CHAPTER 9

Alternative Health Care Systems

Joan Brooks, a 58-year-old grandmother, lives in Toronto. Her husband died a year and a half ago after suffering from cancer and kidney failure. He spent his last nine months in the hospital. The Ontario Health Insurance Plan covered all his medical expenses, leaving her no unpaid bills.

Brooks' only income is her husband's veterans pension—about $15,000 in U.S. dollars. But paying for medical care is not one of her worries. The Ontario health plan, to which every Ontarian belongs, covers those expenses.

She has severe arthritis and gout in both ankles and is unable to walk unless she takes prescription medicine. Not long ago, she was experiencing dizziness; her doctor suspected a drug toxicity affecting her liver and ordered a diagnostic ultrasound procedure. Brooks had the procedure within one week. She says it could have been done sooner but her schedule didn't permit an earlier appointment.

When the ultrasound revealed an enlarged liver, her doctor referred her to a specialist. Within days, the specialist admitted her to the hospital's outpatient unit and performed a needle biopsy. The Ontario plan paid the doctor about $54 for his work. Under the rules of the Canada Health Act, the doctor must accept the plan's payment, which is negotiated by the province and the provincial medical association. He cannot bill Brooks any additional amount.

Across Lake Ontario, in Buffalo, New York, insurance carriers pay doctors about $139 to perform the same procedure, and doctors can "balance bill"—that is, charge their patients more than they receive from insurers.

The biopsy shows that Brooks was suffering from excessive fat in her liver. . . . Her doctor has referred her to a nutritionist at the hospital who is helping her plan low-fat menus.

> *Right now she takes a drug for arthritis that costs $18 a month. The Ontario plan doesn't cover prescription drugs for Ontario residents unless they are over 65 or on welfare. But many people who are employed have drug coverage through private insurance provided by their employers. . . .*
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> *Because of the medication, Brooks' doctor checks her blood every three months to see if the dosage needs fine tuning. Ontario's health plan pays for the lab tests. When she needs to have her eyes examined, the plan pays for that checkup as well. The insurance plan covers the cost of one complete eye exam each year. Recently she had to return to the optometrist because the glasses he prescribed weren't adequate. The plan also covered the second visit, since it pays for subsequent visits if they are necessary.*
>
> *Brooks . . . isn't interested in trading in Canadian health care for treatment in the U.S. "You can't buy the kindness and caring of this system," she says. "I have no dark tales to tell." (*Consumer Reports, *1992: 585)**

On television, in newspapers, and in public discussions, we often hear that the United States offers the best health care in the world. Yet other countries—both Western and non-Western, rich and not so rich—provide far better access to care for their citizenry, at lower costs, and with better health outcomes. In this chapter, we look at alternatives to the U.S. health care system, beginning with some basic measures for evaluating any health care system and then exploring the systems in four other countries—Canada, Great Britain, China, and Mexico. The health care systems in Canada and Great Britain are ranked higher than the U.S. health care system by the World Health Organization (2000b) and are often cited as possible alternative models for the United States (Table 9.1).

Table 9.1 ***Health Care Systems as Ranked by the World Health Organization***

COUNTRY	RANK
Great Britain	18
Canada	30
United States	37
Mexico	61
China	144

Source: World Health Organization (2000b).

The health care systems in China and Mexico demonstrate how poorer countries have struggled to improve their nation's health despite limited resources. Finally, we look at the prospects for reforming the U.S. health care system.

Evaluating Health Care Systems

Universal Coverage

The most basic measure of any nation's health care system is whether it provides **universal coverage,** guaranteeing health care to all citizens and legal residents of a country. The United States is the only **industrialized nation** that neither does so nor recognizes a right to health care (the topic of this chapter's ethical debate, Box 9.1). Instead, the U.S. government provides insurance to a small percentage of the population, and private insurers have nearly free rein to choose whom they will insure and at what prices. In contrast, any legal resident of Great Britain or Canada, regardless of income, place of residence, employment status, age, or any other demographic characteristic, can obtain state-supported health care—although not everything they want when they want it.

In the absence of universal coverage, uninsured U.S. citizens must do without needed care, rely on charity, or try to obtain government-funded health care. When individuals are not eligible for government-funded care, hospitals and doctors may provide care, but must make up the financial losses they incur by raising the prices they charge others through a process known as **cost shifting.** Consequently, from the perspective of the system as a whole, it is more cost-effective to plan to provide care to everyone who needs it and budget accordingly than to have to find ways to pay for that care after the fact.

Portability

A second important measure of health care systems is whether they offer portable benefits. As described in Chapter 8, most U.S. citizens receive their health insurance through their jobs, their spouses' jobs, or their parents' jobs, leaving them vulnerable to losing their insurance if their family or work situation changes. Similarly, individuals who receive **Medicaid** can lose this coverage if they move to another state or if their income rises above the legal maximum; and those who retire or go on disability often find that they cannot move to another area, because the health insurance they receive from their former employer will not cover them elsewhere. In contrast, in other developed nations individuals need not worry about losing their insurance no matter what changes occur in their personal lives.

Box 9.1 *Ethical Debate: Is There a Right to Health Care?*

Every industrialized nation in the world other than the United States considers health care a basic right and provides all its citizens with access to health care. In the United States, on the other hand, many question whether individuals have a right to health care, and no court has ever recognized such a right.

Those who argue against a right to health care draw on the language of autonomy and individualism, stressing the rights of individuals over any socially imposed rights accruing to all members of a society (Sade, 1971; Engelhardt, 1986). Those who take this position note that in asserting individual's rights to health care, we implicitly assert that health care workers have a duty to provide that care. In so doing, therefore, we restrict the rights of health care workers to control their time and resources. If we would not force a baker to give bread to the hungry, how can we force doctors to give their services away, or restrict what patients doctors see, what services they provide, and what charges they assess?

Similarly, in asserting a right to health care, we implicitly assert that all members of a society have a duty to pay the costs of that care. When we subsequently use tax dollars to pay for health care, we restrict the rights of individuals to spend their money as they please. Some individuals, both rich and poor, might consider this a good investment, but many others would prefer to choose for themselves how to spend their money.

Moreover, according to those who take this position, asserting a right to health care fails to differentiate between unfortunate circumstances and unfair ones (Engelhardt, 1986). Although it is certainly unfortunate that some individuals suffer pain, illness, and disability, it is not necessarily unfair. Society may have an obligation to intervene when an individual unfairly suffers disability because another acted negligently, but society cannot be expected to take responsibility for correcting all inequities caused by biological or social differences in fortune.

Finally, if we assert that individuals have a right to demand certain social goods from a society, where do we draw the line? Do individuals have a right only to a minimum level of health care, or do they have a right to all forms of health care available in a given society? And, if we grant individuals a right to health care, how can we deny them a right to decent housing, education, transportation, and so on?

Those who argue in favor of a right to health care, on the other hand, draw on the

Geographic Accessibility

Even those who have health insurance can face obstacles to receiving care depending on where they live. Both rural areas and poor inner-city neighborhoods in the United States typically have relatively few health care providers per capita. Meanwhile, other areas have an excess of doctors—a situation that can pressure doctors to increase their prices or perform perhaps unnecessary procedures to maintain their incomes despite the competition for patients. These problems suggest that, for both economic and medical reasons, we should also evaluate health care systems according to whether they include mechanisms for encouraging an equitable distribution of doctors, such as providing low-cost loans to doctors who work in

language of social justice (Rawls, 1971). Believing each individual has inherent worth, they reject the distinction between unfortunate and unfair circumstances and the idea that health care is a privilege, dependent on charity or benevolence. Instead, they argue that each individual has a right to at least a minimum level of health care. Moreover, they argue, all members of a society are interdependent in ways that a rhetoric of individualism fails to recognize. For example, doctors who believe they should have full control over how and to whom they provide services fail to recognize the many ways they have benefited from social generosity. Medical training relies heavily on tax dollars, as do medical research projects, technological developments, hospitals, and other health care facilities. In accepting these benefits of tax support, therefore, doctors implicitly accept an obligation to repay society through the health care they provide.

Similarly, those who support a right to health care argue that to consider the decision to purchase health care as simply an individual choice misrepresents the nature of this decision, for it hardly makes sense to define something as a choice when the alternative is death or disability. Nor does it make sense to talk about the purchase of health care as a choice when individuals can do so only by giving up other essentials such as housing or food.

Finally, those who support a right to health care recognize that society could never afford to provide all available health services to everyone, but argue that this should not limit society's obligation to provide a decent minimum of care to all. Doing any less denies the basic worth of all humans.

Sociological Questions

1. What social views and values about medicine, society, and the body are reflected in this debate? Whose views are these?
2. Which social groups are in conflict over this issue? Whose interests are served by the different sides of this issue?
3. Which of these groups has more power to enforce its view? What kinds of power do they have?
4. What are the intended consequences of the various policies under consideration? What are the unintended social, economic, political, and health consequences of these policies?

underserved areas or refusing permission for doctors to open practices in over-served areas.

Comprehensive Benefits

Another important measure of health care systems is whether they offer all the essential services individuals need. The difficulty lies in defining what is essential. Although all observers would agree that comprehensive health care must include coverage for **primary care,** agreement breaks down quickly once we begin discussing specialty care. Some individuals, for example, consider coronary bypass surgery an essential service, whereas others consider it an

overpriced and overhyped luxury. Similarly, some favor offering only procedures necessary to keep patients alive, whereas others support offering procedures or technologies like hip replacement surgery, home health care, hearing aids, or dental care, which all improve quality of life but do not extend life.

Any system that does not provide comprehensive benefits runs the risk of devolving into a two-class system, in which some individuals can buy more care than others can. To those who believe health care is a human right, such a system seems ethically unjustifiable. Others object to such systems on practical economic grounds, arguing that it costs less in the long run to plan on providing care for everyone rather than to haphazardly shift costs to the general public when individuals who cannot afford care eventually seek care anyway.

Affordability

Guaranteeing *access* to health care does not help those who cannot afford to *purchase* it. Consequently, we also must evaluate health care systems according to whether they make health care coverage affordable, restraining the costs not only of insurance premiums but also of **co-payments, deductibles,** and other health care services such as prescription drugs.

For health care to be affordable, individual costs must parallel individual incomes. As noted earlier, most insured Americans receive their insurance through employers. Employers typically pay a proportion of the costs for premiums and deduct the remainder from individuals' wages. To pay their share of the premiums, employers typically pass their costs on to their employees, dividing the costs equally among all employees and reducing salaries accordingly (Iglehart, 1999). As a result, low-wage and high-wage workers in essence pay (through reductions in salary) the same dollar amount for their health insurance, even though that dollar amount represents a much higher percentage of income for the low-wage worker. Consequently, paying for health insurance imposes a far heavier burden on poorer persons than on wealthier persons; having to pay $3,000 per year for health insurance, for example, might force wealthier persons to scale back their vacation plans but might force poorer persons to put off reroofing their houses. In contrast, when, as in Great Britain and Canada, health coverage is paid for through graduated income taxes, poorer persons pay a lower percentage of their income for taxes and therefore for health care than wealthier persons. Either way—whether through taxes or lowered wages—citizens pay all costs of health care. The only difference is who pays how much.

Financial Efficiency

Another critical measure of a health care system is whether it operates in a financially efficient manner. Currently, the multitude of private and public insurers in the United States substantially drives up the administrative costs

of the health care system. At the same time, the atomized and essentially entrepreneurial nature of our health care system makes it virtually impossible to impose effective cost controls. For example, in Chapter 8 we saw how the federal government now tries to restrict costs by paying hospitals prospectively for patient care based on **diagnostic-related groups (DRGs)**—paying the same fee for all patients with the same diagnosis. To maintain profits despite the DRG system, hospitals have shifted patient care from inpatient to outpatient settings where DRGs do not apply. Similarly, doctors have responded to financial limits on Medicare payments by raising the fees they charge to non-Medicare patients. For these reasons, true reform probably must include some mechanism for simplifying and centralizing control over the health care system and for restraining entrepreneurial elements.

Consumer Choice

We also need to evaluate health care systems according to whether they offer consumers a reasonable level of choice. Currently, wealthy Americans can purchase any care they want from any willing provider. In addition, Americans who have **fee-for-service insurance** can seek care from any provider as long as they can afford the copayments and deductibles and, if their plan uses **managed care,** as long as their insurer approves the care. Those who belong to **health maintenance organizations (HMOs),** meanwhile, can seek care only from providers affiliated with their plans, unless they have purchased additional coverage and can afford the extra charges. Finally, those who have Medicaid or Medicare coverage can obtain care only from providers willing to accept the relatively low rates of reimbursement offered by these programs, and those who have no health insurance can obtain care only from the few places willing to provide care on a charity basis.

No health care system can afford to grant all individuals full access to all providers. To be acceptable to Americans, however, an alternative health care system probably would need to provide at least the level of consumer choice that **managed care organizations (MCOs)** now offer and that many Americans have come to expect.

Provider Satisfaction

Finally, for a health care system to function smoothly, providers as well as consumers must feel satisfied with the system. Consequently, we must evaluate health care systems according to whether they offer health care providers an acceptable level of clinical autonomy, an income commensurate with providers' education and experience, and some control over the nature of their practices.

Health Care in Other Countries

With these measures in mind, we can now look at the health care systems in Canada, Great Britain, China, and Mexico. Canada and Great Britain guarantee portable, affordable, and universal health care coverage to their citizens. China has a stunning but now fraying record of increasing coverage, while Mexico continues its struggle to improve access to care.

Health care in the United States is primarily organized through an **entrepreneurial system,** that is, a system based on private enterprise and the search for profit. In contrast, Canadian primary care doctors, although also functioning as private practitioners paid on a fee-for-service basis, receive their payments through provincial government insurance programs. In Great Britain, meanwhile, most primary care doctors are paid through a mix of **capitation** and fee-for-service payments directly from the government, with insurance companies playing little role in health care. Finally, the Mexican and Chinese systems combine socialistic and entrepreneurial elements. (Table 9.2 summarizes the characteristics of these systems.)

Not surprisingly, each of these systems has changed over time. More interestingly, the changes seem to have moved these and other health care systems toward increasing convergence. This observation led David Mechanic and David Rochefort to propose a **convergence hypothesis,** which argues that health care systems become increasingly similar over time due to a combination of "scientific, technological, economic, and epidemiological imperatives" (1996: 242).

First, Mechanic and Rochefort argue, doctors always seek the most current medical knowledge and technology, both to improve the services they offer and to increase their incomes and prestige. In recent decades **globalization** has expanded access to such knowledge, as doctors increasingly use medical journals and Internet resources from around the world and as medical and pharmaceutical corporations market new technologies internationally. Thus doctors in many different countries are adopting the same technologies and placing similar economic pressures on their health care systems. In turn, those systems have adopted similar strictures to limit both specialization and the use of technological interventions whose benefits do not justify their costs.

Broader economic shifts also can push health care systems inadvertently toward convergence. In countries with booming economies and largely capitalist health care systems, expenditures on health care typically rise steeply, eventually resulting in efforts to contain costs through *restricting* the role of the market in health care. Conversely, countries with weakening economies and largely socialistic health care systems find it increasingly difficult to support universal health care and typically respond by adopting measures designed to *increase* the role of the market, such as allowing wealthier persons to purchase health care outside of a national health care system. Thus, both sets of countries gradually move toward health care systems in which market forces play a role, but that role is restricted by the state.

Table 9.2 ***Characteristics of Health Care Systems in Other Countries***

Characteristics	United States	Canada	Great Britain	China	Mexico
Nature of system	Entrepreneurial	National Health Insurance	National Health System	In flux from national health system to entrepreneurial	Multiple options, providing unequal access
Role of private enterprise	Very high	Moderate	Low but rising	Moderate and rising	Moderate
Payment mechanism for primary care	Wide variety of mechanisms	Fee-for-service	Capitation	Primarily fee-for-service	Primarily salaried
Payment source for primary care	Mix of private, nonprofit, and government insurers	Government	Government	Primarily individuals	Primarily government
Universal coverage	No	Yes	Yes	No, but good access to primary care	Yes, but with inequitable services
Payment mechanism for hospital doctors	Salaried and fee-for-service	Salaried	Salaried	Salaried	Salaried
Payment mechanism for hospital expenses	Varied	Lump sum from government	Lump sum from government	Lump sum from government	Lump sum from government

Epidemiological changes also promote convergence. As populations have aged around the world, health care systems have had to shift more toward treating chronic degenerative diseases rather than treating acute diseases. At the same time, the globalization of knowledge has increased people's expectations regarding health and health care because they now compare themselves not only to their neighbors but also to those they see in the mass media. This shift has forced health care systems to pay greater attention to patient satisfaction and choice, while providing support for parallel systems that allow the wealthy to buy care unavailable to others.

Canada: National Health Insurance

Like the United States, Canada is an industrialized democracy made up of various provinces and territories more or less equivalent to U.S. states. Although its 2005 gross national income (GNI) per capita of $28,930 is almost 20 percent lower than in the United States, its economy is strong. In addition, because of steady immigration, Canada has a younger population than those in most industrialized nations, which guarantees it a relatively healthy population.

Canada is also, however, the second largest country in the world, with vast social differences reflecting its vast geographic spaces. Its population is highly concentrated along its southern border, as are most health care personnel and facilities. Neither health status nor health access is as good in rural areas or in its remote northern regions, where many of the residents are poor Native Americans (known in Canada as "First Nations").

Structure of the Health Care System

All Canadian health insurance is obtained through one source—the federal government—and is coordinated through the Canada Health Act. For this reason, the Canadian system is referred to as **national health insurance,** or a **single-payer system.** In fact, however, the Canadian system is a decentralized one, with each province retaining some autonomy and offering a somewhat different health care system. This brief discussion of the Canadian health care system necessarily obscures some of these differences.

The national health insurance system has evolved gradually since the late 1940s (P. Armstrong and H. Armstrong, 1998; Woodward and Charles, 2002). Underpinning the system are payments that the federal government gives the provinces yearly to run their health care systems. To receive these payments, provinces must offer comprehensive medical coverage to all residents through a public, nonprofit agency. Provinces must charge residents no more than minimal fees and must allow residents to move from one province to another without losing their coverage.

Purchasing Care

Unlike patients in the United States, most Canadians rarely see a medical bill, an insurance form, or any other paperwork related to their health care. Through a combination of federal and provincial taxes, the health insurance systems cover the costs of hospital care, medical (but not dental) care, and prescription drugs for the elderly (and, in some provinces, for younger persons). It also partially covers the costs of long-term care and mental health services. Because the system is based primarily on graduated income taxes, it is **financially progressive,** placing the heaviest financial burdens on those who can best afford it: Those who earn more money pay a higher proportion of their income in taxes and therefore pay more toward health care than do those who earn less money.

Increasingly, though, costs are being shifted to individuals. Two provinces now charge insurance premiums. (Unlike in the United States, however, those premiums are charged equally to all citizens, rather than charging higher premiums for those who have more health risks.) A growing list of services (such as in vitro fertilization and routine circumcision) are no longer considered medically necessary and so are no longer covered by the insurance system. And, as in the United States, patients are now released quicker from hospitals (where all costs are covered) to their homes (where they must pay some costs on their own).

Paying Doctors

Most Canadian doctors work in private practices and are paid on a fee-for-service basis by the government insurance systems. Doctors submit their bills directly to the health insurance system using fee schedules negotiated annually between the provincial medical associations and provincial governments. Unlike in the United States, in Canada doctors who consider these fees too low cannot **balance bill** (that is, bill their patients directly for the difference between what the patients' insurance will pay and what the doctor wants to charge). In addition, some provinces control costs by setting annual caps on the total amounts they will reimburse either each doctor or the doctors as a group. In practice, this means reimbursing doctors less for each service rendered as the number of services they bill for rises.

Although recent years have seen increasing grumbling among Canadian doctors about their incomes (Woodward and Charles, 2002), overall they express strong support for their country's health care system. Of a random sample of 3,387 Canadian doctors who participated in a nationwide survey in 1992 (the latest data available), about 85 percent preferred the Canadian system to the U.S. system (Himmelstein and Woolhandler, 1994: 265).

Several factors explain Canadian doctors' support for their system. First, Canadian doctors have retained considerably more clinical autonomy than

have U.S. doctors. In addition, most Canadian doctors work in solo private practice, free from the constraints of group settings or regulations. At the same time, doctors' workloads have remained essentially unchanged since the start of national health insurance, and their incomes have remained high. Primary care doctors (about 60 percent of all doctors in Canada, compared with 13 percent in the United States) earn approximately the same net incomes in Canada and the United States, although specialists earn considerably more in the United States. Moreover, because medical education is highly subsidized by the Canadian government, Canadian doctors do not enter practice burdened by heavy debts, so their incomes go farther. (However, this could change quickly, because some provinces are about to dramatically increase medical school tuition.)

Paying Hospitals

To cover their operating costs, Canadian hospitals (most of which are privately owned) receive an annual operating budget from their provincial insurance system. Hospitals can spend their budgets as they like, with no controls imposed by the government, as long as they provide care to anyone in their region who needs services. In addition, hospitals annually receive a capital expenditure budget. Because the government controls both operating and capital budgets, it can limit both unneeded hospital growth and the proliferation of high-cost technologies.

Access to Care

Despite having national health insurance, on average Canadians retain more control over their health care than do most U.S. residents (P. Armstrong and H. Armstrong, 1998; Woodward and Charles, 2002). Whereas most Americans can receive care only from the doctors affiliated with one particular health care plan, Canadians can choose any primary care doctor they want and theoretically can switch doctors at will (although often doctors will not accept new patients, particularly if they practice in underserved areas). However, as in U.S. HMOs in the past, individuals typically must get a referral from their primary practitioner before seeing a specialist.

Nevertheless, access to care has decreased since the early 1990s, as budgetary pressure has led to reductions in federal subsidies for health care (P. Armstrong and H. Armstrong, 1996). As a result, some Canadian provinces now purchase certain high-technology services from providers in the United States (for example, sending persons from Toronto to Buffalo for chemotherapy), and some now offer a more limited package of benefits than in the past. In addition, waiting times for some procedures have grown unacceptably longer. Consequently, some Canadians now purchase certain medical or surgical services out of pocket in Canada or in the United States. Meanwhile, provinces have closed some hospitals, sparking interest among U.S. investors in buying these hospitals and turning them into fee-for-service facilities.

These problems, though real, have been blown far out of proportion by the U.S. media, leading many U.S. citizens to conclude that Canadians have far less access to health care than do persons living in the United States (Brundin, 1993). This image is almost totally inaccurate. It is true that Canadians sometimes cross the border to seek health care, but so do many U.S. residents, for both Canadian and U.S. insurers sometimes find it cheaper to pay to send their patients to the other country for services than to provide those services themselves (Lassey et al., 1997). On the other hand, no Canadian is forced to come to the United States because he or she can't afford needed medical care, whereas many U.S. citizens fraudulently claim to be Canadians to receive medical care they otherwise couldn't afford. For the same reason, many charter buses now regularly go from the United States to Canada (and Mexico) solely to allow individuals to purchase prescription drugs more cheaply. Finally, Canada, like the United States, had in past years permitted the building of unneeded hospital beds, driving up the cost of health care. By closing some of these beds and centralizing services to a smaller number of locations where staff constantly practice their skills, Canada has both lowered costs and improved the quality of care. (However, decisions regarding which hospitals to close are partially shaped by political rather than by strictly health concerns and have increased problems with accessibility in rural areas.)

It is true that affluent U.S. citizens can obtain better (or at least more) health care than the average Canadian can. When we look at the two populations overall, however, Canadians have the same, or better, access to care as U.S. citizens have on almost every measure, such as number of doctor visits per capita, number of hospital admissions per capita, and average length of hospital stay (Himmelstein and Woolhandler, 1994). Canadians do wait longer than Americans do for some forms of high-technology care, but rarely do so in life-threatening situations. Canadians also are less likely to receive some (although not all) high-technology procedures, such as coronary artery bypass graft surgery. However, this more likely reflects *overuse* in the United States than *underuse* in Canada (Himmelstein and Woolhandler, 1994). Moreover, a 1994 national random survey (Donelan et al., 1996) found U.S. citizens slightly more likely than Canadians (or Germans) to report that they were unable to get needed medical care, had postponed getting needed medical care, or had serious problems paying their medical bills (although Canadians and Germans more often reported long waits to get appointments with specialists); Table 9.3 provides details. Finally, in both Canada and the United States poorer residents have worse health and so need more surgeries performed than more affluent residents do. It is therefore not surprising that in Canada poorer persons receive more surgical procedures than do affluent persons. In the United States, on the other hand, poorer residents receive *fewer* surgeries than do more affluent persons, even though poorer persons' needs are greater (P. Armstrong and H. Armstrong, 1998: 47).

Table 9.3 ***Consumers' Self-Reported Experiences with Health Care in the United States and Canada***

	United States (%)	Canada (%)
Not able to get needed medical care	12	8*
Postponed needed medical care	30	16*
Had serious problems paying medical bills	20	6*
Long waits to get appointments with specialists	20	34*

*$p < .05$

Source: Donelan et al. (1996).

Costs of Care

In addition to improving access while maintaining quality of care, the Canadian health care system has at least partially restrained health care costs. As of 2002, the United States spent $5,267 per capita, or 14.6 percent of its gross national product, on health care; Canada spent $2,931 per capita, or 9.6 percent of its national product, on health care (Organization for Economic Cooperation and Development, 2004).

How does the Canadian system restrain health care costs? Most important, a single-payer system dramatically reduces administrative overhead. In a single-payer, nonprofit system, no one need spend money on selling insurance, advertising insurance, or paying profits to stockholders. Nor is money spent on collecting funds to run the system, for those funds are collected from the public through already-existing taxation systems. Doctors, too, have fewer expenses because they need to submit bills to only one insurer using one standard form. Hospitals, meanwhile, need not spend money tracking or collecting bills for each patient, because they receive a lump budget for the year regardless of how many patients they treat or what services those patients receive. As a result, the Canadian insurance system spends only 1 percent of its budget on overhead, compared to the 20 to 23 percent spent by the largest MCOs in the United States (Himmelstein and Woolhandler, 2003).

According to the U.S. General Accounting Office,

> if the universal coverage and single-payer features of the Canadian system were applied in the United States, the savings in administrative costs alone would be more than enough to finance insurance coverage for the millions of Americans

> who are currently uninsured. [In addition,] there would be enough left over to permit a reduction, or possibly even the elimination, of co-payments and deductibles. (1991: 3)

The single-payer system also saves money by centralizing purchasing power. As the sole purchaser of drugs in Canada, the Canadian government has substantial leverage to negotiate with pharmaceutical companies regarding drug prices. As a result, Canadians pay an average of 38 percent less than Americans do for identical drugs (Himmelstein and Woolhandler, 1994: 138). Similarly, Canadian doctors, like fee-for-service doctors in the United States, can increase their incomes by increasing the number of services they perform. But as the sole payer, the Canadian government can control how much it will reimburse the doctors per service. Finally, the single-payer system restrains costs by enabling Canada to implement efficient regional planning and to avoid unnecessary duplication of expensive facilities and technologies.

The Canadian system is not, however, free of problems (P. Armstrong and H. Armstrong, 1998: 124–138). Payment of doctors on a fee-for-service basis makes it more difficult for Canada to control medical costs. When, for example, the provinces banned balance billing, doctors responded by increasing the number of services they performed (with the provinces responding by reducing the amount they reimbursed for each service). Similarly, the provinces have instituted **utilization review** boards to identify any doctors who perform medically unjustifiable tests and procedures, but have given these boards little authority to sanction doctors. Finally, as noted earlier, declining budgets have led to declining benefits across the country and have led Canadian hospitals, like U.S. hospitals, toward outpatient services and shorter patient stays, thus moving some costs from the health care system to family caregivers.

Concern about increasing costs, longer waits, and declining benefits, plus political pressure from political conservatives and corporations interested in profiting from health care provision, has resulted in the increasing incorporation of market forces into the Canadian health care system (P. Armstrong and H. Armstrong, 1998: 138–142). A major report published in 2002 by an influential Canadian Senate committee argued that an additional $5 billion is needed to improve Canadians' access to advanced medical technologies. The report argues that Canada must either raise taxes to cover these costs or allow the development of a parallel tier of health services accessible only to those who can pay out of pocket. It also recommended increasing market competition by having private, for-profit clinics compete to provide certain publicly funded services. This recommendation won support from a 2005 court decision in Quebec that upheld the right to privately purchase health insurance. Although support for the national health insurance system remains strong, that system nonetheless seems increasingly fragile.

Health Outcomes

Perhaps the most important question to ask about the Canadian health care system is how health outcomes compare with those found in the United States. The data suggest that outcomes are at least as good if not better in Canada. Canadians have lower infant and maternal mortality rates, live two years longer on average, and enjoy more years free of disability, even when ethnic differences are controlled (P. Armstrong and H. Armstrong, 1998: 79–80). Of course, these health outcomes tell us more about social conditions than about the quality of health care. Nevertheless, studies that have looked more directly at health care have reached similar conclusions. For example, a study that compared matched populations of elderly persons who received surgery in Manitoba and New England found that long-term survival rates were higher in Manitoba for nine of the ten studied surgical procedures (Roos et al., 1992). These data suggest that the Canadian health care system, although certainly not perfect, is superior to the U.S. system.

Great Britain: National Health Service

As the home of the Industrial Revolution, Britain for many decades was a leading industrial power. Along with its industrial strength came a strong labor movement, as workers united to gain political power within Britain's parliamentary government. As a result, a commitment to protecting its citizens, including a commitment to universal health care coverage, has long been a central part of Britain's identity. During the 1980s and into the 1990s, however, the nation's economy declined and conservatives took over the national government. Both these factors put Britain's health care system in jeopardy, although since 1997 a more liberal government has reinstated the nation's social and economic commitment to the national health care system. Currently, GNI per capita is $26,580, significantly lower than in the United States.

Structure of the Health Care System

Since 1911, Great Britain has provided low-income workers with subsidized care from general practitioners. Due to the sacrifices made by the British people during World War II, however, popular sentiment increasingly held that all Britons had earned the right to a decent quality of living, including access to health care. This sentiment, coupled with other social forces, resulted in the creation of the **National Health Service (NHS)** in 1946.

Whereas Canada provides its citizens with national health *insurance,* Great Britain provides a national health *service.* In Canada, the government provides insurance so individuals can purchase health care from private practitioners. In Great Britain, on the other hand, no individual need purchase health care or health insurance because the government directly pays virtually all health care costs. As a result, the two systems look quite similar

to health care consumers, but differ substantially from the perspective of hospitals, health care workers, and the government.

Purchasing Care

As in Canada, British citizens can obtain comprehensive health care unburdened by bills or bureaucratic forms. The NHS uses tax revenues to pay virtually all costs for a wide range of health care services, including medical, dental, and optical care. In turn, the NHS receives its funds almost solely through general taxation, with small supplements from employers and employees who make national insurance contributions. As in Canada, because the health care system is paid for through taxes it is financially progressive.

To obtain care through the NHS, individuals first must choose a general practitioner. As in Canada, individuals can choose any general practitioner in their area who is taking new patients. But after registering with a general practitioner, they can see only that doctor (or others in his or her practice). Individuals can, however, change their general practitioner at any time, although few choose to do so. Individuals can see specialists only if referred by their general practitioner. However, individuals are free to go to emergency rooms if they feel it is needed, whether or not they see their general practitioner first. In addition, large primary care group practices as well as local governments offer a wide range of public health services, including visiting nurses for the homebound, homemakers for chronically ill persons, and long-term care.

Paying Doctors

British doctors divide sharply into ambulatory care doctors (almost all of whom work in primary care) and hospital-based doctors (all of whom are specialists). Most British general practitioners work as private contractors, although a growing number are choosing salaried government work. Those who work in private practice are paid by **capitation,** receiving a set annual fee from the government for each patient in their practice regardless of how many times they see the patient or how many procedures they perform. In addition, general practitioners receive additional payments for low-income and elderly patients to compensate for the extra expenses of caring for such patients. Doctors also receive allowances to pay for office expenses and bonus payments if they meet targets set by the government for preventive services, such as immunizing more than a certain percentage of children in their practices. In addition, to encourage access to health care, the NHS offers financial supplements to doctors who practice in medically underserved areas.

When the NHS began, most British general practitioners worked in solo practice. Over time, NHS administrators became convinced that working in group practices improved quality of care while reducing costs by enabling

doctors to learn from each other and to share clerical and nursing staff. As a result, the NHS offered financial incentives to those who practiced in groups, and most general practitioners now work in groups of three or more.

To encourage doctors to enter primary care, the NHS increased capitation payments to general practitioners and added supplemental payments for house calls and other services offered by general practitioners. As a result, general practitioners now earn approximately the same incomes as specialists.

Unlike general practitioners, specialists almost always work as salaried employees of the NHS at hospitals or other health care facilities. All specialists, regardless of field, receive the same annually negotiated salary from the NHS. Specialists can, however, earn extra income through merit bonuses (usually given toward the end of a person's career) and through seeing private patients.

Income for all doctors remains far higher than for other occupations in Great Britain. Those incomes go farther than they would in the United States because municipal governments pay most costs of medical training, so British doctors enter practice virtually debt-free.

Paying Hospitals

The vast majority of hospitals in Britain, including mental hospitals, chronic disease facilities, and tuberculosis hospitals, belong to the government (although some of these include beds for private patients). Until recently, hospitals received their funds in an annual budget allocated by their regional health authority. To control costs and increase the role of market forces, the conservative government in the early 1990s encouraged hospitals to compete for patients. Specifically, hospitals were encouraged to bid against each other on contracts to cover hospital care for any patients from a given local Health Authority or general practice. To fund new hospital construction, the conservative government gave hospitals the authority to consolidate, sell land, or relocate to cheaper sites, as well as to solicit and use private funding. These policies continue under the current, more liberal government.

Access to Care

Under the NHS, individual financial difficulties no longer keep Britons from receiving necessary care. In addition, the NHS has reduced substantially the geographic inequities that for generations made medical care inaccessible to many rural dwellers, although serious deficits remain in access to care in inner-city areas.

Although Britons' access to primary care is excellent, their access to high-technology care is somewhat limited. Britain's economic decline during the last few decades has left few funds available for new hospital construction. In addition, during the 1980s and into the 1990s, conservative politicians successfully fought to keep health care funding levels significantly below that in other European countries, a problem that still continues. Consequently, although

the quality of health care offered in Britain remains high, both the quality of hospital facilities and the number of hospital beds fell. British citizens thus continue to receive fewer days of hospital care per capita than do citizens of almost any other country in Europe. At the same time, the government has restricted the purchase of advanced technologies. Nevertheless, although individuals sometimes experience long waits before receiving elective surgery, no one must wait for emergency care. And whereas in the United States, those with the best ability to pay receive surgery first, in Britain those who need it the most receive it first. As a result—and as reflected in recent election results—most Britons have little interest in developing a privatized, U.S.-style health care system and instead favor a return to a strong, well-funded NHS, committed to affordable, publicly sponsored health care. Reflecting these sentiments, the British government has committed to increasing funding to the levels of the best-funded European nations by 2007 (S. Stevens, 2004).

Controlling the Costs of Care

Even with these new increases, Great Britain will be spending (as a percentage of gross domestic product) about one-third less than the United States spends on health care (S. Stevens, 2004). Like Canada, Britain has made its health funds go farther than they otherwise would through national and regional planning, and through keeping salaries relatively low. Because the government owns a large proportion of health care facilities and employs a large proportion of health care personnel, it can base decisions about developing, expanding, and locating high-technology facilities on a rational assessment of how best to use available resources and can avoid the unnecessary proliferation of expensive facilities.

Great Britain also has restrained government health care expenditures by increasing the role of market forces and shifting costs and services from the NHS to the private sector (Lassey et al., 1997). During the 1980s, the then-ruling Conservative Party refused to grant salary increases to specialists to encourage them to develop private practices. As specialists increased their private practices, they had less time for NHS patients, who soon complained of having to wait longer for specialized care. (However, it remains unclear whether patients actually had to wait longer or whether general practitioners had begun putting patients on specialists' waiting lists sooner.) Due to these problems (whether perceived or real), a small number of Britons began buying health insurance so they could buy their way more quickly into a specialist's office.

Similarly, during the 1980s the Conservative Party increased the number of beds set aside for private patients in NHS-owned hospitals. During those same years, private corporations began building private hospitals in Britain. Although these hospitals contain only a small fraction of all beds in the country, they threatened to drain personnel from the NHS by offering higher salaries and better working conditions. Meanwhile, underfunding of

the NHS increased staffing pressures and waiting times at NHS hospitals, contributing to public dissatisfaction. Recent increases in funding for the NHS are expected to significantly alleviate these problems, even while political support for private hospitals continues. However, both public and private hospitals will now have to control costs under a system similar to the DRG system used in the United States (S. Stevens, 2004).

The major change in the NHS since the Labor Party took over is the change from primary care group practices to "Primary Care Trusts" (U.K. Department of Health, 2005). A Primary Care Trust is an integrated group of doctors, nurses, and other health workers involved in primary care in a given community. In theory, the development of these trusts promised a major shift of responsibility and authority from centralized control to local control. Whereas in 1997 primary care doctors controlled about 15 percent of NHS funding, by 2004 they controlled 75 percent. In exchange, the trusts are now responsible for deciding what services should be offered in their areas and how they should be structured. The goal of these changes is to move decision making closer to patients and communities and to provide better, more accessible, and more integrated patient care.

Health Outcomes

Despite the problems in the NHS, health outcomes have remained good. Infant mortality (5.3 per 1,000 live births) is lower than in the United States, and life expectancy is one year higher.

China: Good Health at Low Cost

Although many observers have proposed using the health care systems of Canada and Great Britain as models for a restructured U.S. health care system, few would seriously propose China as a viable model. China's culture differs greatly from that of the United States, and so its citizenry has very different values regarding what constitutes an acceptable health care system. In addition, China's GNI per capita of only $4,520 (Population Reference Bureau, 2004) severely limits its options, and the remaining communistic underpinnings of its economy make some health care options more feasible and some less feasible than in the United States. Nevertheless, China's story provides useful clues regarding how to provide good health to the citizenry of a poor country.

China's health care system reflects its unique history and situation (Lassey et al., 1997). When, after many years of civil war, the Communist Party in 1949 won control of mainland China, it found itself in charge of a vast, poverty-stricken, largely agricultural, and densely populated nation of about 1 billion persons. Most people lived in abject misery while a small few enjoyed great wealth. Malnutrition and famines occurred periodically, life

expectancies for both men and women were low, and infant and maternal mortality were shockingly high. In urban areas, only the elite typically could afford medical care, whereas in rural areas, where most of the population lived, Western medical care barely existed.

Structure of the Health Care System

In 1950, one year after winning control of mainland China, the Communist government announced four basic principles for the new nation's health care system. First, the primary goal of the health care system would be to improve the health of the masses rather than of the elite. Second, the health care system would emphasize prevention rather than cure. Third, to attain health for all, the country would rely heavily on mass campaigns. Fourth, the health care system would integrate Western medicine with traditional Chinese medicine.

These principles reflected both the political climate and the practical realities of the new People's Republic of China. The first goal—improving the health of the masses—stemmed directly from the communist political philosophy underpinning the revolution. The years of bloodshed were to be justified by a new system that would more equitably redistribute the nation's wealth and raise the living standards and health status of China's people. The second and third goals reflected unignorable facts about China's situation. Lacking both a developed technological base and an educated citizenry, China's greatest resource was the sheer labor power of its enormous population, which could be efficiently mobilized because of its now-centralized economy. Focusing on prevention through mass campaigns promised to deliver the quickest improvements in the nation's health. Finally, the decision to encourage both Western and traditional medicine similarly recognized the difficulties China would face in developing a Western health care system, as well as the benefits of including traditional medicine in any new system. By encouraging traditional as well as Western medicine, China could take advantage of its existing health care resources and gain the support of the peasantry, who remained skeptical of Western medicine. At the same time, incorporating traditional medicine into the new, modernized Chinese health care system offered a powerful statement to the world regarding the new nation's pride in its traditional culture. Simultaneously encouraging the growth of Western medicine, meanwhile, would help bring China into the scientific mainstream.

Given its large and poverty-stricken population and its lack of financial resources and medically trained personnel, China needed to adopt innovative strategies if it were to meet its goal of improving the health of the common people. Two of these strategies are the use of mass campaigns and the development of **physician extenders**—individuals (such as nurse practitioners and physician assistants in the United States) who can substitute for doctors in certain circumstances.

One of the more unusual aspects of China's health care policy has been its emphasis, especially in the early years of the People's Republic, on mass campaigns (Horn, 1969). For example, to combat syphilis, which was **endemic** in much of China when the Communists came to power, the government first closed all brothels, outlawed prostitution, and retrained former prostitutes for other work. Second, the government began the process of redistributing income and shifting to a socialist economy so that no young women would need to enter prostitution to survive. During the next decade, the government trained thousands of physician extenders to identify persons likely to have syphilis by asking ten simple questions, such as whether the person had ever had a genital sore. By so doing, the government made manageable the task of finding, in a population of 1 billion, the small percentage that needed to be tested and treated for syphilis.

To convince people to come to health centers for testing, these physician extenders posted notices in villages, performed educational plays in marketplaces, and gave talks around the country, explaining the importance of eradicating syphilis and attempting to reduce the stigma of seeking treatment for syphilis by defining the disease as a product of the corrupt former regime rather than a matter of individual guilt. Those identified as likely to have syphilis were tested and treated if needed. These methods—coupled with testing, among others, persons applying for marriage licenses, newly drafted soldiers, and entire populations in areas where syphilis was especially common—dramatically reduced the **prevalence** of syphilis in China.

Health Care Providers

The second innovative strategy for which China has won acclaim is its use of physician extenders. In urban areas, **street doctors** (sometimes known as **Red Cross health workers**) offer both primary care and basic emergency care, as well as health education, immunization, and assistance with birth control. Street doctors have little formal training and work in outpatient clinics under doctors' supervision.

In rural areas, **village doctors** (formerly known as **barefoot doctors**) play a similar role. Village doctors were first used in 1965 during China's Cultural Revolution, a political movement started by students and fostered by some members of the national government to uproot the last vestiges of the old class structure (as well as to eliminate political dissidents). Village doctors, it was hoped, would alleviate the continued lack of health care providers in rural areas as well as reduce the political power of urban medical doctors, who remained a reminder of the precommunist elites. Novice village doctors were selected for health care training by their fellow workers based on their aptitude for health work, personal qualities, and political "purity." Following about three months of training (supplemented yearly by continuing education), village doctors returned to their rural communes, where they divided their time between agricultural labor and health care. Since the end of the Cultural Revolution in 1976, the number

of village doctors has declined substantially. Training is now more rigorous, and individuals must pass an exam before entering practice, but they still receive relatively little supervision from better-trained health care workers.

Above village doctors in the Chinese health care hierarchy are **assistant doctors.** These individuals receive three years of postsecondary training similar to that received by medical doctors, during which they learn both Western and traditional Chinese medicine. Finally, at the top of the hierarchy are medical doctors. Individuals must complete a minimum of five to eight years of postsecondary training to become doctors, plus a supervised residency program to become specialists. All doctors receive training in both Western and traditional Chinese medicine and may focus on either field, although relatively few choose traditional medicine.

Purchasing Care

As China's economy has changed from a largely socialized and centrally controlled system toward a more decentralized, economically heterogeneous model, so has its health care system (Chen, 2001; Lassey et al., 1997). For the majority of urban residents, these shifts have brought few changes. As in the past, the government pays most costs of health insurance and health care for government employees, military personnel, and students. Public industries and urban industrial collectives also pay for care for their workers. The growing and now significant numbers of urban residents who work in private enterprises, however, often lack any health insurance.

For rural Chinese—about 78 percent of China's population—recent years have dramatically changed the nature of health care. Before the 1980s, rural residents received their care at little or no cost through the agricultural communes where they lived and worked. Within these communes, members shared all profits and costs, including those for health care. Each commune had between 15,000 and 50,000 members and offered its own clinic staffed by assistant doctors (also commune members) who provided both primary care and minor surgery. In addition, communes were divided into production teams of 250 to 800 people, each including a village doctor.

Beginning in the early 1980s, most agricultural communes reverted to their original non-communal village structures, with each family given land to farm by the village. Families now keep their profits, but are responsible for their own welfare should costs exceed profits. Due to this shift in financing, the former communes no longer earn sufficient revenues to continue providing health care. Many village doctors returned to full-time agricultural work, and most rural assistant doctors moved to township or city clinics. Almost all rural residents now receive their primary health care on a fee-for-service basis, and financial difficulties have forced some to cut back on needed care. In addition, waning government support for large-scale public health activities has allowed previously conquered diseases to reemerge. For example, schistosomiasis, a debilitating and sometimes

deadly disease once eradicated by mass campaigns to kill the snails that carry it, is again **endemic** in some rural areas (Yardley, 2005).

Paying Doctors

Currently, ambulatory care doctors in China work primarily on a fee-for-service basis and hospital doctors work on salary. In addition, many townships (made up of six or more rural villages) have a clinic where doctors work on salary. As in many HMOs in the United States, however, these doctors can divide among themselves any profits generated by the clinic and not needed for new equipment or facilities, thus encouraging market forces to play a role in controlling costs.

Paying Hospitals

Unlike primary care, hospital care has remained largely a public enterprise. Almost all hospitals receive their operating and capital budgets from federal or local governments. In recent years, however, budgets have been cut and great pressure has been placed on hospitals to generate income through selling services and starting other enterprises.

Access to Care

Because of the changes in China's health care system, prices for health care have risen and access has diminished, especially in rural areas, where fewer hospital beds and doctors are available per capita. Although primary care remains affordable, even for those who lack health insurance, hospital care is not. To equalize access to care, the government has established a national fund to supplement the health care budgets of poorer regions and an insurance program for childhood immunizations. Those who, for a small premium, purchase this insurance receive free immunization for children to age 7 and free treatment if a child develops one of the infectious diseases the immunization program is supposed to prevent. More than half of all children in the country belong to this program. Finally, a similar insurance program offers prenatal and postnatal care to women and infants; it is not known how many are covered by this program.

Health Outcomes

As a poor country, China spends only 5.8 percent of its GNP on health care, compared with the 14.6 percent spent by the United States (World Health Organization, 2005b). Nevertheless, China's commitment to equalizing both income and health care has allowed it to attain health outcomes far greater than its economic status or investment in health care might predict. Although median income in China remains similar to that in many other developing nations, China boasts health outcomes only slightly below those of the industrialized nations. Whereas in 1960 infant mortality was 150 deaths per 1,000 and life expectancy was 47 years, as of 2004 infant mortality is

32 per 1,000 and life expectancy is 71, only 6 years lower than in the United States (Population Reference Bureau, 2004). Although large and increasing differences in health status remain between rural and urban dwellers, China now stands on the cusp of the epidemiological transition, with chronic and degenerative diseases increasingly outpacing infectious diseases as the leading causes of death. (Lung cancer, especially, is a growing problem because the government relies on tobacco products as major sources of tax revenue and export dollars and so has invested almost no funds in smoking prevention efforts.)

Nevertheless, some regions of China continue to face health problems common in developing nations, such as insufficient access to clean drinking water. The rise of a market economy has contributed to these problems (Chen, 2001). The pressure to develop profitable industries has increased water and air pollution and decreased occupational safety, especially in rural areas. Similarly, pressures on the health care system to control costs and generate profits has led to a decreased emphasis on preventive care and increased emphasis on profit-generating treatments.

Despite these problems, China's great accomplishments in improving the health of its people deserve recognition. To find the key to China's successes, we need to look beyond the nature of its health care system. This topic has been investigated through a series of studies begun by the Rockefeller Foundation (Caldwell, 1993). These studies explored how China, along with Sri Lanka, Costa Rica, Vietnam, Cuba, and several other countries, has achieved substantially better health outcomes at lower cost than have countries that spend more and have higher per capita incomes. Three factors seemed to account for these outcomes. First, health outcomes in these countries improved somewhat when access to medical care improved. Second, and more important, health outcomes improved when nations encouraged education for men and emphasized family planning for both men and women. Finally, and as explained in Chapter 4 health outcomes improved most dramatically when nations made a commitment to educating women. Once women's educational levels increased, their status increased as well, and they gained greater power to control or delay reproduction. Women's lives thus were less often cut short by childbirth, and their babies were born healthier. A rise in women's status also brought a more equitable distribution of food between women and men, so that both women and the children who relied on them for food were less likely to suffer malnourishment and more likely to survive.

Mexico: Struggling to Provide Health Care Equitably

Understanding Mexico's health care system is particularly important for U.S. citizens because Mexico shares a long and permeable border with the United States. As a result, health issues in Mexico directly affect the United States, as people (and often diseases) travel across the border in both directions to seek

work or pleasure (Skolnick, 1995). In addition, both Mexicans *and* U.S. citizens sometimes cross the border to the other country to seek health care, although Mexicans more often seek basic medical care for life-threatening health conditions, whereas U.S. citizens more often seek inexpensive cosmetic surgery, dental work, or pharmaceutical products.

Mexico stands on the cusp between being an industrialized and a developing nation. As Mexican industry has developed, many have moved off the land, and now more than three-quarters of Mexico's population live in cities. Those cities contain both middle-class neighborhoods, which enjoy health and living conditions similar to those found in the industrialized nations, and impoverished slums that lack such basic facilities as running water and sewer systems. These slums are inhabited primarily by migrants from rural areas. Rural areas, especially those inhabited primarily by Indians, generally are poor, with only 37 percent having sewer systems (Pan American Health Organization, 2005). Mean GNI per capita remains only $8,800—far higher than in China, but far lower than in any of the other nations discussed in this chapter (Population Reference Bureau, 2004).

Structure of the Health Care System

Unlike any of the other countries described in this chapter, Mexico has a three-tiered system for health care: private health care for the wealthy, high quality government-provided insurance for the middle third of the population, and lower-quality government-provided services for the poor (Durán-Arenas et al., 2002; Lassey et al., 1997). This three-tiered system is a product of Mexico's unique history, in which revolutionary fervor and conservative sentiments have always counterbalanced each other and in which the social and economic division between Indians (who now make up less than 10 percent of the population) and others (who are primarily a mix of Spanish and Indian) has remained important.

Over the centuries, Mexico has experienced several revolutions—some violent and some at the ballot box. Throughout the twentieth century, these revolutions resulted in gradual improvements in the health care available to Mexico's citizens. In 1917, Mexico's new constitution first gave the federal government responsibility for health care. Simultaneously, many large estates were taken out of private control and divided into small cooperatives owned by the local peasantry. These rural cooperatives subsequently received funding from the federal government to establish local clinics, typically run by minimally trained health aides. Staffing improved during the 1930s when, responding to the revolutionary spirit of the times, the federal government established a continuing program under which all new physicians must work for one year in a rural community.

The next major change in the health care system occurred in 1942, when the government established the Social Security program and opened a network of modern health clinics and hospitals around the country. However, only

salaried workers employed by private industries in Mexico's cities were eligible for Social Security and allowed to use these facilities. Since then, the system has expanded to include government employees and salaried agricultural workers, covering about half of the population by 2001 (Durán, 2002). In addition, other individuals now purchase Social Security insurance—some using their own funds and others under an experimental governmental program that subsidizes these costs for the poor.

Social Security provides a comprehensive package of ambulatory and inpatient benefits. However, some Mexicans receive considerably more and better quality benefits than others do because benefits are allocated through several separate Social Security organizations with separate clientele and budgets. For example, the Social Security organization responsible for the health care of workers in the oil industry spends twice as much per capita as does the organization responsible for the health of workers in the private sector.

Mexicans who are not eligible for health care under Social Security receive a less comprehensive package of coverage through the Ministry of Health. The ministry has expanded access to health care steadily, building clinics and hospitals in both rural and urban areas. In general, however, these facilities are inferior to facilities run by Social Security. On the other hand, the ministry also runs some of the country's best specialized hospitals, used by private patients as well as by ministry patients. In addition, the ministry and other governmental agencies have funded widespread improvements in living conditions—food subsidies, new school construction, fluoridation of water, home improvements, and sanitary water systems—which have improved the health of the population. Between Social Security and the Ministry of Health, 99.5 percent of Mexicans now have regular access to modern health care.

Despite this coverage, affluent Mexicans sometimes choose to purchase private insurance or care from private doctors on a fee-for-service basis. Although most Mexican doctors work as salaried government employees, most also take private, fee-for-service patients on a part-time basis and some work solely for private patients. Because the government does not regulate the private purchase of medicine, little is known about this sector of the health care system.

Purchasing Care

Individuals who purchase health care in the private sector have, of course, a wide choice of doctors and hospitals. Other Mexicans, however, must use the doctor or the clinic to which they are assigned for primary care (although in theory they have some choice). Copayments vary by source and type of service, but range from nominal to nonexistent.

To obtain specialty care, patients must first get referrals from their primary care doctors. Such referrals can be difficult to get, however, because of government cost controls that restrict the number of practicing specialists. For the same reason, patients who do get referrals typically have long waits

before they can get appointments with specialists. As a result, many patients subvert the system by instead seeking specialty care at emergency clinics or from private doctors, if they can afford to do so.

Mexicans' access to technologically intensive care remains limited. In addition, these services are haphazardly distributed, with more services available in cities compared with rural areas and in northern regions of the country compared with the south. Consequently, some hospitals and clinics are underutilized whereas others are overburdened.

Health Outcomes

Although Mexico remains rife with social and economic inequities and resulting inequities in health, it has nevertheless achieved notable improvements in health outcomes for much of its population. Consequently, by some measures Mexico appears to have completed the epidemiological transition—cancer and heart disease now kill more Mexicans than do infectious diseases, and life expectancy is 75 (Population Reference Bureau, 2004). On the other hand, the infant mortality rate remains high (25 per 1,000 live births). In addition, poor rural Mexicans still experience health conditions characteristic of developing nations, and rates of some infectious diseases, such as malaria and tuberculosis, are rising. Nevertheless, preventive health campaigns have improved health throughout the nation: A massive vaccination program eradicated polio in 1991, and, as of 2004, 95 percent of children receive all recommended vaccinations by age 1 (Pan American Health Organization, 2005).

These health outcomes have been achieved at relatively little cost. As of 2000, Mexico spent 6.1 percent of its gross domestic product (GDP)—compared with the 14.6 percent spent by the United States—on health care (World Health Organization, 2005b).

Reforming Health Care in the United States

According to the World Health Organization (2000b), the United States spends a higher percentage of its gross domestic product on health care than do any of the other 191 member countries, but it ranks only thirty-seventh in performance in 2000 (the latest data available). Clearly, this system needs reform.

As Box 9.2 describes, Physicians for a National Health Program (along with numerous other organizations and individuals) continue to fight for a single-payer system. Even if they don't succeed, their efforts add to the political pressures that may eventually result in the incremental reform that most observers believe is more likely.

Since the defeat of President Clinton's 1993 attempt to overhaul the health care system, numerous proposals have been presented at the state and federal level to incrementally expand health insurance coverage. These proposals have

Box 9.2 *Making a Difference: Physicians for a National Health Program*

Physicians for a National Health Program (PNHP) has been at the forefront of the U.S. movement for universal health care coverage under a single-payer plan. More than 10,000 doctors, medical students, and other health care providers have joined the nonpartisan, nonprofit organization since it started in 1987.

To the members of PNHP, the corporate control of our current health care system makes it impossible to carry out what they consider the primary mission of physicians: to act as advocates for their patients, providing the best care they can. A national health care system, they argue, run on a nonprofit basis and funded by tax dollars, would allow physicians to provide high-quality care to all patients, rather than forcing physicians to make decisions about who they treat and how based on what will best protect their profits or their corporate employers' profits.

The core mission of PNHP is to educate health care workers and the general public about the need for universal health care as well as the need for a single-payer system to make such care economically feasible. Because the core of its leadership is comprised of respected, nationally prominent physicians, PNHP brings considerable credibility to its arguments, which it presents often in town hall meetings, debates, conferences, medical journal articles, popular books, newspapers articles and editorials, and television and radio presentations across the nation. The PNHP website (www.pnhc.org) provides access to a speakers bureau as well as to a wealth of material on the need for a single-payer system, including press releases, articles, and PowerPoint presentations. Members engage in such activities as writing letters to newspapers and medical specialty journals, giving or arranging for lectures on health care reform at pizza parties for medical students or local medical society meetings, and lobbying legislators regarding proposed health care legislation. Through all these activities, PNHP members encourage both their fellow health care workers and other Americans to think deeply about the underlying ethical, medical, and economic issues involved in health care.

generally taken two forms: expanding eligibility for already-existing government-run health insurance programs or combining tax incentives with other options and regulations to make commercial insurance more affordable.

Those who favor expanding government programs have proposed, for example, extending Medicaid to children who are near-poor or to disabled persons with middle-class incomes. Such proposals have the benefit of taking advantage of existing structures rather than requiring new bureaucracies, but run the risk of straining already overburdened programs.

Those who favor making commercial insurance more affordable have proposed such tactics as providing tax credits or tax deductions to individuals to subsidize the cost of insurance or requiring all employers to provide health insurance, coupled with developing statewide insurance purchasing pools that would provide affordable insurance for small firms. These proposals present a different set of problems. With tax credits, individuals can reduce their federal taxes by the amount they have spent on health insurance,

up to a set limit. All the proposals so far, however, have set limits so low that they would cover only a small portion of the cost of health insurance. As a result, these proposals seem more likely to benefit those who already have health insurance than those who currently find insurance unaffordable. Proposals offering tax deductions, which allow individuals to deduct part of the cost of health insurance from their income before calculating their federal taxes, offer even less benefit, especially to poorer persons who are in low tax brackets anyway. Moreover, the existence of tax credits or tax deductions might make it easier for employers to justify not offering health insurance to workers, thus increasing the number of uninsured Americans. Proposals to require employers to provide insurance, on the other hand, will do nothing to reduce the administrative inefficiencies built into our current system with its hundreds of insurance providers. And in either event, if more people do start purchasing private health insurance, insurance companies would likely respond to this increased demand by raising prices.

Incremental change in the health care system could also come about through state-level reforms. During the last decade, the federal government has supported innovation at the state level, allowing states to develop their own programs to serve persons eligible for Medicaid and Medicare. Some of these programs could eventually serve as models for the nation as a whole.

Hawaii's program has generated especially great interest. In 1974, Hawaii's legislators passed the Prepaid Health Care Act, which required employers to pay at least 50 percent of the cost of health insurance for all full-time employees (Neubauer, 1997). Small businesses that cannot afford to pay their share of premiums can draw subsidies from a special fund established under the act, although very few have done so. Because of Hawaii's booming economy and the resulting competition for workers, most employers voluntarily insure employees' families as well as their employees and pay more than their required 50 percent of the costs.

As in other states, elderly persons and very poor persons receive their health insurance from Medicaid or Medicare. To provide insurance coverage for the "gap group" of unemployed persons and part-time workers who earn too much to receive Medicaid but too little to purchase insurance on their own, Hawaii in 1989 established a state health insurance program (SHIP), which purchases insurance from HMOs for these individuals. By closing the insurance gap, Hawaii secured health insurance for 90.5 percent of its residents (R. Mills, 2002). Because such a high proportion of the state's population is insured, insurers can use community ratings rather than risk ratings—keeping rates affordable for all purchasers—and still remain financially viable.

In addition to ensuring a high level of coverage, the new system enabled Hawaii to achieve unusual success in restraining health care costs. In part, this success resulted from the unintended development of monopolistic, nonprofit insurance plans. About 70 percent of Hawaiians receive their insurance from one of two nonprofit insurers: the Hawaii Medical Service

Association (a **Blue Cross/Blue Shield** plan) and Kaiser Permanente (an HMO that still uses a salaried staff). Because they control such a large share of the market, these two insurers exert considerable control over medical costs. Doctors who refuse to accept their reimbursement schedules or salaries can attempt to seek patients elsewhere, but will find few patients who do not belong to these plans.

More important, Hawaii restrained costs through reducing hospital use and costs. Neither of the major insurers charges deductibles, so individuals have less incentive to put off needed care. As a result, health problems more often are caught at early stages, when treatment is relatively inexpensive. In addition, and unlike most U.S. insurers, both of these insurers pay only for stays in hospital wards, not in semiprivate rooms. Finally, Hawaii has implemented a strict system for prospectively reviewing any hospital capital expenses. Hospitals cannot purchase major equipment or construct new facilities unless they can demonstrate need for those services. Therefore, consumers need not pay the costs of maintaining unused hospital beds or duplicative technologies.

Conversely, the continued existence of Medicare and Medicaid has hampered Hawaii's ability to restrain health care costs. Because these plans do not reimburse hospitals at rates high enough to cover the actual costs of providing care, hospitals have shifted costs to patients with private health insurance. At the same time, Medicaid's and Medicare's low reimbursement schedules have produced problems in access to health care because many doctors will not accept patients who belong to these plans. To control costs, and to equalize the benefits available under SHIP and Medicaid, Hawaii in 1994 merged Medicaid into SHIP (now renamed "QUEST"). Nevertheless, costs have continued to climb (although not as steeply as in other states), largely because of nationwide economic shifts resulting in a larger pool of part-time workers who fall into the gap group. These cost increases have forced Hawaii to reduce the benefits available through its insurance program.

In sum, the Hawaii experiment demonstrates both the advantages of moving toward a single-payer, nonprofit system with strong centralized control and the problems when multiple payers—in this case, public and private insurers—continue to function in the same economic sphere. It also demonstrates the benefits available from a reasonably unified managed care system, and the difficulties of sustaining a strong system in the face of external economic pressures.

Whether a Hawaii-type program or any other program for reforming health care is adopted will likely depend on **stakeholder mobilization,** and especially on whether powerful stakeholders line up in favor of change. At this point, the most important indicator that change might come is the growing support for health care reform among major corporations, which have come to view reform as essential to controlling their costs; in a recent survey, 96 percent of corporate executives identified

health care costs as a significant or critical concern (National Coalition on Health Care, 2005: 6).

As the National Coalition on Health Care (2005: 6), a nonprofit alliance that includes corporations as well as labor, consumer, and medical groups, explains:

> The escalation of health care costs is not only a health care issue; it is also a major national economic problem. As these costs rise, they eat into corporate margins, reducing the capacity of firms across the economy to grow their businesses by investing in research, new plants and equipment, and product development. Health care cost increases slow the rate of job growth by making it more expensive for firms to add new workers. . . . And double-digit premium increases—on top of what are already the highest per-worker health care costs in the world—put American firms at a steep and growing disadvantage in global markets, where they must compete against companies with much lower health care costs.

Conclusion

A critical approach to health care reform suggests that for meaningful reform to occur in the U.S. health care system, we must be willing to challenge the power dynamics underlying the current system. Once we do so, the way becomes clearer for us to learn from the experiences of countries that have reformed their health care systems. Canada's history, for example, suggests that eliminating private insurers—major power holders in the current system—can reduce costs substantially by eliminating the costs of selling, advertising, and administering the various insurance plans. Eliminating private insurers also eliminates the costs that accrue when doctors, hospitals, and other health care providers must track and submit bills for each client to each insurance company. Similarly, moving hospitals and other health care centers from private to public control, as Britain has done, and placing them under a single national authority (probably with some decision making reserved for local authorities) would give the government control over both operating and capital budgets for these facilities. As a result, centralizing control of health facilities would allow the government to restrict the duplication of services and proliferation of technologies that have driven up the costs of the existing system. By the same token, establishing a national fee schedule for service providers, such as Canada uses, would enable the government to restrict the rise of those fees. Even more control is possible if the government, like Britain's, restricts doctors to salaried practices so that doctors cannot increase their incomes by increasing the number of procedures they perform. At the same time, mandating national health coverage would guarantee a large enough risk pool to make community rates feasible and affordable while eliminating the possibility of a **rate spiral.** Finally, using income taxes to pay for health care would more equitably distribute the costs of financing the system.

Of course, any proposals incorporating a critical approach would meet major opposition from those who benefit from the current system. Such a proposal, however, would be worth fighting for.

Suggested Readings

Twaddle, Andrew C. 2002. *Health Care Reform Around the World.* Westport, CT: Auburn House. An excellent overview of fifteen health care systems, covering industrialized nations, developing nations, and formerly Communist nations.

Getting Involved

Physicians for a National Health Program. 332 South Michigan Avenue, Suite 500, Chicago, IL 60604. (312) 782–6006. www.pnhp.org. Organization of U.S. physicians for a Canadian-style health care system.

Review Questions

Define the eight measures of health care systems and explain why each is important.

What is the convergence hypothesis? What evidence of convergence can be found in the histories of health care in Great Britain and China?

How are doctors and hospitals paid in Canada? in Great Britain?

What is the difference between national health insurance and a national health service?

How does access to primary and hospital care in Canada compare with access to care in the United States?

What aspects of the health care systems in Canada and Great Britain have helped them to restrain costs? What aspects have kept costs high?

How has the rise of market forces affected health care in Great Britain?

What aspects of its health care system have enabled China to provide good health at low cost to its people?

In what ways is health care in Mexico a two-class system?

Internet Exercises

1. Choose a country you are interested in. Then use the Internet to see what you can find out about its health care system, looking for information comparable with that presented for other countries in this chapter.

2. Using the website for Health Hippo, an online archive of health law materials, find information on a current health policy issue of interest to you. What are some of the current proposals on this issue, and what are some of the arguments that have been offered for or against those proposals?