Throughout most of the world, employers are becoming more, rather than less, involved in the funding and delivery of health care to employees and their dependents (Figure 3). Companies—typically multinationals—offer supplementary health insurance or share in its cost, oftentimes to distinguish themselves as “employers of choice,” even in public single-payer systems. In single-payer systems in advanced economies, these supplemental plans may be directed toward executives or complement care provided by the public system. In single-payer systems in emerg-

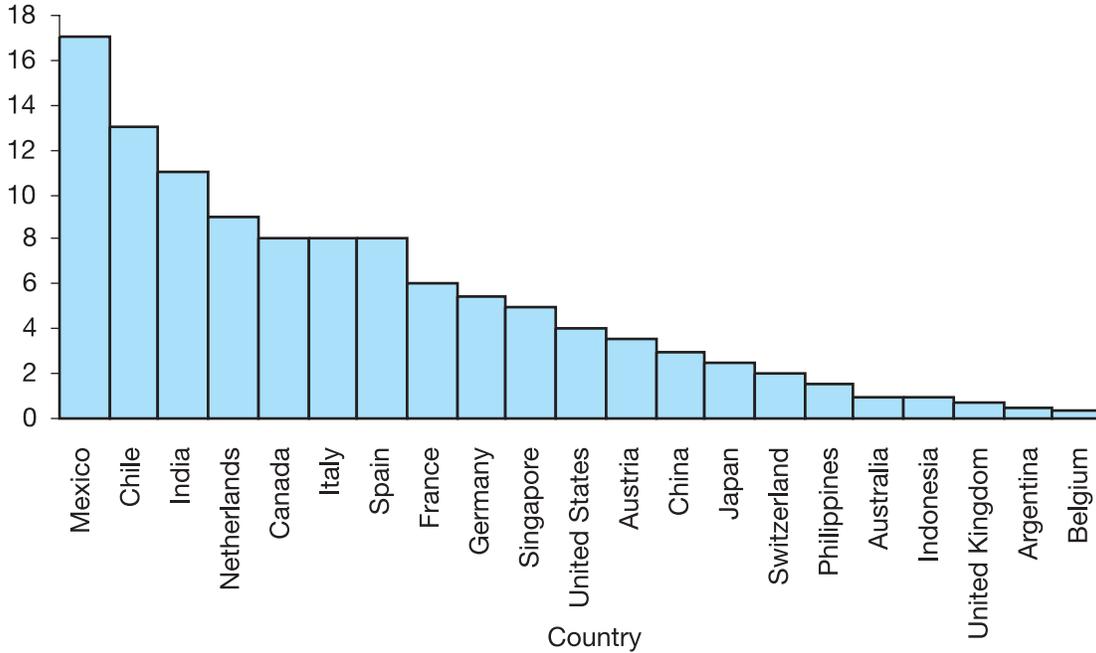
ing economies where the public health care system maintains its universality by providing only very basic care, health care benefits play an important role in attracting and retaining employees.

**SINGLE-PAYER SYSTEMS—
CANADA, THE UNITED KINGDOM
AND AUSTRALIA**

Single-payer health care systems—regardless of whether they are located in the Americas, Asia or Europe, advanced or emerging markets, or countries governed by conservative or social democratic parties—share a common goal: to provide universal, comprehensive care without impediments to reasonable access. While the goal is common, the actual operation of single-payer systems and their interaction with the private sector tend to differ, reflecting the structure of the government, the robustness of the economy and the country’s demographic profile, among other factors.

FIGURE 3

**ANNUAL GROWTH OF COMPANY EXPENDITURE ON HEALTH CARE
RELATIVE TO GENERAL INFLATION (1998-2002)**



Source: World Health Organization.

Public Health Care Systems

Administration and Delivery

Health care in Canada falls under provincial and territorial rather than federal control. Each province and territory is responsible for the administration of a health care plan that meets the criteria established in the Canada Health Act, federal legislation that sets the framework to which the subnational governments must adhere. In the United Kingdom, the national government, through the National Health Service (NHS), is responsible for health care; however, administration of care is managed by local “strategic health authorities” and “trusts” that plan and purchase health care services. In Australia, the national health insurance system is a national-level system, administered at the commonwealth (federal), state and local levels by Medicare Australia. The state and territorial governments’ responsibilities include hospital services; home and community care; child, adolescent and family health services; and rehabilitation programs.

The majority of health care facilities are publicly owned in the United Kingdom, and health care per-

sonnel work for the government. NHS offers individuals a limited choice of medical facilities in which they may be treated. In Canada, patients have the right to choose their own doctors; approximately 95% are in private practice. However, hospital facilities are overwhelmingly public—Over 96% of hospital beds are found in provincial and federal hospitals. Australian health care professionals are generally in private practice. Approximately 58% of all hospitals in Australia are publicly owned; the remaining 42% are run by the private sector. Doctors in Canada and Australia are reimbursed by the government according to a schedule of fees (usually around 85% of the scheduled fee); similarly, private hospitals providing services to patients covered by the health care system are subject to a fee schedule.

Financing

The public health care system is financed primarily through general tax revenues in all three countries. In Canada, employer contributions (in Manitoba, Newfoundland and Labrador, Ontario, and Quebec), and employee premiums (in Alberta, British Columbia, Northwest Territories and Nunavut, and Ontario)

supplement federal grants to the provinces and territories. In the United Kingdom, more than 80% of NHS funding comes from general taxation; the remaining 20% is financed by national insurance contributions and patient copayments. Funding for the Medicare Australia system is supplemented by a *medicare levy* of 1.5% of an employee's taxable income. A *general threshold* is applicable to out-of-pocket costs (the difference between medicare benefits and the doctor/hospital fees). Private insurance may cover the gap for inpatient services, and under current government proposals, it may be possible for private insurance to cover any charges above the fee schedule paid by insureds for services provided outside a hospital.

Eligibility

The public health care system is open to residents and their dependents. In the United Kingdom, residents meeting legal requirements are eligible for care after six months in the country. All employees paying national insurance contributions and income taxes are immediately eligible. In Canada, all provincial and territorial plans provide coverage for residents in need of emergency care and treatment while temporarily absent from their home jurisdiction. Home jurisdiction coverage is continued for two months after the month of arrival in the new jurisdiction plus in some cases, time spent in transit. In addition to residents, all three countries have reciprocal health care agreements with certain countries that entitle short-term visitors to medical benefits.

Coverage

The three health care systems provide comprehensive coverage including general medical, inpatient hospital and outpatient services. Dental and vision care and medical supplies and appliances are typically subject to guidelines. Prescription drugs are covered by the public health care systems in the United Kingdom and subsidized by Medicare Australia. In Canada, prescription drugs for residents under age 65 are generally excluded from provincial and territorial coverage (except in Saskatchewan, Manitoba and British Columbia). Several provinces provide limited/catastrophic drug coverage for residents under age 65. Quebec also guarantees drug coverage for all residents, although it is largely provided by private plans.

PUBLIC SECTOR AND PRIVATE SECTOR RESPONSIBILITIES FOR HEALTH CARE

During the past two decades, Canada, the United Kingdom and Australia have been following differ-

ent approaches to sustaining their single-payer systems by sharing the responsibility for care with employers and individuals. In Canada, a robust private insurance market exists along with the public health care system, and employers step in to provide supplemental coverage. In the United Kingdom, the market for private insurance is steadily growing; however, under the current system of tax incentives, employees are not clamoring for employer-provided coverage. The Australian government has put individuals front and center by giving them incentives for the purchase of private health care insurance.

Canada

The private sector has long played an important role in the provision and delivery of health care in Canada. Since the institution of a public system during the 1960s, employer-provided health insurance has served to supplement government-provided benefits. During recent years, escalating health care costs, increasing wait times for care and a growing talent shortage created by an aging population have encouraged employers to play a more active role. Most provincial governments encourage employers to fill the gaps in their health care systems with favorable tax treatment for employer contributions to supplemental medical, dental and vision care. Employer contributions are deductible; the employer contribution is not considered a taxable benefit to the employee; and no tax is assessed on the benefit payout.

► THE AUTHORS

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TABLE I**PREVALENCE AND CHARACTERISTICS OF EMPLOYER-PROVIDED MEDICAL PLANS IN CANADA¹**

| Plan Characteristics | Percent of Employers |
|---|-----------------------------|
| Choice in Medical Plans | |
| No choice | 58% |
| Flexible benefit plan/choice of options | 42 |
| Two options | 5 |
| Three options | 15 |
| Four options | 17 |
| Five or more options | 5 |
| No coverage | 0 |
| Prescription Drug Cost Containment | |
| Coinsurance less than 100% | 42% |
| No cost-containment features | 40 |
| Other | 18 |

1. For active employees only.

Source: Statistics Canada.

In Quebec, however, the cost of medical and dental coverage is added to taxable income for purposes of Quebec income tax.

On average, 42% of employees have employer-provided medical/dental, life and disability insurance benefits.¹ Of employers with over 25 employees, 99-100% offer health care benefits. If employees have only one nonwage benefit, medical insurance is the most common benefit. (See Table I.)

The most common private medical plan coinsurance percentages provided by employers are 100% and 80% for both major medical and prescription drug coverage. Many employers offer medical and dental plans or medical alone for their retired employees, and most of these plans do not require contributions from the retirees.

In general, provincial governments prohibit private plans from covering the services offered under the provincial plan. Supplemental plans cannot be used to purchase enhanced care for government-provided services. In June 2005, the Supreme Court of Canada ruled that individuals in Quebec have the right to obtain private health insurance for services already available under the public health care system (*Chaoulli v. Quebec*), thereby reopening the debate

about the role of private insurers and payment in the current system.

In December 2006, the government of Quebec passed legislation (An Act to Amend the Act Respecting Health Services and Social Services and Other Legislative Provisions) reaching, at least, partial resolution to the discussion. Now, Quebecers are allowed to purchase private health insurance for three surgical procedures with long waiting lists—knee replacement surgery, hip replacement surgery and cataract surgery.

The court ruling and the new Quebec legislation have led the other provinces to examine whether an expanded private sector would create greater efficiencies or inefficiencies in the provision of health care in their jurisdictions. The concept of a two-tier health care system is not popular with most Canadians, who fear that the funding and quality of the public system would deteriorate if a parallel, rather than complementary system, was created. While the debate continues, employers continue to plug at least some gaps as employees demand better care.

United Kingdom

Overall, the quality of services provided by NHS remains high, but there may be long waits, especially for nonessential (elective) care. A private health care system has grown up to supplement NHS. Private medical insurance covers approximately 10% of the population; an estimated one-fifth of private care patients do not have insurance but pay directly upon admission.

Company-paid premiums for health insurance plans are deemed to be taxable income to the employee. Consequently, lower-paid employees have traditionally not wanted coverage since the premiums were taxable and NHS was viewed as “free.” Employers provide preretirement medical benefits mostly to executives and upper-level salaried employees. Typically, employers cover the entire cost of insurance for executives and family members; cost-sharing plans are common for nonexecutives.

In 2000, the government released a new NHS plan, a ten-year effort to improve the system by upgrading facilities, increasing the number of health care personnel, decreasing wait times, and fostering cooperation between purchasers and providers. “Competition” is being introduced into the system by giving patients a choice, albeit limited, of health care facilities. This latest round of reforms continues to focus on NHS itself; it displaces an explicit review of the role of private insurers in the provision of health care and the role of employers and individuals in assuming responsibility for health care.

Australia

To reduce individuals' dependence on the public health care system, the Australian government has created a series of incentives and surcharges to promote the purchase of private health insurance by individuals.

- **Lifetime Health Cover**—Individuals who purchase hospital coverage early in life and maintain this coverage pay lower premiums throughout their lives when compared to individuals who purchase coverage later in life. To lock in the lowest premium, hospital coverage must be purchased shortly after the individual turns age 31. Individuals who take out coverage after age 31 pay a 2% loading on top of their premium for every year after age 31; the maximum loading is 70%.
- **Federal Government Rebate on Private Health Insurance**—The government offers a 30%, 35%, or 40% rebate on premiums for private health insurance depending on the age of the oldest person covered by the policy and the number of days this person was in a given age category. The rebate is 30% if the oldest person covered by the policy is under age 65, 35% if the oldest person is age 65 to age 69, and 40% if the oldest person is age 70 or older. Anyone who is insured under medicare and who is enrolled with a licensed health benefit organization is eligible for the rebate.
- **Medicare Levy Surcharge**—High-income individuals who are eligible for medicare but have not purchased an appropriate level of health insurance with a registered health fund are subject to an additional 1% surcharge on taxable income.

Employers, on the other hand, have few incentives to provide employees with private coverage. Under the Fringe Benefits Tax Assessment Act 1986, employment-related noncash fringe benefits are subject to tax, unless specifically exempt. The *fringe benefits tax (FBT)* is a federal tax separate from income tax. It is levied on an employer when employees or associates of employees receive fringe benefits either from the employer or from a third party. Benefits subject to an FBT—including private health care insurance—are tax free for employees and FBT payments are deductible from corporate income tax. However, a decline in employer-provided health insurance has been caused by FBT rates (46.5% per year through March 31, 2007), the additional administrative costs attached to calculating FBT and employees' preference for choosing their own health fund.

According to data from the Australian Institute of Health and Welfare (AIHW), private health insurance covered 31.8% of total nongovernment expenditures on health services in 2004/2005. Insurance is provided through “health benefit organizations” (or health insurance funds) that are licensed in accordance with the terms of the National Health Act of 1953. According to the Private Health Insurance Administration Council (PHIAC), there are 37 health benefit organizations nationwide, 28 of which are open to the general public and nine reserved for specific groups (for example, teachers' federations).

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As of December 2006, 43.4% of the population purchased private health insurance for hospital coverage and 42.8% purchased ancillary coverage (e.g., physical therapy, dental, and vision), according to PHIAC. Premiums are determined on the basis of “community rating”—Single, family, couple and single-parent coverage is available.

SINGLE-PAYER SYSTEMS—CHINA AND INDIA

While China and India attract economic investment in all industries—from low-cost manufacturing to the business process outsourcing of professional services and research and development—talent issues are becoming more and more complex. In order to attract, retain and manage their workforce, employers are taking a hard look at their benefits packages, particularly those elements related to health care. Despite increased government attention, the public health care systems have not been able to meet demands for care.

TABLE II
EMPLOYER-PROVIDED
SUPPLEMENTAL HEALTH
BENEFITS IN CHINA

| Benefit | Prevalence |
|--------------------------------|-------------------|
| Employee Medical Checkup | 91.0% |
| Dependent Medical—Children | 58.9 |
| Maternity Insurance | 53.9 |
| Critical Illness Insurance | 41.9 |
| Hospitalization Cash Allowance | 40.3 |
| Dependent Medical—Spouse | 10.1 |
| Dependent Medical—Parents | 2.0 |

Source: Hewitt's 2005 Compensation and Benefit Survey with 654 multinationals responding.

China

The search for a health system model in China has been complicated by the move from a planned to a market economy. This move disrupted the traditional structure and financing of health care and encouraged other societal changes, specifically rapid urbanization that put additional stress on the system. The disruption in the traditional model and the transition to a new health care system can be seen in the distribution of health care expenditures. From 1983 to 2003, government and social insurance expenditures fell, respectively, from 37.43% and 31.12% in 1983 to 16.96% and 27.16% in 2003. Out-of-pocket expenditures have become the primary source of health care financing, as expenditures increased from 31.45% to 55.87% over the same period.

Public Health Care System

In 1998, the State Council issued guidelines for a new national medical plan with the stated goal of *di shuiping, guang fugai* (low benefit levels, wide coverage). The guidelines established a social insurance approach in urban areas—pooled risk at the municipal level. (Community-based financing is being reestablished in rural areas.) The urban systems consist of individual medical savings accounts with a social risk pooling account for inpatient and catastrophic expenditures.

Municipal health insurance is financed through employer and employee contributions. Retirees are exempt from contributions. Under the guidelines, employers contribute 6% of pay, distributed between the pooled account and individual accounts; employees

contribute 2% of pay, all of which is deposited in their individual account. The percentage of the employer contribution that is allocated to individual medical accounts varies by the individual's age.

The minimum contribution is based on 60% and the maximum contribution is based on 300% of the city average wage for the previous year. Contribution rates are adjusted to each city's prevailing economic conditions, and in many locations, the employer contribution has been increased.

Individual medical accounts cover an employee's outpatient and emergency care and pharmaceutical drugs. In some cities, the employee also is responsible for a deductible before payment begins from the social pool. In Shanghai, the deductible is equal to 10% of the city average wage for the previous year.

The social risk pool covers only those medical expenses specified by the Ministry of Health and local health authorities. Expenses include hospitalization, extended emergency care (prior to hospitalization), and treatments for serious illnesses on an outpatient basis. Eligible expenses are paid according to a co-insurance schedule, and payments are limited to four times the city average wage for the previous year. Any expenses exceeding this amount are paid by supplemental insurance plans or by the employee directly. Social pools generally restrict their coverage to low-expense and medically necessary treatment in designated public hospitals.

Public Sector and Private Sector Responsibilities for Health Care

With the privatization of the health care system, employees increasingly have been looking to employers to provide comprehensive health care coverage. To distinguish themselves as "employers of choice" and help employees avoid high health care costs, employers have begun to develop their own health care benefit strategy in China. Employers may deduct their expenses related to health care provision, and health care coverage and benefits are not considered to be taxable income to employees.

Nearly 90% of employers in China provide some kind of supplemental health insurance benefit to employees. Almost all plans are paid completely by the employer; the employee makes no contribution. The typical plan covers 80% to 90% of outpatient and 100% of inpatient costs with a combined maximum annual benefit of CNY\$20,000.

Supplemental benefits vary from a single benefit to comprehensive coverage. (See Table II.)

In the short-to-medium term, China's "one-child" policy is likely to put pressure on employers to provide dependent coverage for spouses and parents, as

each child is culturally—and financially—responsible for two parents and four grandparents.

India

Public Health Care System

A limited social insurance system has been in place for private sector employees since 1948. The program is administered by the states under agreement with, and reimbursement by, the Employees' State Insurance Program. State governments arrange for the provision of medical care through government hospitals and dispensaries, state government facilities or private doctors under capitation contracts. Benefits include outpatient medical care, surgery, specialist services, hospitalization, medicines, maternity care, and disability and cash compensation. This program, though attractive on paper, suffers from operational weaknesses. There are currently about 35 million beneficiaries. The system has not been implemented in some states and some union territories.

Coverage applies to employees in companies with more than ten or 20 employees (depending on the type of establishment). Most states and districts currently provide benefits for dependents as well. Seasonal employees, agriculture and certain other sectors, and employees earning more than INR\$10,000 are excluded. Disabled and insured employees are covered upon payment of a nominal monthly fee. If employee contributions cease, benefits continue to be available for 26 to 39 weeks, depending on the employee's contribution record, and may be extended up to an additional 52 weeks for certain long-term diseases.

State governments pay 12.5% of the cost of medical benefits. Employers contribute 4.75% of payroll for covered employees; employees earning more than IND\$50 per day contribute 1.75% of earnings.

Public Sector and Private Sector Responsibilities for Health Care

Due to inadequate funding, individuals seeking care from public providers typically experience long waits in facilities with only basic medical equipment. Since many public facilities suffer from a poor reputation, many individuals use private facilities for health care services. According to a 2003 National Council of Applied Economic Research report, only 35% of individuals seek care from public facilities for major illnesses, regardless of income level.

Consequently, it is not surprising that the private health care market is growing at a rapid pace. In addition to the 65% of the population that use private hospitals for treatment of major illnesses, over 80%

of outpatient services are provided by the private sector. The main services provided are diagnostic and curative; they also include other services such as dentistry and pharmaceuticals.

Since most employees in multinational and large domestic companies earn more than INR\$10,000, they are excluded from the employee state insurance scheme. These employers generally provide their employees with private health care insurance. Corporate group health insurance plans are often based on a *floaters design* under which the policy may be extended to a spouse, children and sometimes parents. Under this type of plan, the employee has the option of structuring health coverage on an individual or group basis (for example, selecting coverage for himself or herself up to INR\$300,000 or for the individual and two other family members at INR\$100,000 each).

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Company-sponsored plans usually provide 100% of medical costs, up to certain maximums. Employee contributions are rare. Dental and vision care are usually covered under the outpatient medical. However, unlike China, the provision of health insurance coverage is not tax effective for employers in India—the cost of health insurance is subject to an FBT. An FBT is levied on an employer where employees or associates of employees receive benefits either from the employer or from a third party at the corporate income tax rate of 33.66% (including surcharge). The taxable value of an employer-provided health insurance plan (provided by a third party) is 20% of the actual cost. Benefits are tax free for employees. FBTs are not deductible against corporate income taxes.

However, the value of medical facilities made available by an employer to an employee and the employee's family free of charge is not subject to an FBT and not taxable to the employee. Some large employers and public sector enterprises operate group health policies for their staff or provide on-site health care services. The reimbursement of medical expenses to the employee is also tax free, provided that the amount does not exceed INR\$15,000 per year.

Historically, health insurance was sold to companies as a rider to more lucrative property and casualty insurance policies. In 2005, the Insurance Regulatory and Development Authority (IRDA) approved the establishment of standalone health insurance companies and, as a result, the private health insurance market is evolving rapidly. In 2006, several insurance companies announced that they would not offer health insurance as a standalone product. Meanwhile, some foreign companies have demonstrated an interest in the market.

CONCLUSION

This article has explored government-provided health care in countries outside the United States, in an attempt to provide context to the debate of how best to pay for health care in this country. Several systems, including Canada, the United Kingdom and Australia, are well established and are generally regarded as successful. Yet these three systems take vastly different approaches. Australia, in particular, has been more willing to hold individuals accountable for their health-related behaviors, for example, by penalizing people who delay buying health insurance until they are older (and more likely to need health care services). In the Australian system, there are few incentives for employers to offer coverage.

This system, in contrast to other systems around the world, combines a primarily public system with little supplemental coverage and a strong sense of individual responsibility.

The United Kingdom and Canada, on the other hand, focus on providing urgent care when needed, without incentives for early entry into the system. Consequently, much money spent by these systems is for urgent and critical care, and there are substantial waiting periods for basic and elective procedures. Employers have filled the gap here as a way to attract workers. In many cases, individuals pay directly for services if they are not covered by government or private insurance.

In China, the move to a market-based economy has greatly disrupted health care, and employers are moving aggressively to provide benefits in an effort to be "best employers." In India, a government-run system has been implemented inconsistently and overwhelmed by the rapid growth of the rest of the economy. Here, too, it is primarily employers that have filled in any gaps.

The global health care problem is not likely to be solved any time soon. Any successful system must ultimately balance the interests and financial resources of the primary stakeholders—governments, which aim to spread risk and prevent catastrophic claims; employers, which must attract a present and productive workforce to compete in a global economy; and individuals, who must maintain their health and have the financial resources to meet any supplemental needs. How best to balance these interests will continue to be the source of passionate debate for some time. ◀

Endnote

1. Statistics Canada, *Canadian Labor Market at a Glance*, 2003.

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