HEALTH CARE:

WHAT DO OTHER COUNTRIES DO?

THE HEALTH-CARE SYSTEMS OF OTHER COUNTRIES INCLUDE PAYING FOR MEDICAL TREATMENT OUT-OF-POCKET, PRIVATE INSURANCE, NON-PROFIT SICKNESS FUNDS, SOCIALIZED MEDICINE, AND GOVERNMENT SINGLE-PAYER PLANS. U.S. HEALTH CARE IS CURRENTLY A MIX OF THESE.

Most people in the world get medical treatment only if they can pay for it out of their own pockets. Out-of-pocket systems exist mainly in poor and developing countries. Many people fall into debt and poverty because of their medical expenses. Private insurance is usually available, but is too expensive for most people. The government in such countries provides few adequate public health-care services.

Except for the United States, each of the world's major economically developed countries has a universal nationwide health-care system. These countries provide health coverage for everyone (even foreign tourists). They also require all citizens to participate in the system.

Despite their common characteristics, universal systems are generally organized around one of three national health-care models:

- **Non-Profit Sickness Funds:** These privately run non-profit funds either pay doctors and hospitals for their services or reimburse patients for their medical expenses. The funds are financed by mandatory private insurance premiums and taxes.
- **Socialized Medicine:** The central government owns and operates the hospitals and pays the salaries of doctors. This system is mainly financed by taxes.
- **Government Single-Payer Plans:** The province or central government pays private doctors and hospitals for their medical services. Financing is mainly by taxes.

By contrast, the **American Mixed System** differs from other major countries' health-care systems in that it does not guarantee universal care for all. Rather, health care in the U.S. is an uncoordinated mix of voluntary private insurance, government health care for certain groups, and out-of-pocket payments by the uninsured.

Non-Profit Sickness Funds

In 1883, Otto von Bismarck, the conservative leader of Germany, created the first universal health-care system. He did this to undermine the appeal of socialism and communism that were gaining in popularity among German workers. Bismarck's system required all workers and their employers to jointly pay premiums (set payments) for health insurance through paycheck deduction.

Today, about 200 non-profit sickness funds throughout the country collect the premiums. The job of the fund is to pay patient medical bills submitted by doctors and hospitals. Funds cannot deny medical claims, but doctor and hospital fees are tightly regulated by the government. In recent years, patients have been required to make small payments (co-pays) up to a certain amount per quarter for each doctor visit or hospital stay.

Germans choose their doctor and hospital, which are mostly private. Workers are not dropped from their insurance when they change or lose a job. Premiums for unemployed workers are paid by the government. The funds compete over providing such things as health services not covered in the basic plan. Some Germans also buy private insurance to supplement the basic benefits.

France adopted the universal sickness fund system after World War II. It is financed by worker-employer premiums and taxes. French patients, however, pay doctors and hospitals at the time of service and later are reimbursed partly or fully. In most cases, patients are required to pay something out-of-pocket in order to deter overuse of the system.

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German statesman Otto von Bismarck (1815–1898) created the first system of universal health care.

The sickness funds negotiate medical fees with private doctors through their unions. The same fee chart for treatments covered by the national health plan is posted in every doctor's office. Doctors also make house calls. The income of French doctors is much less than that of American doctors, but medical school is free, and they get special tax breaks.

France has led the world in digitizing patient medical information. All people in France have a *card vital* with a microchip that contains their medical record going back to 1998. Any French doctor can insert the card in a small reader to display the patient's medical history and other records.

At the end of an appointment, the doctor uses the *card vital* to send the medical charges to the patient's sickness fund. The fund then can electronically deposit the reimbursement amount into the patient's bank account.

The non-profit sickness fund health-care system is the most common one in Europe. Japan has also adopted such a system. With rapidly aging populations, medical costs are increasing sharply, and the funds often run a budget deficit. These largely private systems may have to boost patient co-pays or depend more heavily on taxes.

Gail Reed/World Health Organisation

An intern checks an outpatient in a Havana clinic. The Cuban medical system is an example of socialized medicine.

Socialized Medicine

In 1948, the United Kingdom (U.K.) of Great Britain and Northern Ireland created the National Health Service (NHS). It was based on the principle that no one would ever have to pay an insurance premium or fee for any medical services.

To do this, the British adopted socialized medicine. Financed by taxes, the NHS operates almost the entire health-care system. The central government owns most hospitals and other medical facilities. While some doctors are employees of the government, most are private practitioners who own and operate their offices. Rather than reimburse doctors for every treatment, the NHS pays them a flat annual sum based on the number of patients who are registered with them.

Patients may choose any primary care doctor in their area. This doctor treats patients and acts as a "gatekeeper" who refers them to specialists. Primary doctors are paid extra to make house calls and for treatments that are successful ("pay for performance").

Over the years, small fees have been added for such things as prescription drugs, some dental care, and eyeglasses. Private insurance is available to supplement the NHS benefits.

To help control costs, the NHS promotes preventive care to keep people healthy by such means as nationwide flu shot drives. In addition, a special NHS board may decide not to pay for certain expensive tests, treatments, and drugs because they are not cost effective.

The British people pay little out of pocket but endure high taxes for their free medical care. They also may have to wait for months to see a specialist or have elective surgery.

Italy, Spain, and Portugal have adopted socialized health-care systems similar to the one in the U.K. Since most doctors in the U.K. run their own businesses, the system is not quite 100 percent socialized medicine. The best example of that exists in communist Cuba.

Cuba's tuition-free medical school trains all the doctors and other medical personnel in the country. Cuba even has a surplus of doctors who are sent to other countries in Latin America. Within Cuba, all doctors and nurses are employed by the government, which assigns them in teams to every village, town, and city neighborhood.

The doctor and nurse teams provide free primary treatment, medicine, preventive care, and referrals to specialists and the government-owned hospitals. The quality of health care in Cuba is comparable to and sometimes exceeds that in major developed countries. The Cuban people, however, have little choice of doctor or hospital.

Single-Payer Plans

Different variations of universal care single-payer plans exist in a few European countries, South Korea, Taiwan, and Canada, which originated this system after World War II. These plans combine elements of the German system where most doctors and hospitals are private with the socialized system in the U.K. where the government pays most medical expenses.

In Canada, health care is decentralized so that the provinces and territories operate the system under national guidelines. They each act as a "single payer" to compensate doctors and hospitals for all medically necessary services.

Most Canadians pay nothing for doctor visits, emergency treatment, hospital stays, tests, shots, and psychiatric care. Not covered are regular dental care and prescription drugs for most people. Many carry private insurance to cover these.

The central federal and provincial governments finance the system with taxes. The federal government negotiates a fee schedule for all doctors with their medical associations. It also negotiates nationwide drug prices.

Government cost-control cuts to doctor fees have reduced the income of Canadian doctors to about half of U.S. doctors. This has resulted in fewer students going to medical school in Canada, causing a doctor shortage and a serious waiting problem for patients. Canadians usually have no trouble getting emergency and primary care. But they may have to wait up to a year or more to see a specialist and additional months for non-urgent or elective surgery.

American Mixed System

The Patient Protection and Affordable Care Act, passed by Congress in 2010, was an attempt to move American health care closer to the universal health-care plans in the other major developed countries. This law was not scheduled to be fully implemented until 2014. Therefore, the description of U.S. health care that follows is how it currently exists.

Large-scale health insurance started in the U.S. during World War II. There was a shortage of workers and government controls on wages. To attract workers, employers began to offer them free or low-cost private health insurance.

The practice of tying health insurance to work continued after the war. Today the majority of Americans get their health insurance through their employers. But this is voluntary. Many employers do not offer a health

Comparison of Health-Care Data for 10 Developed Countries

Country and Type of Health-Care System	Spending as % of GDP	Spending Out-Of-Pocket Per Capita	Spending for Prescription Drug Per Capita	CT Scans Per 1,000 Population
Canada Government Single Payer	11.4	$635	$743	125.4
France Non-Profit Sickness Funds	11.8	$290	$640	138.7
Germany Non-Profit Sickness Funds	11.6	$552	$628	N/A
Italy Socialized Medicine	9.5	$616	$572	N/A
Japan Non-Profit Sickness Funds	8.5	$454 (2008)	$558 (2008)	N/A (2008)
Sweden Government Single Payer	10.0	$620	$465	N/A
South Korea Government Single Payer	6.9	$609	$422	93.5
Switzerland Non-Profit Sickness Funds	11.4	$1568	$521	N/A
United Kingdom Socialized Medicine	9.8	$364	$381 (2008)	N/A
United States Mixed	17.4	$976	$956 (2007)	227.9

Source: Based on data for 2009 (unless otherwise noted) as reported in *OECD Health Data 2011*. GDP: Gross Domestic Product Per Capita: Per Person

insurance benefit or have dropped it because of its increasing cost.

Insured workers usually pay monthly insurance premiums, co-pays, and other out-of-pocket expenses while employers also make a contribution. Those without an insurance work benefit may try to purchase an individual insurance policy. But these are usually more expensive, and insurance companies can refuse to sell policies to those with an existing medical problem.

Health care in the U.S. is the most privatized of any developed country. Most doctors are independent private practitioners or members of private doctor groups. Many hospitals are privately owned. The private health insurance companies are mostly for-profit.

Medical costs began to grow rapidly in the 1990s. To control costs, the insurance industry developed "managed care" policies. An insurance company typically required its insured members to select their doctors from within a certain group or network that it managed.

In addition to work-based and other private health insurance, the U.S. government provides free or low-cost tax supported health care for certain Americans. These stand-alone programs reflect features of other health-care systems in the world.

Medicare for those over age 65, Medicaid for the poor, and health care for children from low-income families that do not qualify for Medicaid all operate much like the Canadian single-payer plan. Qualified Americans get treatment from mostly private doctors and hospitals that are paid by the government from federal and state matching funds.

For the most part, the active military and their families, veterans, and Native Americans get their health care from doctors employed by and hospitals owned by the federal government. This is similar to the U.K. and Cuban socialized systems.

American medicine is by many measures the best in the world. The medical training for primary doctors, specialists, nurses, and technicians is unmatched. The U.S. has the most modern hospitals, labs, and other facilities. American medical research leads all other nations. Medical personnel utilize the most advanced treatments, drugs, and technology.

At the same time, access to American medicine is a serious problem for many. The number of Americans with no private insurance or government health care rose from just under 15 million in 1990 to nearly 50 million in 2010.

Uninsured individuals must either pay out-of-pocket for treatment or depend on hospital ERs (emergency rooms). Under federal law, ERs must treat them even if they cannot pay. Unpaid ER costs are usually shifted to those with insurance who then pay higher premiums. Most of the uninsured are those who have no insurance benefit at work or who have lost a job with insurance.

Another major problem is that the American mixed system is the most expensive in the world. Total spending for health care in the U.S. each year is about 17 percent of GDP (Gross Domestic Product — the value all goods and services produced in the country in a year). This far exceeds the cost of the other systems in major developed countries.

Why is U.S. health care so expensive? Like in other developed countries, older people in the U.S. are living longer and have greater health-care needs and costs. The greater overall cost of American health care, however, is due to a number of causes unique to the U.S., such as:

- Greater and sometimes unnecessary use of expensive tests, treatments, and technology like CT body scans.
- Higher prescription drug prices and usage.
- Higher hospital prices partly due to unpaid ER charges.
- More doctor malpractice lawsuits. ➤

- More doctors paid for each medical service than for the successful treatment of their patients ("pay for performance").
- Fewer digitized patient medical records.
- Duplication and inefficiency in the mixed system.
- For-profit insurance company administrative costs for reviewing, approving, and sometimes denying patient treatments and claims.

Ranking Health-Care Systems

One measure of a nation's health system effectiveness is the infant mortality rate: deaths of infants per 1,000 live births. From the highest to the lowest infant death rate, the current CIA *World Factbook* ranks the U.S. 174th of 222 countries. All the other major developed countries rank better than the U.S.

Another measure of the health-care system of a country is life expectancy at birth. The *World Factbook* ranks the U.S. 50th in average life expectancy at 78.49 years. All the other major developed countries have a higher life expectancy, with the Japanese living the longest at an average of 83.43 years.

Perhaps a better measure of a nation's health-care system is "healthy life expectancy" developed by the U.N.'s World Health Organization. This calculates how many years the average citizen can expect to live in "full health" before declining and dying. In a 2000 study, Japan ranked at the head of all countries at 74.5 years with the U. S. ranked 24th at 70 years.

A bright spot in American health care is its success in treating cancer. In a 2010 study, the U.S. had the highest five-year survival rates for breast and colon cancer among 12 major developed countries.

FOR DISCUSSION AND WRITING

1. How is health care in the U.S. similar to that in other major developed countries? How is it different?
2. Why do you think the American health-care system is so different?
3. Do you think that the U.S. should adopt a system of universal health care? Why or why not?

For Further Reading

Organization for Economic Co-operation and Development. OECD Health Data 2012. URL: www.oecd.org/health/healthdata. See "Frequently Requested Data" for country health-care system comparisons.

Reid, T. R. *The Healing of America*. New York: Penguin Books, 2010.

ACTIVITY

Debate: What is the Best Health-Care System?

1. Form four debating groups to each argue for one of the following:
   a. Non-Profit Sickness Funds
   b. Socialized Medicine
   c. Government Single Payer
   d. American Mixed System
2. Form a fifth group as a judging panel.
3. The debating groups should each make a presentation that covers how their system works and why it is the best. Students should use information from the article and statistical data provided in the comparative chart.
4. After each group presentation, the other debating groups should ask questions and point out flaws in the group's health-care system. The group should have a chance to respond.
5. After all debating groups have finished, the judging panel will discuss and decide the debate question while the other students observe.

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