

## HOW SHOULD WE PROVIDE HEALTH CARE?

Bioethics: Course Notes | Brendan Shea, PhD ([Brendan.Shea@rctc.edu](mailto:Brendan.Shea@rctc.edu))

Rich countries have developed a number of different health care models<sup>1</sup>. Here is a brief overview (I have taken the names from TR Reid's *The Healing of America* <sup>2</sup>).

**The Beveridge Model.** In this system, the government uses tax revenues to build and maintain health facilities (such as hospitals or clinics), and to pay the salaries of the medical staff. There may also be (some) private hospitals and non-government health care workers. Health care is treated in much the same way as the US treats defense, policing, or fire-fighting. This system is named after William Beveridge, who helped found the United Kingdom's National Health Service (NHS). Other "rich" countries (with a per capita GDP comparable to that of the US) that use this system include Spain, Denmark, Norway, New Zealand, and Sweden. This system allows the government considerable control over the prices of drugs and treatments (after all, it purchases nearly all of them!).

**The Bismark Model.** In this system, every citizen is required to contribute to non-profit insurance companies (or "sickness funds"), which are used to pay for services at privately owned health care facilities. The government maintains strict control over the prices of drugs and medical treatments. This system originated in Germany (Otto van Bismark helped create the modern German state, and helped start this policy), and is also used in France, Japan, and the Netherlands.

**Switzerland** has adopted a modified version of the Bismark system that requires (for-profit) insurance companies to provide universal access to *basic* plans at cost (they can't make a profit on these plans), but which allows them to sell (and profit from) more comprehensive plans. Obamacare is (partially) modeled after the Swiss model, except that it allows insurers to make (some) profit off of basic health care plans. The US and Switzerland are similar in that they (1) have low tax rates and (2) have very strong insurance sectors (both of which make adopting other models politically difficult). However, they also (3) have among the highest costs of health care (considering both private and public spending).

**The National Health Insurance Model (NHI).** In this system, all citizens are required to pay into government-provided, non-profit health insurance. This is then used to pay private health providers. This system is used in Canada, Australia, South Korea, and Taiwan. Because the government-run insurance program is the largest purchaser of drugs and treatments, they have considerable control over prices. (This is the primary reason why drugs are often cheaper in Canada than in the US).

**Singapore** has a somewhat unique model of *Medisave* (a mandatory health care saving account for "ordinary" health costs), *Medishield* (a mandatory government insurance plan for catastrophic costs), and *Medifund* (government support for the poor who have exhausted their Medisave/Medishield accounts). Singapore has strict government regulations on different "levels" of care (with citizens choosing between fancy "A" level hospitals or bare bones "C" level hospitals; Medifund will only pay for C-level care). Singapore is often mentioned by reformers because it seems to get decent results despite spending *very* little on health care (less than \$3,000 per capita). However, Singapore is also quite a bit different from nearly any other rich nation: it has a small population (of around 5 mil, with a large proportion of recent immigrants from other rich countries) all confined to one small island, and it is governed by a significantly less democratic government. It is unclear whether this system could be implemented in other rich countries, such as the U.S.

**The Out-of-Pocket Model (OOP).** This system requires that most health care costs be paid for by individuals using private funds. This was the norm in the developed world until the early- to mid-20<sup>th</sup> century, when nearly all rich countries went to one of the models listed above (the US is a partial exception—see below). It is still widely used in the poorest parts of the world, including much of sub-Saharan Africa and parts of the Indian subcontinent. It is also used in poor, rural areas of middle-income countries, where government health care and/or insurance has traditionally been difficult for residents to access. In recent years, many middle-income countries—especially China, where health coverage for rural residents has quadrupled since the early 2000s—have made substantial improvements.

**The US (Mixed) Model.** The US has a unique "mixed" model of health care.

- **Veterans Administration.** Health care for many veterans and their families is provided by the Veterans Administration, which is a Beveridge-style system (the staff are US government employees, and the government owns the facilities).
- **Employers/Government.** People who have full-time jobs for mid- or large-sized companies are given coverage by the Bismark system (joint employer-employee contributions, which are subsidized by government tax benefits if the health care plans chosen meet certain minimal requirements).
- **Medicare/Medicaid.** People over 65 and people with low-income are covered by a National Health Insurance system (Medicare and Medicaid); however, the government is not allowed to bargain over drug prices (Americans generally pay 1.5 to 3 times as much for drugs as citizens of other rich countries).

<sup>1</sup> Commonwealth Fund, "Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care," accessed June 4, 2019, <http://www.commonwealthfund.org/interactives/2017/july/mirror-mirror/>.

<sup>2</sup> T. R. Reid, *The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care* (Penguin, 2010).

- **Uninsured/Underinsured.** The out-of-pocket model is used by part-time or self-employed workers who do NOT qualify for Medicare or Medicaid. The Affordable Care Act (“Obamacare”) has helped to reduce this somewhat, by creating a system of “exchanges,” though recent changes to the healthcare law (in 2017) may increase this number again.

In the U.S., people in the first three categories are generally HAPPY with their own healthcare (which explains why reform is hard). However, people in the last group are NOT happy, and many studies have found that Americans have considerable anxiety regarding the health care system as a whole (often because they are worried they might lose the coverage they have, they dislike the high costs, etc.).

#### WHICH SYSTEM IS CHEAPEST? WHICH GETS THE BEST RESULTS?

A number of large studies have suggested that the US SPENDS MORE per person on health care (including taxes, health insurance, and out of pocket costs) than do other industrial countries and gets WORSE RESULTS. So, for example, here are some recent statistics on health care spending in rich countries taken from the OECD or the World Bank (2019 or most recent available). US citizens also get less face-time with doctors, are discharged from hospitals earlier, and have higher long-term disability rates and pre-term birth rates. Obamacare seems to have helped a bit with cost (in recent years, global healthcare costs continue to increase, but the *\*rate\** of increase has fallen), but given the changes over the past few years, it is difficult to project what exactly will happen.

Country	\$/person	Physicians per 1,000	Hospital beds per 1,000	MRI exams per 1 mil	Life expectancy	Infant mortality per 1,000	Overall Tax Rate	Bloomberg Health Ranking*
Italy	\$3649	4.0	3.2	28.2	84	2.8	High	2
New Zealand	\$3820	3.0	2.7	13.9	83.9	5.7	Avg	18
Finland	\$4578	3.2	4.0	25.5	82.5	1.9	High	14
UK	\$4653	2.8	2.6	7.2	81.2	3.8	Avg	19
Australia	\$5187	3.6	3.8	14.3	84	3.1	Low	7
Japan	\$4823	2.4	13.1	51.7	85	2.0	Low	4
Canada	\$5155	2.6	2.6	9.5	83.0	4.7	Low-Avg	16
France	\$5376	3.1	6.1	13.5	83.1	3.7	High	12
Denmark	\$5568	3.7	2.6	...	80.9	3.1	High	25
Sweden	\$5782	4.3	2.3	15.7	83.3	2.5	High	6
Germany	\$6646	4.2	8.1	34.5	81.2	3.4	High-Avg	23
Netherlands	\$5765	3.5	3.6	12.8	82.8	3.5	High	15
Norway	\$6647	4.5	3.7	..	82.9	2.2	High-Avg	9
Switzerland	\$7732	4.3	4.6	22.3	84.3	3.6	Low	5
US	\$11,072	2.6	2.8	36.7	79.1	5.9	Low	35

\*The Bloomberg Global Health Index is “calculated taking into account variables such as life expectancy, causes of death, incidence of high blood pressure, high blood glucose, tobacco use, and physical inactivity. Other parameters taken into account are childhood malnutrition, mental health, vaccination coverage, greenhouse gas emissions.” The U.S. ranking is brought down by our overweight/obesity rates, among other things.

As you can see, the U.S. has the highest total cost (per person) and the worst life expectancy (and we’re actually getting worse here, especially after COVID) and infant mortality rates (we’re improving here!). We also have smaller than average numbers of physicians and hospital beds. (Canada and the UK also have low numbers of physicians, which suggests there may be a physician shortage in English-speaking countries, perhaps as a result of the way we set up things like medical education, or the availability of other high-paying careers in law/software engineering.) However, we have very high rates of use of advanced technologies (such as MRI scans and CT scans). The US is the only rich country on the chart that has any *significant* number of uninsured or underinsured people. Weirdly enough, the US government currently spends more *taxpayer* money on health care per capita than do countries like the UK or Canada. In Commonwealth Fund Surveys (2016), the US had *many* more citizens (23%, vs. an average of around 5%) say the health system needed to be “completely rebuilt” than any other country.

#### WHAT MAKES HEALTH CARE IN THE US EXPENSIVE? WHY DO WE GET SUCH POOR RESULTS?

**Different Populations.** The US has more overweight and obese people than do most other rich countries. We also have higher rates of car accidents, illegal drug use, homicide, and suicide. However, we have less smokers, consume less alcohol, and are generally younger. In

addition, the US has higher rates of income inequality (more extremely poor and extremely rich) and lower rates of lifetime social mobility (it's much tougher in the US to "work your way to the top"). These all affect things like life expectancy and infant mortality.

**Different Use of Health Care Resources.** Healthcare providers in the US spend a huge amount of money on complex conditions, such as treating solid-tumor cancers (breast, prostate, and lung), and it shows—the US does better than average in five-year survival rates for nearly all of these cancers. However, these improvements in treatment are very expensive (they involve more MRIs, CT scans, oncologists, surgeons, chemotherapy drugs, white-cell boosting drugs, and so on), and save relatively few years of life. We also have many of the world's top *specialty* hospitals (just in the Midwest, we have Mayo, Cleveland Clinic, and Northwestern Memorial), and Americans generally have shorter waiting times for elective surgeries. By contrast, many other countries focus resources on primary, preventive, and follow-up care, which offer better "returns on investment." However, it is unlikely that these factors (considered by themselves) can account for the large differences in cost, since many countries (e.g., Germany, Japan, and Switzerland) also have comparable number of specialists and uses of high tech equipment, and comparable waiting times to the US.

**Administrative Costs.** In other rich nations, insurance plans/governments are required to provide coverage for all citizens (and in return, citizens are not allowed to "opt out" of paying for coverage). In the US, insurance companies have historically been allowed to reject people (or charge them different costs) based on things such as age or "pre-existing" conditions. Because of this, US insurance companies spend lots of time and money trying to figure out who to cover (and which claims to deny). Insurance plans in other countries (and Medicare/Medicaid/VA in the US) spend around 1 to 3% of their revenue on administration and billing; while US insurance companies, clinics, and hospitals in the US have historically spent 10 to 20%. The Obamacare "individual mandate" (and the requirement that insurers cover everyone) was projected to address some of these problems (at least for insurance companies). However, this mandate was effectively repealed in 2017, and it's unclear how this will affect costs in the long run.

**Profits.** Certain industries make a lot of money off the current system. The biggest gainers have probably been the multi-national drug and medical technology companies, and the associated pharmacy benefit managers (who have huge profit margins, often above 15%), and private insurance companies (who have smaller profit margins, often below 5%). Physicians (and especially specialists) also earn more in the US than in other rich countries (even after we take into account their more expensive medical schools, longer hours worked, and higher cost of malpractice insurance). Many US providers use a "pay per service" model in which providers are compensated for each procedure they perform, and this may encourage them to give patients expensive and unnecessary (and possibly even harmful) treatments. The Mayo Clinic, among others, has rejected this model (and instead pays staff fixed salaries). Obamacare addresses *some* of these issues (e.g., by mandating insurers spend 85% of their money on patient care, and by changing Medicare payment systems). Other countries avoid this problem by giving the government more power over the rates charged for medical care, which results in lower drug costs, medical equipment costs, and salaries (Japan is especially famous for this).

**Costs Due to "Free Riders."** People without health insurance (or who are underinsured) pass on considerable costs to tax payers, insurance companies, and health care providers. In particular, because they are often unable or unwilling to pay for primary or preventive care, they will let preventable conditions become very bad. They will then show up to the emergency room for (very expensive) treatment that will be paid for by the government and/or hospital (after it bankrupts the patient). This does not occur in other countries, since everyone is covered. Fixing this issue was one purpose of Obamacare's **individual mandate**, which requires that most people carry some sort of health insurance, or pay a fine. Again, with the elimination of this mandate in 2017, this will again become a problem (since people will once again have an incentive to forgo having health insurance until they "need" it).

## REVIEW QUESTIONS

1. Describe (in general terms, and in your own words) how the following health care systems differ from the U.S. model.
  - a. National Health Insurance (e.g. Canada)
  - b. Beveridge (e.g. Britain)
  - c. Bismark (Germany, France, Japan or Switzerland.)
2. How does the U.S. compare to other countries in terms of cost? In terms of effectiveness? What are some possible explanations for this?
3. If you had complete freedom to reform the health care system (and didn't need to worry about "politics"), what sort of system would you choose to adopt? Why? Defend your answer using some of the principles we've been studying in class (especially justice and beneficence).