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Health of Nations

National Healthcare=Socialism, OOGA BOOGA!

Most of us agree our healthcare system has problems, and depending on where we fall economically, medically, geographically, socially, and politically, we would have varying degrees of conviction as to just how bad those problems are. Reform is needed, we all nod sagely, but the prospect of change isn't very reassuring...we'll end up paying more for less! Employers will have to lay people off to cover the higher costs! Doctors won't make enough money and we'll have a shortage of physicians! There'll be long wait times, people won't get critical care, government bureaucrats will make our healthcare decisions! We'll have to pay for people who don't have jobs, and they'll get everything on our dime, and our taxes will go up, and we won't get to choose our doctor! Next thing you know, we'll be like those bastards, the French, the dirty socialist pigs. Our neighbors to the north have national healthcare, but our cousin's brother's best friend's neighbor's jogging partner says that all the good things we hear about their system are a bunch of lies and propaganda. Sure, Canada has nationalized healthcare, we're told, but we're warned of wait times of several months to see a specialist. England has healthcare, our American cohorts tell us, but the use outdated equipment and no one can afford the latest medical advancements

In short, we are constantly told that compared to healthcare in other countries, it could be much worse. But think for a moment who's telling us these things. What's their motivation? What do they have to gain from the current system, from keeping the status quo? More importantly, are they even right?

In April 2005, Ezra Klein (healthcare wonk extraordinaire, and now a writer for *The American Prospect*) did a week-long series on his blog that he subsequently titled "Health of Nations", in which he compared five major first world nations' healthcare systems to that of the U.S. Ezra is one of the best healthcare policy wonks you'll find, and his series neatly boils down each country's system in comparison to ours. It's a handy primer for familiarizing yourself with the basics of nationalized, universal, and/or single-payer health care.

This serves as a jumping off point for doing more research on your own as the country begins having a serious discussion about healthcare reform. You'll hear scare quotes tossed around regarding proposed changes "socialized medicine" and "government doctors", but before you react, consider that the United States is the only industrialized nation that does not offer universal healthcare. We have the highest infant mortality rate – higher, even, than some second-world nations – the highest healthcare costs, highest prescription medication costs, lowest adoption of revolutionary medical techniques/procedures (yes, you read that right), the shortest average lifespan across all groups, and the most inefficient medical delivery system of any first world country in the world. Sure, there are disadvantage in every country's system – no system is perfect, after all. But once you spend a little time learning about those other systems, talking or reading about other people's experiences in those other systems, or even just getting a rudimentary overview of those other systems, as yourself this: just what's so great about *our* system?

NOTE: Each of the following are taken entirely from Ezra Klein's stellar series "Health of Nation". Links to the individual articles are provided, and you are HIGHLY encouraged to check out each link for supplemental information and further discussion.

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France

http://www.prospect.org/csnc/blogs/ezraklein_archive?month=04&year=2005&base_name=health_care_france

Da' basics: France has a basic system of public health insurance that, as of January 2000, covers everybody in the nation. Before then, portions of the population lacked insurance. The reimbursement rates are wholly uniform, despite the fact that there are actually three health care funds, a main one covering most workers, and then one for the self-employed and one for agricultural workers.

As that hints, the health care is occupationally based. It's paid for through employer and employee contributions (much like Social Security), in addition to personal income taxes. The latter have been increasing in recent years.

The funds are private entities under the joint control of employers and unions, which are in turn supervised by the state. As might be expected, that doesn't work particularly smoothly, and there's a constant battle for authority and control. Creative tension, one might kindly call it. The funds are mandatory, no one may opt-out, and they're not allowed to compete with each other nor micromanage care.

The public system covers around 75% of total costs. Half of the rest is paid out-of-pocket and the remaining is made up by supplementary insurance companies. About 85% of the French have some form of private insurance, which pays for the various procedures and equipment the public insurance doesn't wholly cover. This of course led to inequality, so in January 2000, a means-tested public supplementary insurance program came online in order to ensure that the poor got top care.

France is the only country where access to care is unlimited. Patients can see as many doctors as they damn well please. They don't need referrals to see specialists, and there's basically no gatekeepers at all (this is going to change, recent reforms mandate a principal doctor -- a gatekeeper -- if you want full reimbursement).

The health care system is mainly under state control. The state plans out hospitals, the allocation of specialized equipment, etc. Some of this is done at the regional level, a trend which seems to be increasing. The hospitals offer about 8.4 beds per 1,000 people (America, btw, offers 3.6. Ouch.) The public sector provides 65% of the beds, private hospitals -- which operate on a fee-for-service basis -- make up the rest, and primarily concentrate on surgeries. French citizens choose which one to go to and get the same reimbursement at either. How's that for choice? Not good enough? The French also get to choose their physicians, their physicians get to choose where they practice, and there's patient-client confidentiality.

Problems: France still has class and geographical disparities in their health care outcomes. They're not nearly what ours are, but they exist nonetheless. In addition, various hospitals offer varying levels of care, health costs are rising (again, not as much as here, but still significantly), and physicians often don't feel they're paid enough for their services, leading to a number of recent strikes. As it is, French physicians only make US \$55,000, about 1/3rd what their American counterparts pull in.

Yes, but are we better? Right, you say, that's all very not interesting. But how do we stack up with France? Better? Worse?

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Yeah, the second one. France's health care system bodyslams us on most every metric. Beyond the beds per 1,000 stat mentioned above, France has more doctors per 1,000 people (3.3 vs. 2.4), spends way less, has 3.2 more physician visits per capita (6 in France vs. 2.8 in America, which probably accounts for the better preventive care in France), has a much higher hospital admission rate, and beats us handily on the most important measure: potential years of life lost. American women lose 3,836 years per 100,000, while American men give up 6,648 in the same sample size (yes, we get screwed). In France, the comparable numbers are 2,588 years for the women and 5,610 for the men. Still not great, but quite a bit better.

So France spends less, gets more, and does so through a public-private hybrid that's heavily, heavily public. Socialized medicine sure is scary.

England

http://www.prospect.org/csnc/blogs/ezraklein_archive?month=04&year=2005&base_name=the_health_of_nations_england

Da' Basics: Britain's health care system finds its roots in a document called the Beveridge report. The report argued that the health care system Britain had in the 40's -- which covered about half the country and used political patronage as its sorting mechanism -- should be combined with the rest of the country's fragmented social programs and administered in a uniform way. Thus the National Health Service was created.

The NHS is mostly funded through taxes -- 82% of it is, to be exact. Of the remaining, 13% comes from employer-employee contributions (much like Social Security) and 4% is user fees. Unlike France, Britain's health care system is entirely separate from employment, and there's no distinction between its social insurance aspects (covering those who contribute) and its public assistance aspects (covering those who need it). The system simply takes care of everyone on British soil.

Unlike Canada, Britain allows supplementary insurance for those wanting special treatment (shorter waits, private rooms, etc). It's not nearly so widespread as in France (where 90% have it and the poor get it through public subsidies), but 11% have some form of SI and many jobs offer it as a perk. To accommodate this, doctors can have both private and public practices, meaning they can treat patients under public rules complete with queues for non-pressing procedures while, at the same time, be performing the same procedures with quick turnaround for those with supplementary private insurance. This obviously creates a certain degree of inequality in the system, and, indeed, it's a source of widespread discontent.

The NHS has a gatekeeper system in which every person who wants treatment must have a general practitioner (GP) as their primary care physician. Patients can choose their PCP, and even switch if they don't like their choice. The GP's get paid via a small monthly sum per patient (capitation), not adjusted for services rendered. This is basically community rating -- GP's have long lists of patients, most don't need anything in particular during the month, so the small payment is pure profit on the majority of patients, who never come in, and thus covers the losses on the patients who do come in. Since GP's get more money for more patients, they've an incentive to keep huge lists of people. Since patients choose their GP, however, the GP theoretically can't cherrypick patients by looking for only the healthy ones. But GP's can turn patients away by saying their list is full, so it seems possible that some degree of cherry-picking can go on.

Cost Control: I'm giving this it's own category because it's both what's right and what's wrong with the British system. The NHS is a remarkably frugal operation. Health expenditures in the UK accounted for

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7.6% of GDP in 2002; in America, they were 14.6%, or almost double Britain's expenditure. The cost differential comes from a few places. First and foremost, single-payer systems are able limit budgets and negotiate better deals. Further, the mode of reimbursement, capitation rather than fee-for-service, is much cheaper and carries with it a disincentive, rather than incentive, to treat. In fee-for-service systems, the doctors get paid more if they run tests, perform surgeries, etc. That leads to a certain profligacy, a willingness to advocate treatment when the patient may not need it. On the other hand, capitation brings the opposite problem: an unwillingness to order treatment when the patient may need it. As a result, the UK rate for coronary artery bypass surgery was only 20% of ours, renal dialysis is performed far less often, and there are significant worries about underprescription. That's not to say everything is rationed, but much is.

Further, the capitation system has led to a severe shortage of doctors, with only 2 for every 1,000 people, far below the OECD average of 2.9 and the EU average of 3.3. The lack of doctors and the paucity of funds have also led to long waiting times; 38% of patients wait more than four months for elective surgeries. The basic issue is that, as Blair has admitted, the British health care system is severely underfunded, partially because Britain's got a low GDP per capita (though I don't think he admitted that part).

Interestingly, the NHS has become a major political football. Check out the Labour splash page. Every voter who heads to the Labour website is first greeted by a scare ad showing how much the Tories want them to pay for hospital procedures. The main site prominently touts the improvements Labour's made to the speed of the system and the number of doctors, particularly specialists. So, though cheap, the NHS is underfunded and providing relatively poor service and Britons know it.

How Do We Stack Up?: As noted above, America's health care system is much, much more expensive than Britain's, but also less generous. But does that affect the outcomes?

Yes, but only if compared to a functioning health care system. When stacked up against ours, Britain's broken system still comes out on top. American women lose 3,836 years of life per 100,000 while our men lose 6,648. By comparison, British women lose 2,947 and their men sacrifice 4,815 (go here to see how this is calculated). On the other hand, they have longer wait times and fewer doctors. The disparity comes because America's system works okay for most, but not at all for many. Britain's, by contrast, offers mediocre service but offers it to everyone in the country. If they injected their health care system with the sort of cash we pump into ours -- which'd mean spending the equivalent of 7% more of their GDP on it, it's safe to say we'd be beaten quite handily.

Sources: I stupidly closed some windows and so don't have as full an accounting of my sources as I did yesterday. But I mainly used Thomas Bodenheimer's excellent *Understanding Health Policy*, OECD data sets, and the British government's websites.

Canada

http://www.prospect.org/csnc/blogs/ezraklein_archive?month=04&year=2005&base_name=the_health_of_nations_oh_canad

Da Basics: Canada care is unapologetic, no-holds-barred single-payer. The single-payer, by the way, is not Canada as a whole, but each specific province, so it's not quite as monolithic as we think. It's financed by taxes, but the taxes vary from province to province, so there is a certain amount of variation in how the system pays its bills. But I'm going to stay away from that -- keeping you guys still for health policy is dicey enough, if I start throwing in tax policy, my blog will have tumbleweeds blowing through it (and maybe a shoot-out in the saloon, but that's another story).

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Like England, Canada's insurance has nothing to do with occupation, age, citizenship, or any other variable. If you're on the grounds of our Northern neighbor, you're covered. The system covers everything, though drug benefits and long-term care vary a bit across provinces. What's interesting about Canada's incarnation of single-payer, though, is how pure it's kept. France and England, as we saw, both have a significant role for supplementary insurance beyond the government's basic offering. Not so in Canada, where add-on insurance isn't even allowed. That makes for a remarkably level playing field. Care varies only according to province (and, assumedly, individual doctors and hospitals), not according to class. Interestingly, low-income Canadians actually receive more care than do the affluent, owing to the higher rates of disease in poorer communities.

To be clear, there is a little bit of supplementary insurance floating around, but it can only be used for certain amenities, like private rooms. Hospitals are simply not allowed to bill private insurers for services covered by the provincial plans. So say nighty-night to the private sector.

Canada is a gatekeeper system, and 55% of their doctors are general practitioners playing that role. Specialists can see patients without a GP referral, but they don't receive the highest compensation from the government and so most won't do it. As that alludes to, Canada's doctors are paid on a fee-for-service basis, so there's no incentive (a la Britain) to withhold treatment. Hospitals, on the other hand, negotiate a global budget with provincial government, which is to say they get a lump sum rather than a fee-for-service. That makes adapting to changing circumstances or varying needs harder than it'd otherwise be, as the money is allocated from the start, rather than in response to circumstances.

Cost: In 1970, the year before Canada's health care system came online, Canada and the US spent about the same on health care, 7.2% and 7.4% of GDP respectively. By 1990, it was 9% and 11.9%. And by 2002, it was 9.6% and 14.6%. So while our health care spending shot up by 7.6% of GDP and still doesn't cover out citizenry, theirs had a 4.5% climb and got everyone in the goddamn country covered (remember: the first number is pre-universal health insurance). During the 90's, Canada's health care costs (as a % of GDP) actually dropped. Dropped! And these differences aren't a result of fewer services rendered. Indeed, Canadians, on average, spend more days in the hospital and have more visits with their physicians than Americans do. The lower costs are accounted for by three things:

- 1) Lower administrative costs. This one will blow some minds. Despite being a bureaucratic leviathan or whatever, America's administrative costs are 300% greater per capita than Canada's. So much for the vaunted efficiency of the private market.
- 2) When Canadians do spend a day in the hospital, it's much cheaper. Costs per patient per day are quite a bit higher on our side of the border.
- 3) Physician's fees and pharmaceutical prices, which are way higher on this side of the border.

The fiscal austerity of the 90's, which helped drop costs of the program, did make for a worse health care system, or at least one that netted less satisfaction. Wait times for elective surgeries increased, though it should be noted that Canadians wait, on average, less time for vital operations such as transplants. Oh, and the "hordes of Canadians rushing across the border for care thing"? Mostly myth.

The only verified cases are a) folks in the US on vacation or b) folks who don't want to wait for an elective procedure and can pay to do it out of pocket. Think about that for a second -- the primary criticism of the Canadian system is the "wait times/they come here" combo, but what's really going on is a prioritization of procedures and a few rich folks deciding not stand in line. So in Canada, it's the rich who can't get the care they want, but everybody can get the care they need. Here, the rich can get all the care they want, and many of our poor and lower-middle class can't simply wait in line for elective procedures - they simply can't get them. It's all about priorities.

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Recently, the Canadian government, in response to the drop in citizen satisfaction, substantially increased the program's funding (by \$33 billion, I think) and began some restructuring. The effects of those changes aren't in yet, as they were just passed in 2003.

How Do We Stack Up? In simple ratings, Canada is 30th while we're 37th (according to the OECD). So they're a bit better, but it's not like the giant disparity we had with France, whose system takes the coveted top slot. As noted above, the Canadian system is significantly cheaper as a percentage of GDP than is the American system, despite the fact that the former covers everyone and the latter leaves a fair chunk of its population out in the cold. On the years of life lost metric, American women lose 3,836 years per 100,000 women and the men give up 6,648. The comparable Canadian figures are 2,768 and 4,698 respectively.

Canada's health care system, much more so than the others we've looked at, is a pure single-payer effort. It's really run by the government, private insurance is barred from interfering in any significant way, and so on. And despite the vaunted inefficiencies of government, they manage to cover their entire population with administration costs that're 300% less than ours per capita. Considering that 42 million of our folks aren't even in the system, the difference is even greater than that. Much of it comes from the simplicity of having the government pick up the tab rather than forcing doctors to haggle with insurers, but not all. In any case, that metric blows my mind.

In any case, Canada's got some problems. Wait times for elective surgeries can suck real bad and, according to an LA Times article from April 10th, some folks do cross the border to speed things up. But vital procedures are done quicker and, amazingly, any Canadian can get any necessary surgery done that they want. If elective, it may take some time, but there's never a question over whether they'll be treated. So next time someone goes off on Canadians-in-line to you, remember: the question they're facing is whether to allow the rich to pole vault over the poor. America looked at that calculus and chose the rich; our poor don't have mere waiting times to face, many of them simply can't get any non-emergency medical care. That doesn't happen in Canada, and it doesn't happen because their system is aimed at never letting it happen. Frankly, if our uninsured knew they could do it, it'd make much more sense for to flee to Canada for treatment than it does for the Canadian rich to cut their wait times by paying out-of-pocket here.

Sources: LA Times articles from Lexis-Nexis, Thomas Bodenheimer's *Understanding Health Policy*, OECD data sets, Matthew Holt.

Germany

http://www.prospect.org/csnc/blogs/ezraklein_archive?month=04&year=2005&base_name=health_of_nations_germany

Da Basics: Germany was the first nation to enact mandatory health insurance, doing so way back in 1883. The system is funded through employer contributions, with half the money coming from your paycheck and half coming from your employer. Participating Germans -- about 90% of the country -- are enrolled in "sickness funds", some of which are organized by geographical region, some of which are organized by trade, and some of which are organized by company. The funds are a mix between private and public entities and are all nonprofit. They can't discriminate, and can't charge customers at different rates corresponding to their health/age/lifestyle. That means no cherry-picking.

Various sickness funds have different contribution levels (so some will deduct 7% of your paycheck, others 8%), but all are required to cover a broad range of benefits (including prescription drugs) and demand only a modest copay. These funds, which are conducted through your employer, remain with you even after you lose or retire from a job. So if you're fired, your employer will still have to make contributions for you, but the government will take up your end of the bargain. Same deal if you retire,

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though in that case the sickness fund covers a bit less of your expenses and your retirement pension makes up the gap. The funds are administered by a board that's half company representatives and half worker representatives.

Insurance is mandatory for all Germans with incomes under \$40,000. Those above can opt out, but few do. All told, about 8% of the country opts out of the sickness funds, and most of them are very wealthy. Private insurers pay doctors at much higher rates, and thus the folks they insure get preferential treatment. This way, the rich can pay for better service, unlike in Canada where the only way to attain kingly treatment is paying out of pocket in America. 2% of the country are covered through the armed forces or policy, and .2% of the country -- mostly the superrich -- have no insurance at all.

The financing method is pretty regressive. The sickness funds can vary the percentage of your paycheck they deduct under the rationale that those with larger earnings need a smaller percentage to cover expenses. So the idea is not to have the rich covering the poor, but for everyone to be covered. Eventually, however, this got out of hand and a slight reform was made: Because various sickness funds draw from differing slices of the population, some were requiring quite small percentages to run the fund, as they had healthier, richer enrollees, while others needed quite a chunk because they covered poorer, sicker demographics. So in 1994, Germany created a program that forced sickness funds with richer, healthier members to contribute a portion of their payroll revenues to a national pool, which then distributes it to the poorer funds. That means the financing is still regressive, but less so.

Germany's not traditionally been a gatekeeper system, but that's changing. Nowadays, 55% of their doctors are generalists, compared with 35% of American physicians. Non-hospital (ambulatory) physicians are required to join their regional associations, which pay them from a global fund. If the physicians bill beyond what they're budgeted for, fees are reduced in proportion to the excess spending the next quarter. This seems to present a problem, in that some physicians could over-prescribe and force others to under-prescribe, as no particular physician would know what his colleagues were doing and thus be able to judge what he could do. Whether the associations have a way of evaluating physicians individually I don't know. Otherwise, the system seems flawed as doctors lack necessary cost information.

Cost Control: The 1977 German Cost Containment Act created a body called "Concerted Action", comprised of representatives from the nation's health providers, sickness funds, employers, unions, and various levels of government. CA meets twice a year to set guidelines for hospital fees, physicians rates and so forth. Since 1986, physician's fees have been capped. As a result, their health spending actually fell a bit between 1986 and 1991. But in 1991, costs resumed their march upwards, so the German government tried to make the Sickness Funds more competitive by allowing greater flexibility in choosing them. This heightened the inequality, forcing the aforementioned law transferring wealth from healthy, rich sickness funds to worse off ones. As of 2001, Germany's health spending was at 10.7% of GDP, third highest in the world. America, for comparison, is #1.

How Do We Stack Up? Due to some concerns over the viability of GDP spending and OECD rankings, I'm going to be changing some of the metrics I use here. Per capita, Germany spends \$2,817 on health care for its citizens. America spends \$5,267 (which is unbelievably high, by the way -- you should really check out how nuts that is, a point well-made by this Excel file comparison). According to the WHO, Germany's health care system is #6 in fairness of financial burden, #14 in overall goal attainment, and #14 in terms of overall performance. America's system is 54th in fairness(!), 15th in goal attainment, and 37th in overall performance.

Sources: Thomas Bodenheimer's *Understanding Health Policy*, WHO data,

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Japan

http://www.prospect.org/csnc/blogs/ezraklein_archive?month=04&year=2005&base_name=health_of_nations_japan

Da Basics: Japan's health insurance is another one of these employer-based systems, and has been since 1922. Universal insurance was achieved in 1961, through the National Health Insurance Act. Employers with 700+ employees are required to operate insurance plans for workers and their dependents. The plans are called "society-managed insurance". About 1800 of these employer-run plans exist, with 85% of them being single company programs and the balance being jointly administered by two or more companies. The boards of these plans are 50% company reps and 50% worker reps, much like in Germany. Dependents are required to enroll in the plans and the whole thing is funded through payroll taxes. These employer-based, "society-managed insurance" groups cover 26% of Japan's population.

Employees and dependents in companies with fewer than 700 workers are automatically enrolled in the small business national health plan operated by the government. This plan covers about 30% of Japan and is paid for by both payroll taxes and general fund revenue.

The third category of insurance is the "citizens insurance program", which covers the retired and the self-employed. The plan is administered by municipal governments who levy a compulsory premium on the self-employed in their districts. Further, the employer run health care and the government run small business system are both required to contribute to the citizens program in order to cover the retirees. The contributions from the other two programs cover about 40% of the citizens insurance program costs. Any further amount needed comes from general revenue.

A variety of small insurance programs exist to mop up the folks between the cracks, government workers and various other special occupations use them. The unemployed remain in their employer's program (or whichever program they were in before) with the payroll contribution waived. All plans are required to cover a range of benefits, which include dental care, maternity care, and prescription drugs.

The plans place no restriction on hospital or physician choice and have no preauthorization requirements, i.e. no gatekeepers (save in certain, rare cases). Japan has a much more independent class of physicians, with most clinics and small hospitals being family-owned and operated by independent doctors -- a far cry from our non-profit and private-based care. The government builds and operates the large medical centers, though the distinctions are size rather than care. Small clinics can have hospital beds and multiday care, the distinction between clinic to hospital is simply having 20+ beds.

Hospital stays are longer in Japan but surgery is only 1/3rd as prevalent, mostly owing to a resistance towards invasive procedures. Nevertheless, patients stick around longer -- an average of 33 days in the hospital -- and are allowed to convalesce there.

Payment for both hospitals and clinics is done on a fee-for-service basis. Government regulates the fees, as well as prescription prices, with the help of the Central Social Insurance Medical Council. In Japan, primary care services are often more expensive than specialized care services, an inversion of most countries. Physician visits are often brief, but the Japanese hit the doctor's office 2.5 times more often than do Americans, Canadians, Germans or the English.

Cost Control: Like in the UK, Japanese health care is cheap, clocking in at a mere 7.6% of GDP. Put another way, Japan spends a bit less than \$2,000 per capita on health care, America spends more than \$5,000 despite not covering 43 million of its citizens. Problems are cropping up, however. Japan's got one of the most long-lived populations in the world, in addition to a quickly-dropping birth rate. By 2020, the proportion of Japanese of 65 should be about 26%, up from 10% in 1986. That's trouble. Americans, by contrast, are only supposed to see a 4% increase in codgers during the same time period.

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To stem rising costs, Japan raised their copay from 10% to 20%, though the elderly were exempted from copaying for prescription drugs. Copays, however, are ineffective at limiting costs, they were capped at \$500 a month, and so they did nothing to help on the costs -- mainly due to catastrophic illness -- that're hurting the system. So Japan is cheap, but having cost problems.

How Do We Stack Up? Japan is 8-11 (three way tie) on fairness of cost distribution and #1(!) on attainment of health care goals. Their system's performance, overall, puts them at #10. America, to compare, is 54th in fairness(!), 15th in goal attainment, and 37th in overall performance. All that and we only have to spend a bit over twice as much to get it! What a deal!

Health Care Wrap-Up

http://www.prospect.org/csnc/blogs/ezraklein_archive?month=04&year=2005&base_name=health_care_wrapup

Having spent the last week of my life drowning in health care statistics and system comparisons (the products of which you can read here), I want to make a few wrap-up points on the whole thing. First, I see why Clinton's plan failed. In an effort to avoid the political baggage of single-player, he tried to emulate Germany's system, which is really the worst of the bunch. Complicated, bad at controlling costs, and obviously jury-rigged to accommodate an evolution that wasn't necessarily organized. Bad move.

Employer-based health care, which Germany and Japan's universal systems rely on, is a poor choice. There's no compelling fiscal or policy reason to use it, and employer's, frankly, should not be in charge of their worker's health care. It's just a silly way of organizing it.

Canada's system is too biased against the private sector; some degree of private, supplementary insurance should be allowed. We do not live in an equal society and we've never had a problem with allowing the richest to benefit from their funds. But if Canada's problem is that they have a ceiling, our problem is that we don't have a floor. Liberals shouldn't construct a system that stops Americans from getting ever-better health care, but we need one that guarantees a certain level of care. In essence, we want a floor without a ceiling.

France and Britain are more interesting, Britain for their enormous cost control and France for the fact that their health care is really very good. But Britain's frugality has a price -- care simply isn't as good, surgeries are underused, medicines under-prescribed, and so forth. While they still have better outcomes than we do, it's only because so many of our citizens are totally without access to health care. If you had to decide where to be treated, you definitely want it to be here.

France is more my speed. Government provided, ceiling without floor, etc. The lack of a gatekeeper leads to overuse (i.e., the French go to the doctor's too often), but that's changing their, and it could easily be side-stepped here. What a shame, then, that France is so off-limits in political dialogue. But whether or not we can invoke the French, they're the closest thing to a model structure out there, and we should study them for ideas.

Moving beyond countries and into specifics, our doctors make too much money and we credential too few of them. The road to an MD is torturous, inefficient, bottle-necked and enormously, enormously expensive. It's such a terrible path that high pay is the least we can do. But the AMA has codified this absurd state of affairs, and serious reforms will need to chip away at it. Doctors either need to make less, or we need to radically increase the usage and training of nurse practitioners. One way or the other, we need cheaper general providers who don't have crushing debt they need to pay off. To achieve the last, the government needs to step in and subsidize medical training. That shouldn't be hard, our public universities do it, to some degree, already. It's time to radically increase the degree.

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What really leapt out at me during this series was how normal government provided health care is. Other nations have doctor choice, hospital choice -- in France, they don't even have limits on specialist choice. Americans have somehow fooled themselves -- or been fooled -- into believing that government-run health care is somehow different from what they enjoy now. I genuinely believe they carry some sort of dystopian vision around with them, of gray waiting rooms and faceless bureaucrats and bread lines with stethoscopes, rather than grain, at the front. In order to keep that prophecy whole, they've had to mentally classify medicare as some weird, third sort of category -- government paying for private health care.

Medicare, of course, works great, and its beneficiaries are enormously pleased with the service. it doesn't seem like government-run health care because, well, it's like normal health care, only the government pays. We need to use that. Which is why my vote for health care reform would be a radical expansion of Medicare, almost exactly along the lines of what Ted Kennedy has proposed. Americans need to be assured that government run health care is not, in some weird way, a wholly different state of affairs. They need to know that it's the health care they enjoy now, just better, cheaper, and guaranteed. Medicare, because it's already used and liked, comes with those benefits.

Lastly, all my comments are on the structure of health care systems. There are many other problems too, the rapid advance of technology and ever-longer life spans chief among them. Changing our structure won't solve those issues. But our dysfunctional system currently makes them worse. The poor get care, but only once the situation is catastrophic and the costs of healing them have drastically increased. We pay too much, get too little, and remain tied to bad jobs because we can't sacrifice our coverage, In the end, our health care system is a lead weight on employers, a shackle on employees, and a great drag on our economy. It's not the best in the world, it's not near it, and we shouldn't pretend otherwise. Instead, we should set out on the task of making it better.

Mandatory Reading & Other Resources

Links

MichaelMoore.com – the official website

<http://www.michaelmoore.com/>

Frontline: Sick Around the World – Frontline special covering healthcare systems in England, France, Germany, Japan, Taiwan, and Switzerland

<http://www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/>

Five Capitalist Democracies & How They Do It – summarized healthcare fact comparison between five different democracies

<http://www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/countries/>

Graphs: U.S. Health Stats Compared to Other Countries – charts drawn from the 2007 report done by the Organisation for Economic Co-operation and Development (OECD)

<http://www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/etc/graphs.html>

Books

Understanding Health Policy

Thomas Bodenheimer
