The U.S. Health Care System: Best in the World, or Just the Most Expensive?

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."
— Martin Luther King, Jr.

Introduction

For many years, politicians and insurance companies could blithely proclaim that the U.S. had the best health care system in the world, but as its major shortcomings become more visible, Americans are finding it harder to accept this assertion. The 42.6 million people in the U.S. currently without health insurance are acutely aware that our health care system is not working for everyone, and there is growing recognition that the major problems of rising costs and lack of access constitute a real crisis. However, the search for solutions has not been easy or clear cut. Policymakers often attempt to address the symptoms of our health care crisis through short-term, patchwork solutions, under the pressure of time and the constraints of political decision-making, rather than analyzing the system itself as a whole. One important step in searching for effective longer-term solutions is to ask a deceptively simple two-fold question: how can we know whether a health care system is both "good" – that is, how well it does its job – and fair, in terms of financing health costs? If we can then analyze how well our health system performs, in comparison to other countries in the world, we will have a basis from which to explore possible alternatives.

Characteristics of a Good and Fair Health Care System

A number of recent studies have compared the health systems of various countries. Using information and concepts from these studies, it is possible to evaluate the health care system of the U.S. and other countries, with respect to such fundamental issues as cost, access to health care, and how well the health system succeeds in producing good health outcomes in a population.

The World Health Organization (WHO) released a groundbreaking report in 2000, with data on the health systems of 191 member countries.[1] In this analysis, WHO developed three primary goals for what a good health system should do: 1) good health: "making the health status of the entire population as good as possible" across the whole life cycle, 2) responsiveness: responding to people's expectations of respectful treatment and client orientation by health care providers, and 3) fairness in financing: ensuring financial protection for everyone, with costs distributed according to one's ability to pay. [2] The WHO study also distinguished between the overall "goodness" of health care systems ("the best attainable average level") and fairness ("the smallest feasible differences among individuals and groups"). A health system which is both good and fair would thus ideally have:

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[1] World Health Organization, *The World Health Report 2000 – Health Systems: Improving Performance* (Geneva: WHO, 2000).

[2] *Ibid*., p. 27-35. Data from this study are also analyzed in Gerard Anderson and Peter Sotir Hussey, "Comparing Health System Performance in OECD Countries". *Health Affairs*; Vol. 20: No. 3 (May/June 2001); pp. 219-232.

1) overall good health (e.g., low infant mortality rates and high disability-adjusted life expectancy);
2) a fair distribution of good health (e.g., low infant mortality and long life expectancy evenly distributed across population groups);
3) a high level of overall responsiveness;
4) a fair distribution of responsiveness across population groups; and
5) a fair distribution of financing health care (whether the burden of health costs is fairly distributed, based on ability to pay, so that everyone is equally protected from the financial risks of illness).[3]

Other major sources of international health system data include the OECD (Organization for Economic Cooperation and Development) data on its 29 member countries,[4] the U.S. Census Bureau, and other international studies, including two studies comparing patient satisfaction in various countries.[5] By using these health system data, we can compare the U.S. with a number of other roughly comparable, high-income OECD countries (e.g., relatively developed or industrialized).

Here are some basic facts that stand out in doing such international comparisons:

1) COST: **The United States has by far the most expensive health care system in the world**, based on health expenditures per capita (per person), and on total expenditures as a percentage of gross domestic product (GDP). As shown in Figure One and Table One, the United States spent $4,178 per capita on health care in 1998, more than twice the OECD median of $1,783, and far more than its closest competitor, Switzerland ($2,794).[6] U.S. health spending as a percentage of GDP, 13.6 percent in 1998, also outdistanced the next most expensive health systems, in Germany (10.6 percent) and Switzerland (10.4 percent).

The reasons for the especially high cost of health care in the U.S. can be attributed to a number of factors, ranging from the rising costs of medical technology and prescription drugs to the high administrative costs resulting from the complex multiple payer system in the U.S. For example, it has been estimated that between 19.3 and 24.1 percent of the total dollars spent on health care in the U.S. is spent simply on administrative costs.[7] The growing shift from non-profit to for-profit health care providers, such as the growth of for-profit hospital chains, has also contributed to the increased costs of health care. By 1994, research showed that administrative costs among for-profit hospitals had increased to 34.0 percent, compared to 24.5 percent for private non-profit hospitals, and 22.9 percent for public hospitals.[8]

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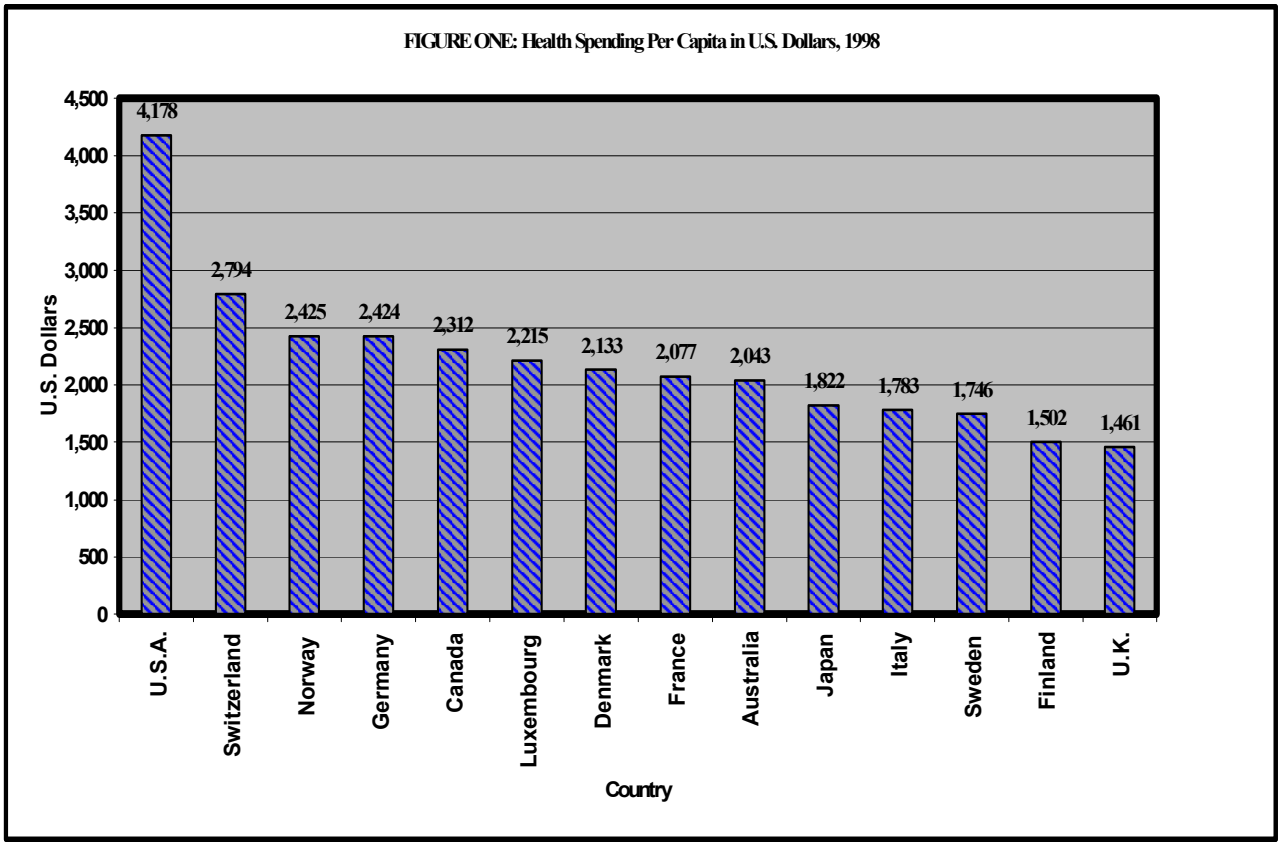
[3] WHO (i*bid.*), p. 35.
[4] OECD, *OECD Health Data 2000: A Comparative Analysis of Twenty-nine Countries* (Paris: OECD, 2000).
[5] These studies, including Eurobarometer 49 (1998) and the Harvard School of Public Health, are described in: Robert J. Blendon, Minah Kim, and John M. Benson; "The Public Versus The World Health Organization on Health System Performance"; *Health Affairs*; Vol. 20: No. 3; (May/June 2001); pp. 10-20.
[6] The data in Figure One replicate OECD cost data in Table One (source: OECD; Anderson and Hussey, *ibid.*)
[7] Steffie Woolhandler, M.D., M.P.H. and David U. Himmelstein, M.D., "The Deteriorating Administrative Efficiency of the U.S. Health Care System"; *New England Journal of Medicine* 324:1253-1258 (May 2), 1991. In contrast, administrative costs in Canada are from 8.4 to 11.1 percent of health care spending. The high level of administrative costs in the U.S. are due in large part to the additional personnel needed for billing and processing of private insurance, as well as advertising, market analysis, and tracking patients. (David Hackney and Debra Rogan, "A Single Payer Health Care System for the United States", American Medical Student Association, July 1, 2001). (http://www.amsa.org/hp/sp.cfm)
[8] Steffie Woolhandler, M.D, M.P.H.. and David U. Himmelstein, M.D.; "Costs of Care and Administration at For-Profit and Other Hospitals in the United States"; *New England Journal of Medicine* 336:769-774 (March 13), 1997.
In another stunning example demonstrating how for-profit health care contributes to high costs, Physicians for a National Health Plan reports: "When U.S. Healthcare merged with Aetna in 1996, the $967 million received by CEO Leonard Abramson could have provided health insurance to every uninsured child in the state of Massachusetts until they reached puberty." (Hackney and Rogan, *ibid.,* citing Physicians for a National Health Plan, 1996).

In addition, the high proportion of people who are uninsured in the U.S. (15.5 percent in 1999)[9] contributes to expensive health care because conditions that could be either prevented or treated inexpensively in the early stages often develop into health crises. Treatment of crisis conditions later on is much more expensive, such as emergency room treatment, or intensive care when an untreated illness progresses to a more serious stage[10]. Finally, the aging of the population in the U.S. is also contributing to mounting increases in the cost of health care.

FIGURE ONE:
Health Spending Per Capita in Selected High-Income OECD Countries
(in U.S. Dollars), 1998



Given that we spend so much more of our societal resources on health care, what kind of return is the nation's population receiving? This can be addressed by looking at some measures of health outcomes.

2) ACCESS to health care: **The U.S. is "the only country in the developed world, except for South Africa, that does not provide health care for all of its citizens."**[11] Instead, we have a confusing hodge-

[9] "Health Insurance Coverage", Current Population Reports, U.S. Census Bureau, September 2000.
[10] American College of Physicians-American Society of Internal Medicine (ACP-ASIM), "Statement for the Record of the Ways and Means Health Subcommittee Hearing on the Nation's Uninsured", April 4, 2001. (http://www.acponline.org/hpp/ways_means.htm)
[11] Stephen M. Ayres, M.D.; *Health Care in the United States: The Facts and the Choices*. Chicago and London: American Library Association: 1996, p. xii. South Africa, while providing universal coverage in principle, has not extended universal access in practice to all of its townships. (Ida Hellander, personal communication, 6/25/01, Physicians for a National Health Plan).

podge of private insurance coverage based primarily on employment, along with public insurance coverage for the elderly (Medicare), the military, veterans, and for the poor and disabled (Medicaid, which varies greatly in its implementation across states). Such a "non-system" creates serious gaps in coverage. And as insurance rates rise, more and more employers are forced to either drop their insurance benefits altogether, or to raise premiums and deductibles.

According to the most recently available figures**, 42.6 million people in America were uninsured in 1999**, down slightly from 1997 and 1998 figures[12]. It is an embarrassment to many policy makers in the U.S. that we do not have universal coverage, but more seriously, it is a matter of life and death in many cases for people who do not have access to care. As the American College of Physicans-American Society of Internal Medicine has pointed out, "people without health insurance tend to live sicker and die younger than people with health insurance".[13] The lack of health insurance for a significant portion of Americans also has other far-reaching consequences, as hospitals and other care providers are forced into cost shifting, at the expense of taxpayers and higher premiums for those with private insurance.[14]

TABLE ONE:

Health Care System Indicators and Rankings
in Selected High-Income OECD Countries, 1997-1999

COUNTRY	(OECD) Health Spending Per Capita in U.S. Dollars, 1998	(OECD) Health Spending as a Percent of GDP, 1998	(US Census) Infant Mortality Rate, 1998	(WHO) Disability-Adjusted Life Expectancy & Rank, 97/ 99	(WHO, Rank) Fairness of Financial Contributions, 1997	(WHO, Rank) Responsiveness of Health System, 1997	(WHO, Rank) Health System Overall Performance, 1997	(See Blendon) Percent Satisfied with Health System, 1998 & 2000
United States	**4,178**	**13.6**	**7.2**	**70.0 (24)**	**54-55**	**1**	**37**	**40**
Australia	2,043	8.5	5.2	73.2 (2)	26-29	12-13	32	N.A.
Canada	2,312	9.5	5.2	72.0 (12)	17-19	7-8	30	46
Denmark	2,133	8.3	5.2	69.4 (28)	3-5	4	34	91
Finland	1,502	6.9	3.9	70.5 (20)	8-11	19	31	81
France	2,077	9.6	4.6	73.1 (3)	26-29	16-17	1	65
Germany	2,424	10.6	4.9	70.4 (22)	6-7	5	25	58
Italy	1,783	8.4	6.1	72.7 (6)	45-47	22-23	2	20
Japan	1,822	7.6	4.0	74.5 (1)	8-11	6	10	N.A.
Luxembourg	2,215	5.9	5.1	71.1 (18)	2	3	16	67
Norway	2,425	8.9	4.0	71.7 (15)	8-11	7-8	11	N.A.
Sweden	1,746	8.4	3.5	73.0 (4)	12-15	10	23	58
Switzerland	2,794	10.4	4.7	72.5 (8)	38-40	2	20	N.A.
U.K.	1,461	6.7	5.9	71.7 (14)	8-11	26-27	18	57
OECD Median	**1,783**	**8.2**						

[12] *Ibid*., "Health Insurance Coverage", U.S. Census, Sept. 2000. During 1999, 15.5 percent of the U.S. population was without health insurance coverage during the entire year. The three states with the highest percentage of uninsured people were Texas, Arizona and New Mexico. Minnesota, Rhode Island and Hawaii had the lowest.

[13] The ACP-ASIM statement to the Ways and Means Subcommittee Hearing on the Nation's Uninsured (*ibid*.) also points out that more than 80 percent of the uninsured are in working families.

[14] A recent study by the Commonwealth Fund also found "sharp disparities in access to health care" among income groups in the U.S. In this survey, almost half (48 percent) of people with below-average incomes in the U.S. reported that it was "extremely, very, or somewhat difficult" to get medical care when they needed it; far higher than in the other four countries surveyed. (Cathy Schoen, Karen Davis, Catherine DesRoches, Karen Donelan, Robert Blendon, and Erin Stumpf; "Equity in Health Care Across Five Nations: Summary Findings from An International Health Policy Survey", May 2000. (http://www.cmwf.org/programs/international/schoen_5nat_ib_388.asp).

3) HEALTH AND WELL-BEING: There are many different indicators of the overall health status and well-being of a country's population, but among the most commonly used measures are infant mortality rates, and life expectancy, particularly disability-adjusted life expectancy ("the number of healthy years that can be expected on average in a given population").[15] As of 1998, the infant mortality rate in the United States was 7.2 infant deaths per 1,000 live births (identical to the rates for 1996 and 1997).[16] Although this number is a historic low for the U.S., our infant mortality rate is nonetheless the highest among the OECD countries in Table One and Figure Two. In 1996, **the U.S. ranked 26th among industrialized countries for infant mortality rates.**[17]

These infant mortality figures for the U.S. are somewhat misleading, however, since they obscure the persisting wide disparities among racial groups, based in large part on economic differences. As the U.S. Department of Health and Human Services indicates, the infant mortality rate for black children (14.3 in 1998) is more than twice that of white children (6.0 deaths per 1,000 live births), and it is higher still in some areas of the country.[18] For example, the 1999 infant mortality rate for black children in Alabama was 16.0 infant deaths before age one, among 1,000 live births.[19] Many health policy analysts consider such figures a shocking indictment of living conditions for segments of the population in the richest country on earth.

The WHO figures also show that **the U.S. ranks very low (24th) on disability-adjusted life expectancy (DALE)** among high-income OECD countries (see Table One); only Denmark ranked lower (28th). The U.S. also has a very unequal distribution of disability-adjusted life expectancy; particularly among males (in which some segments have a much longer disability-free life expectancy than others)[20]. This should not come as a surprise, however. When a sizable portion of the population lacks access to health care, particularly preventive care, one should expect that they would also be likely to experience more years of disability.[21]

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[15] WHO; (http://w3.whosea.org/healthreport/pdf/dale.pdf). Disability Adjusted Life Expectancy (DALE) "summarizes the expected number of years to be lived in what might be termed the equivalent of 'full health'." (http://www-nt.who.int/whosis/statistics/dale/dale.cfm?path=statistics,dale&language=english)

[16] U.S. Health and Human Services, "Preventing Infant Mortality", 2001 and 1997.

[17] The most recent complete comparative data analysis for infant mortality rates are from 1996, according to both the National Center for Health Statistics and the U.S. Department for Health and Human Services ("Preventing Infant Mortality", HHS Fact Sheet, U.S. Department of Health and Human Services, April 18, 2001.) The HHS fact sheet also points out that gains in medical research, public health and social services have produced a sharp decline in infant mortality rates in the U.S. since 1960. Figure Two replicates data in Table One (source: U.S. Census Bureau, *ibid.*)

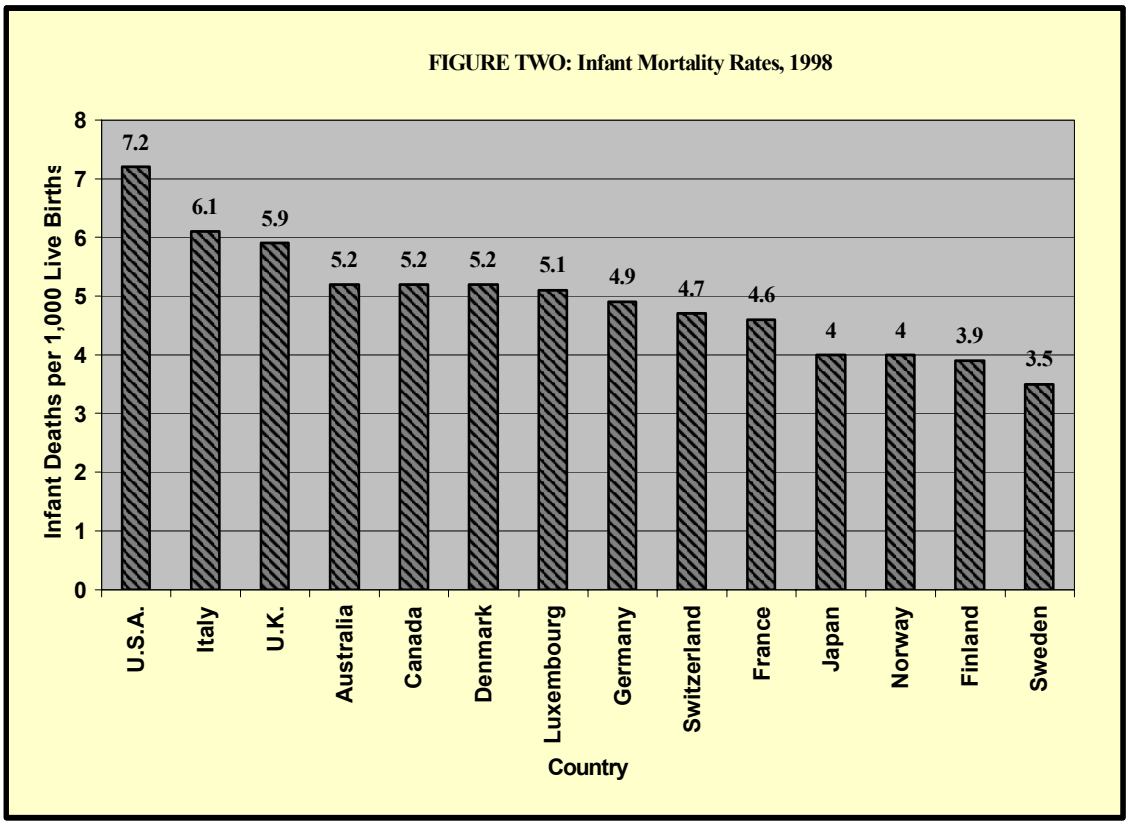
[18] *Ibid.*

[19] News Release, Alabama Department of Public Health, "Alabama's infant mortality rate improves in 1999;" (http://www.alapubhealth.org/press/pr081600.htm).

[20] *Ibid.*, WHO; World Health Report 2000, *ibid.*, p. 31.

[21] In addition, the U.S. has fairly high rates of H.I.V. infection, violence, coronary heart disease, and tobacco-related illnesses, compared to most industrialized countries. (WHO Press Release, "WHO Issues New Healthy Life Expectancy Rankings: Japan Number One in New 'Healthy Life' System"; June 4, 2000.) (http://www.who.int/inf-pr-2000/en/pr2000-life.html)

FIGURE TWO:
Infant Mortality Rates In Selected High-Income OECD Countries, 1998



4) RESPONSIVENESS: Based on WHO's international comparisons, **the U.S. was first among the 191 member countries in the category of responsiveness**, the extent to which caregivers are responsive to client/patient expectations with regard to non-health areas such as being treated with dignity and respect, etc. However, this figure almost certainly covers over the existence of extreme disparities in responsiveness among different populations. In particular, it is obvious that the millions of people with either no insurance or else very limited access to health care via Medicaid, etc., have far greater problems finding responsive caregivers than those with an adequate degree of private health insurance coverage.

5) FAIRNESS IN FINANCING: This measures the degree to which financial contributions to health systems are distributed fairly across the population. Table One shows that while OECD counties such as Luxembourg, Denmark and Germany have health systems which are very fair in financial contributions to the system, other countries such as the U.S. and Italy have very unfair systems of health financing. **The U.S was the lowest (least fair) of all the OECD countries in Table One; tied for 54th and 55th place.**

An unfair system of financing has consequences for much of the population, but especially for those who are uninsured or underinsured, and for the poor. As the WHO report states, "the impact of failures in health systems is most severe on the poor everywhere, who are driven deeper into poverty by lack of financial protection against ill-health."[22]

[22] World Health Organization Press Release, "World Health Report 2000: World Health Organization Assesses the World's Health Systems", June 21, 2000. The report adds, "The poor are treated with less respect, given less choice of service providers and offered lower-quality amenities. In trying to buy health from their own pockets, they pay and become poorer." (p. 2). (http://www.who.int/whr/2000/en/press_release.htm).

6) ATTAINMENT AND PERFORMANCE: In addition to evaluating the world's various health care systems using these criteria and providing other relevant health-related information, the WHO also ranked the world's countries in terms of the overall attainment of their health systems (based on all five of the criteria, above), and the performance of their health systems – that is, how well a country's health system is performing, compared to how well it could perform given its levels of resources. The results for overall attainment and performance were quite revealing: among the 191 countries listed**, the U.S. health care system ranked 15th in the world for overall attainmen**t (data not included in Table One), and **37th in the world for performance** (see Table One).

7) SATISFACTION WITH HEALTH CARE SYSTEM: One more interesting question is the extent to which ordinary people are satisfied with their country's health care system. As shown in Table One, the two countries with the highest percentage of people who were either very satisfied or fairly satisfied with their country's health care system overall were Denmark (91 percent!) and Finland (81 percent). Italy was the lowest among the European Union countries surveyed in the "Eurobarometer" study, at 20 percent**. The U.S. was comparatively low also, with only 40 percent of people who were satisfied** with their health care system. Even the United Kingdom, which has had persisting problems with its national health service in recent years,[23] had almost 60 percent of its people saying they were either very satisfied or fairly satisfied.

Implications and Discussion

This paper has briefly described some of the most critical problems affecting the health care system in the U.S., such as access to health care, high costs, fairness, and effectiveness in bringing about good health in its population. There are many other major issues which also contribute to our mounting health care crisis, such as declining patient choices, the increased control in health care decisions by managed care companies as they seek to further limit access to care, the crisis in the nursing profession as nurses desert the profession in droves, and quality of care issues. It is becoming increasingly clear that these continuing dilemmas are unlikely to be solved without a thorough and creative overhaul of our present system.

Despite the efforts of insurance companies and managed care companies to limit the range of political choices in health care reforms, there appears to be growing broad-based support in the U.S. for a single payer system which would greatly resolve some of the most serious problems of cost, access and fairness. Furthermore, recent studies have shown that a single payer plan would not only be economically feasible, but would be an enormous improvement over what we have. In 1991, for example, both the U.S. General Accounting Office (GAO) and the Congressional Budgeting Office (CBO) issued reports stating that a single payer system similar to that of Canada's would more than pay for itself, due to reduced administrative costs, as well as having universal access to health care, especially preventive care.[24] A single payer health insurance plan would not rule out a continuing role for private insurers, since it would probably provide only a basic level of coverage.[25] In addition, recent surveys in the U.S. have documented the growing frustration with our health care system, and an interest in exploring a single payer plan for health insurance with universal coverage.[26] Finally, recent efforts by Massachusetts health care policy

[23] In 2000, the U.K. government unveiled "The NHS Plan", a new plan for reforming its National Health Service, in part to repair the damage from years of underfunding by previous governments. The British Council, "Health Insight August 2000". (http://www.britishcouncil.org/health/themes/insight/aug00/aug.htm)

[24] Physicians for a National Health Program, "How Much Does Single Payer National Health Care Cost?" PNHP Newsletter, October 1999. (http://www.thirdworldtraveler.com/Health/HowMuchSPCost.html)

[25] In Canada, most of the population carries additional health insurance through employers for services not covered by the provincially administered national insurance program. Karen S. Palmer, M.P.H., M.S.; "O Canada, Health Care Myths from the Great White North"; California Physicians Alliance, January 13, 1999. (http://www.thirdworldtraveler.com/Health/O_Canada_KP.html)

[26] Palmer, *ibid*. For example, 79 percent of Americans in a 1999 survey said that health care should be a right.

analysts have shown that a single payer health care plan in Massachusetts would also be economically feasible[27].

One possible approach that has been advocated by some health care experts, for example, is to simply expand Medicare, an existing and highly successful public program which could be extended beyond the elderly to the entire population. Interestingly, Medicare costs for administration are currently less than two percent.[28] This and other alternative models need to be explored and discussed, with the help of current and unbiased information. It is clearly imperative, therefore, that policymakers and lay people alike educate ourselves on the issues, and to exercise our collective imagination and creativity in meeting these challenges.

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[27] Massachusetts Medical Society House of Delegates Report 207, A-99 (B), cited in Physicians for a National Health Program, *ibid*., "How Much Does Single Payer National Health Care Cost?"
[28] *A Profile of Medicare: Chartbook 1998*, U.S. Health Care Financing Administration; May 1998, p. 27.