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The Need for Health Care Reform:

Finding solutions to health care issues in the U.S. by looking at foreign models

Research Project

Submitted in partial fulfillment of the requirements for the degree of Master of Arts in Public Policy at Trinity College, May 2013.

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Introduction

The United States has one of the best medical systems in the world, but at the same time has one of the worst health care systems among developed countries[1]. The country spends more on health care than 12 other industrialized countries: The U.S. spent approximately $8,000 per person in 2009 on health care, according to a study by the Organization for Economic Cooperation and Development (OECD), while other developed countries spent one-third or two-thirds as much[2]. There are a number of programs and reforms that have been implemented throughout the years in order to improve the quality, cost, and access of health care in the U.S. However, American policy makers and public health leaders rarely look at health care programs and models that other industrialized

countries have successfully implemented and then adapt them to national policies.

In this research paper, I plan to study three different health care systems in industrialized countries and analyze the programs that these countries have used in order to improve the overall quality, organization, and cost of health care delivery. I will look at Canada and England, two countries that have different approaches to the delivery of their health care but nonetheless have proven to be successful in their own outcomes. Considering that there is a wide array of topics to discuss in this matter, this project will focus on two specific issues. The first one concerns the increasing number of uninsured people that live in the U.S, resulting in a lack of access to proper health care or the financial hardship that families have to endure due to the high cost of health care in the country. The second issue deals with the elderly and the different long-term care programs that all three countries offer to their citizens. With an aging population of baby boomers in the United States, there is a need to implement policies to secure their financial stability and provide health care services.

The research paper will be divided in three parts: the first one will look at the key policy issues that need to be addressed for both the uninsured and the elderly population. The second part will focus on the organization of health care in Canada and England, while looking at the different programs for the elderly that these countries have and how some

of their policies could be implemented in the United States. The third part will focus on the problems of comparability and some of the limitations that implementing foreign health care models can have in the United States. The objective of having these three parts is to demonstrate through comparisons and by looking at foreign models that the reason for which the health care system in the United States is flawed is not for the lack of finding a successful health care model. The problem of health care in the United States is a consequence of lack of will and political polarization, while in the meantime more American citizens are falling ill due to the lack of insurance or the high costs of health care.

Part I

Identifying the Issues in the Health Care Arena

There are three key policy issues that will be addressed in this part of the research project: the quality, cost, and access of health care in the United States. The U.S. has one of the highest spending averages per capita, if not the highest, of industrialized countries but does not necessarily have the same high quality care. For instance, the country has one of the highest rates of potentially preventable deaths from asthma and

amputations due to diabetes, in addition to no better than average in-hospital deaths from heart attacks and strokes[3]. One of the methods of analysis used in the health care industry that has proven helpful is that of Comparative Effective Research (CER), which is a tool utilized by physicians and health policy analysts to determine through scientific research and evidence-based medicine the best alternatives for treatment[4]. The government created the Agency for Health care Research and Quality (AHRQ) in order to monitor medical practices in to provide the best quality possible. However, the issue of the quality of health care became a constant topic of debate, which led the Institute of Medicine (IOM) to create a Committee on Quality of Health Care in America. The report provided by this committee showed that the problems with medical mistakes are not principally due to individual human errors, but instead are caused by faulty systems, processes, and conditions that led people to make mistakes or fail to prevent them[5]. There have been policies created to avoid these faults in the structure, such as creating a reporting system and having organizations to oversee health care quality, but the AHRQ recognizes that even though quality is improving, it is doing so at a slow pace[6].

The cost of health care in the U.S. has been increasing rapidly over past decades, and it has gotten to a point where the government has to intervene in order to regulate the cost of it to prevent a collapse of the system. The table below compares the cost of health care in industrialized

countries, showing how the United States has the most expensive system among these countries.

Table 1.

Exhibit 2. Health Spending in Select OECD Countries, 2009

	Population (millions)	GDP per capita[b]	Total health spending		Health spending, by source of financing		
			Per capita[b]	% GDP	Public	Private	Out-of-pocket
Australia	22.0	$39,924	$3,445[a]	8.7%[a]	$2,342[a]	$476[a]	$627[a]
Canada	33.4	$38,230	$4,363	11.4%	$3,081	$646	$636
Denmark	5.5	$37,706	$4,348	11.5%	—	—	—
France	62.6	$33,763	$3,978	11.8%	$3,100	$587	$291
Germany	81.9	$36,328	$4,218	11.6%	$3,242	$424	$552
Japan	127.5	$32,431	$2,878[a]	8.5%[a]	$2,325[a]	$99[a]	$454[a]
Netherlands	16.4	$41,085	$4,914	12.0%	—	—	—
New Zealand	4.3	$28,985	$2,983	10.3%	$2,400	$184	$399
Norway	4.8	$55,730	$5,352	9.6%	$4,501	$43	$808
Sweden	9.3	$37,155	$3,722	10.0%	$3,033	$69	$620
Switzerland	7.7	$45,150	$5,144	11.4%	$3,072	$504	$1,568
United Kingdom	60.9	$35,656	$3,487	9.8%	$2,935	$188	$364
United States	306.7	$45,797	$7,960	17.4%	$3,795	$3,189	$976
OECD Median	*10.7*	*$33,434*	*$3,182*	*9.5%*	*$2,400*	*$193*	*$559*

[a] 2008.
[b] Adjusted for differences in cost of living.
Source: OECD Health Data 2011 (Nov. 2011).

Scholar David A. Squires suggests in his article "Explaining High Health Care Spending in the United States: An international Comparison of Supply, Utilization, Prices, and Quality" that the higher spending is more likely due to higher prices, the misuse of technology, and greater obesity[7].

The use of expensive medical technology is more common in the U.S. than in other developed countries, meaning that there are more medical procedures and operations that use expensive technology and therefore generate more costs for patients. For example, the U.S. is one of the two countries that perform the most knee replacements[8] and also has an excessive number of magnetic resonance imaging (MRI) machines.

Furthermore, the utilization of imaging machines was also highest in the U.S. with 91.2 MRI exams and 227.9 CT exams per 1,000 people[9]. Furthermore, the fees for the utilization of these machines are far higher than what is charged in other developed countries. The chart below illustrates these points and presents quantitative data that supports this claim. **Table 2.**

Exhibit 9. Diagnostic Imaging in Select OECD Countries

	MRI machines			CT scanners			PET scanners	Mammographs
	Devices per million pop., 2009[c]	Exams per 1,000 pop., 2009[c]	MRI scan fees, 2011[d]	Devices per million pop., 2009[c]	Exams per 1,000 pop., 2009[c]	CT scan (head) fees, 2011[d]	Devices per million pop., 2009[c]	Devices per million pop., 2009[c]
Australia	5.9	23.3	—	38.7	93.9	—	1.1	24.3
Canada	8.0	43.0	—	13.9	125.4	$122[e]	1.1	—
Denmark	15.4	37.8[a]	—	23.7	83.8[a]	—	5.6	17.0
France	6.5	55.2	$281	11.1	138.7	$141	0.9	—
Germany	—	—	$599	—	—	$272	—	—
Japan	43.1[a]	—	—	97.3[a]	—	—	3.7[a]	29.7[a]
Netherlands	11.0	43.9	—	11.3	65.7	—	4.5	—
New Zealand	9.7	—	—	14.6	—	—	0.5	26.4
Switzerland	—	—	$903	32.8	—	$319	3.0	33.2
United Kingdom	5.6[a]	—	—	7.4a	—	—	—	9.0
United States	25.9[b]	91.2[b]	$1,080[f]	34.3[b]	227.9[b]	$510[f]	3.1[a]	40.2[a]
Median (countries shown)	***8.9***	***43.0***	**—**	***15.1***	***122.8***	**—**	***1.1***	***17.3***

[a] 2008.
[b] 2007.
[c] Source: OECD Health Data 2011 (Nov. 2011).
[d] Source: International Federation of Health Plans, *2011 Comparative Price Report: Medical and Hospital Fees by Country* (London: IFHP 2011).
[e] Nova Scotia only.
[f] U.S. commercial average.

This information suggests that there is a need to regulate and supervise the use and prices of these machines, as health care spending in these areas could be reduced by paying more attention to the use of these machines and the over diagnosis of unnecessary surgical procedures such as knee or hip replacements. Other OECD countries have shown to use less these machines, and still have healthier citizens

than the United States. Therefore, the use of these is not linked and is not proven to improve health conditions. Higher spending and the cost of medical care in the U.S. can also be attributed to an aging population, which results in higher use of prescription drugs, retirement costs, and greater health care needs. In addition to the elderly, a large population of obese individuals also attribute to the high costs of health care. One-third of the U.S. population is obese, meaning that more medical attention will need to be delivered to individuals with weight issues- increasing yet again the cost of medical care. One study estimates that medical costs attributable to obesity in the U.S. reached almost 10 percent of all medical spending in 2008[10]. In addition to an above average use of technology equipment and an obese population, one of the main reasons why health care costs in the U.S. are so high is due to the number of uninsured that use medical services and lack the financial means to pay for these.

The Uninsured Population in the United States

Access to health care has also been a key policy issue that affects outcomes. However, there are several reasons why access to health care can be delayed in the U.S. These include being a low-income individual, uninsured, African-American, or even a patient without a regular physician, and they all contribute to the delay in the access to health care. For patients in lower socioeconomic positions, cost was an important factor as some of these individuals would chose to delay doctor visits in order to save costs. Nonetheless, these actions would result in more

expenses in the long term, as diseases or illnesses would develop further instead of addressing them at an early stage.

Understanding key health policy issues and analyzing the reason for their existence is important to make adjustments or create new policies. However, when looking at all the different areas that need improvement it can become overwhelming since there are many different actors that have to be considered when creating policy. In this paper, I will focus on two main health issues that have been addressed, not only in the United States, but also throughout developed nations. The first topic that I will address will be the uninsured. The structure of the health care system in the country has created a notable difference among those who are able to pay to receive top quality health care through private or public insurance programs, and the less fortunate who are not covered by any type of insurance programs. This gap has been increasing constantly, to the point where in 2009, 16.7% of people living in the United States were uninsured. This percentage represents 50.7 million people who did not have insurance for the entire year, excluding those who were without insurance for some period of time during that year[11]. As a result of their lack of health insurance, this population is often unable to receive care and therefore faces health conditions and illnesses that are preventable with the right medical care[12].

Data from the US Census Bureau in 2010 shows that a high percentage of the uninsured population can be found in households that

earn up to $50,000 per year.[13] Interestingly, 30.5 percent of the uninsured come from low-income families that earn less than $25,000 per year while approximately 50 percent of the uninsured come from families with a household income between $25,000 and $75,000[14]. Within the group of uninsured, forty-one percent are young adults and fifteen percent are children while only less than two percent are elderly[15]. These numbers indicate that young adults are more likely to be uninsured than children or adults, since they make up 70 percent of the non-elderly population but 84 percent of the uninsured[16]. Low-income children qualify for Medicaid or Children's Health Insurance Program (CHIP) and the elderly are enrolled in either Medicare or Medicaid. Furthermore, the data from the ethnography of the uninsured shows that minority groups are more likely to be uninsured. Specifically, Hispanics and African Americans are the largest groups of uninsured people[17]. Moreover, the majority of the people that are uninsured in this country are native or naturalized U.S. citizens[18]. Undocumented and legal non-citizens are approximately three times more likely to be uninsured citizens but they only account for less than twenty percent of the uninsured population[19]. Non-citizens usually have less access to employer benefits because they earn lower wages and therefore have less access to employer benefits. In addition, the number of uninsured has increased in the recent decade due to economic instability: having a weaker job market affects employer-sponsored coverage in many institutions.

Over 75 percent of the uninsured come from working families where low-wage workers do not have access to health coverage through their employers. Most of these employers are small businesses that can't afford medical expenses, leaving their workers uninsured. Empirical data shows that approximately half of low-wage workers were offered the opportunity to participate in employer-health insurance, with the remainder not being eligible for the employer's plan. However, as wages rose, the percentage of workers who were offered insurance or had access to health insurance increased almost to 100 percent[20]. The size of the company in which a person is employed can also determine whether they will have coverage or not, considering that smaller firms offer less health insurance benefits to their employers. One of the reasons for this is because insurance companies offer better premiums and discounts to bigger companies who are willing to enroll larger numbers of employers. Small businesses or firms such as restaurants or independent retail stores usually rely on lower-wage workers to run their business, which means that providing health insurance for them becomes extremely expensive.

The Importance of Preventive Care

The uninsured population is less likely than the insured to receive timely preventive care, letting diseases such as hypertension and diabetes develop to an extent where it becomes highly costly to treat. Therefore, uninsured patients are usually diagnosed in later stages of diseases that if detected early in time can be treatable and save a

patient's life[21]. The lack of preventive medicine takes a toll on the uninsured population's finances since treatment for diseases in later stages is more expensive and time consuming than preventive treatments. Even though it seems evident, those who are currently uninsured are risking their own health by not taking the necessary precaution and preventive actions in order to live a healthier life. In the long run, being uninsured can be more expensive that paying for health insurance on a regular basis, especially if a patient develops a medical condition that might have been prevented.

However, the risk of being uninsured does not only affect this population but also the entire country. The Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals to treat and provide medical assistance to anyone needing emergency treatment regardless of their insurance status or ability to pay[22]. The burden of uncompensated care has been growing simultaneously with the number of uninsured in the country, partly because it is the uninsured population who use emergency medical services at hospitals, creating unpaid medical bills that increase the overall cost of health care. The cost of health and medical services is certainly linked to the growing number of uninsured people in the country. The total amount of expenditures among all of the uninsured can be staggering; in 2004, people who were uninsured spent approximately $125 billion dollars on health care and medical services[23]. This number includes expenditures of people who didn't have health insurance for part

of the year and used medical services while being uninsured. These people then paid for some or all the cost of treatment received through private funds or once they had acquired insurance. This left approximately $40.7 billion dollars of uncompensated care or 2.7 percent of the projected total personal health care spending in 2004[24]. As mentioned earlier, some uncompensated care is assumed by hospitals, reducing physicians and medical institutions' income since the government does not cover all of these expenditures. In 2004, the government paid for $34.6 billion or 85 percent[25] of the total cost of uncompensated care, leaving a $6.1 billion deficit for hospitals and physicians. This was approximately a decade ago, meaning that with rising costs the amount of expenditure has most likely increased over the past years. In 2008, uncompensated costs increased to $57 billion, and unlike 2004, the government only covered 75 percent[26]. This means that in only 4 years, uncompensated care increased by $17 billion or almost 41%.

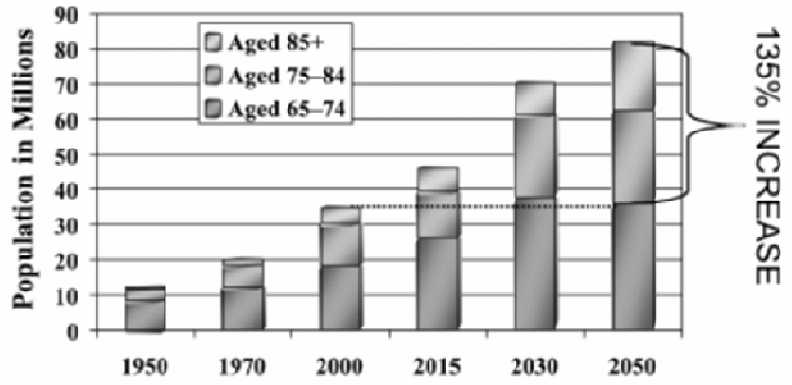
If health care costs rise, then insurance companies have to raise their premiums in order to maintain the quality of service provided. When health insurance becomes more expensive, employers might reduce the benefits for their employees, which means they will now have to pay for medical services from their own pocket. If there are more people paying for medical services without insurance, it is most likely that a percentage of this population will choose not to have health insurance since it saves

them costs. Without health insurance, these people will opt out of using preventive medicine due to its cost.

The Elderly Population

Besides having a vulnerable uninsured population, the United States is also facing complications with the increasing elderly population in the country. Baby boomers, or children born between 1946 and 1964[27], are now reaching their retirement age and many are using their social security checks as their main source of income. Between 2000 and 2010, the 65 year old and over population grew 15.1 %, which means in that decade, the number of elderly people grew at a faster rate than the total population of the United States[28]. Among the elderly, the population between 65 and 69 years old grew 30.4% in that decade, growing more than any other age group among the elderly. Some of the problems of having a growing elderly population include: increasing social security payments, growing medical care insurance and medical expenses for pharmaceuticals becoming a burden for senior citizens. These issues will not only bring financial challenges for government and private companies, but also to the elderly. Economists such as Peter Peterson and others in the Concord Coalition have argued that caring for an aging society could disable the American economy, as a growing elderly population has as a consequence a drop in the number of active workers in the country[29]. The following chart shows the projection of the increase in the elderly population if present trends continue.

Figure 2



Source: (NP-T4) Projections of the Total Resident Population by 5 Year Age Groups, Race, and Hispanic Origin with Special Age Categories: Middle Series, 1999 to 2100

Population of Americans Aged 65 and over, in Millions

In order to prepare for the increase of the elderly population, projects such as the Future Elderly Model (FEM) have been conceived in order to lessen the economic impact on Medicare. The FEM, started by the RAND Corporation in 1997, was "a tool to help policy analysts and private firms understand future trends in health, health spending, medical technology and longevity"[30]. Funded by the US government and Centers for Medicare and Medicaid services, the FEM aimed to develop sustainable models for elderly health care in the country with the help of experts in the matter. Interestingly, one of their sources of income came from Pfizer, a global pharmaceutical company. This corporation gave 2 million dollars to promote pharmaceutical innovation[31] that would improve the elderly population standard of living. The FEM project continued to work under the RAND Roybal Center for Health Policy Simulation, continuing to research and develop models to improve the quality of health care in the country.

The use of pharmaceuticals in the United States is becoming a problem for the health care system as they provide the older population with the option of living longer and therefore consuming more health care. Experts in geriatric health care claim that the growth in the pharmaceutical industry has led to inappropriate medication use in elderly patients, mainly due to excessive health care utilization and adverse drug reactions[32]. Margie Rauch Goulding writes in her article "Inappropriate Medication Prescribing for Elderly Ambulatory Care Patients" about the ineffectiveness of specific drugs and the harmful effects these drugs have had in elderly patients[33]. According to Goulding, there has been an increase in the over prescription of drugs for the elderly, resulting in the risks of adverse effects outweigh the benefits that these drugs might provide. The research concluded that the most common drugs are pain relievers, anti-anxiety agents, sedatives and antidepressants. The research also showed that inappropriate prescriptions are more common among elderly women and those who are not subscribed to an HMO, since the physician does not have access to the patient's full medical condition[34]. This lack of coordination of care affects patients since they are getting the wrong or too much of their prescription, and also unnecessarily increases the demand of drugs in the country.

The OECD study shows Goulding's claim is accurate, as the prices in the United States for the 30 most commonly prescribed drugs in the

years 2006-2007 are higher than many developed countries. The following table[35] shows empirical evidence of the disparity in prescription drug costs in the U.S:

Table 4.

Exhibit 6. Drug Prices and Physician Fees in Select OECD Countries

	Prices for 30 most commonly prescribed drugs, 2006–07 (U.S. set at 1.00)[a]			Primary care physician fee for office visits, 2008[b,c]		Orthopedic physician fee for hip replacements, 2008[b,c]	
	Brand name	Generic	*Overall*	Public payer	Private payer	Public payer	Private payer
Australia	0.40	2.57	0.49	$34	$45	$1,046	$1,943
Canada	0.64	1.78	0.77	$59	—	$652	—
France	0.32	2.85	0.44	$32	$34	$674	$1,340
Germany	0.43	3.99	0.76	$46	$104	$1,251	—
Netherlands	0.39	1.96	0.45	—	—	—	—
New Zealand	0.33	0.90	0.34	—	—	—	—
Switzerland	0.51	3.11	0.63	—	—	—	—
United Kingdom	0.46	1.75	0.51	$66	$129	$1,181	$2,160
United States	1.00	1.00	1.00	$60	$133	$1,634	$3,996
Median (countries shown)	***0.43***	***1.96***	***0.51***	***$53***	***$104***	***$1,114***	***$2,052***

[a] Source: Analysis by G. Anderson of IMS Health data.
[b] Adjusted for differences in cost of living.
[c] Source: M.J. Laugesen and S.A. Glied, "Higher Fees Paid to U.S. Physicians Drive Higher Spending for Physician Services Compared to Other Countries," *Health Affairs*, Sept. 2011 30(9):1647–56.

The Need for Change in Elderly Health Care

There have been studies where simulation of projected socioeconomic and demographic patterns in the year 2030 show that social and public policy changes must begin soon in order to meet the long-term care needs of Baby Boomers. The "2030 problem" concerns the challenge of creating and an effective medical service system that will provide sufficient resources for an elderly population that will double by this date. This research states that the challenges of caring for the elderly in 2030 will involve: creating better payment and insurance systems for

long term care than the present ones, taking advantage of advances in medicine and technology to keep the elderly as healthy and active as possible, changing the way society organizes community services so that care is more accessible, and altering the cultural view of aging so that people from all ages are integrated into the active community[36].

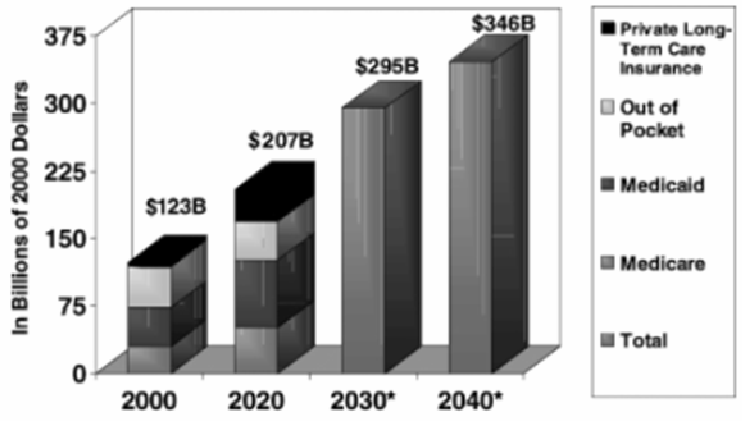
Therefore, the long-term care system in the United States is becoming a central policy concern due to the increasing number of senior citizens over the age of 65. With a growing need for this type of care, the efficiency and cost of nursing homes has become increasingly expensive while there are fewer personnel to take care of this population. The workforce for long-term care consists mostly of nursing assistants who are home health and home care aides, personal care workers, and personal care attendants[37]. Recently, federal and state policymakers have realized that there is a labor shortage crisis for long term care that can result in a reduction of quality of care and quality of life for the elderly. One of the reasons why the quality of long-term care has begun to decrease in recent years is due to the rising number of vacancies in the workforce of the industry. As long-term care jobs are seen by society as low-wage and unpleasant, many workers have opted to pursue other careers[38]. With a shortage in the supply of paraprofessional workers whose job is to assist the elderly with daily activities and to help them achieve a better quality of life, the elderly population often lacks proper care. This shortage has brought negatively affected the long-care system,

as providers, consumers and workers are all affected by this phenomenon. Furthermore, programs like Medicare have focused primarily on protecting and providing the best service to its beneficiaries, which resulted in limited attention to its workers and their continued career growth or development.

For this reason, states have created incentives in order to motivate long-term care workers to excel in their job and stay in the industry for longer periods of time. This turnover can also increase the costs of the health care system, as nursing homes have to spend more money in training and recruiting new people interested in the industry. There are also monetary losses due to the decrease in productivity and therefore decrease of quality in their service. A study in 2000 found that inadequate staffing levels could affect a client's physical and mental functioning[39]. With a shortage of workers there is less attention provided to the patients, which can result in poorer nutrition or hospitalizations that could be prevented with proper care. The federal government has created policies that aim to restore the workforce in the industry by creating incentives. Some of these incentives include: increase in workers' benefits such as health insurance and payment for transportation time, developing new worker pools, and establishing public authorities to provide independent workers and consumers ways to address issues about wages and benefits, job quality and security[40].

The problem of long-term health care in the United States affects at an even higher degree the population over 85, as they are not able to care for themselves at that stage of their lives[41]. According to data from the U.S Census Bureau site[42], half of all the people in nursing homes and one fourth of all people requiring long-term care are over 85. With a large number of aging residents, the census estimates that those over 85 will grow from 12.2 percent of the elderly population in 2000, to 19.2 percent by 2040[43]. The growth will lead to higher expenditures from the federal government in Medicare, up to the point where it will not be sustainable by the trust fund, leaving future generations without a secure program for their retirement years. The following chart shows a projection of the expenditures for long-term care services for the elderly if present trends continue.

Figure 1



Source: "Projections of expenditures for long-term care services for the elderly," CBO 1999
Dollar totals in 2030 and 2040 are not disaggregated by payer due to uncertainty about projections.

Projections of National Long-term Care Expenditures for the Elderly

As a result, the government has begun to rethink their funding strategy and come up with new policies such as the Medicare expansion in the Affordable Care Act. The U.S. also provides a Social Security program for the elderly retired population that consists of a stipend given to these citizens, based on how long they have worked and how much they have earned throughout their lives. Paying for long term care in the present day has become a burden for many elderly people in the country as Medicare only pays approximately 12 percent of the nursing home care[44]. Furthermore, Medicare only covers the full cost for a specific number of days, and after that period it is the patient's responsibility to pay the cost in their retirement stage of their lives. Because of the lack of nursing home care coverage of Medicare, many elderly people have found themselves paying those expenses with their own life savings. Considering that it costs approximately $60,000 per year to pay for nursing home care without Medicare coverage[45], many senior citizens have found themselves in bankruptcy due to the high costs of this type of medical assistance.

Part II

Organization of Health Care in other developed nations

Evidence in the previous chapter of this research project shows that being uninsured and paying for medical expenses at an older age can

be problematic for many Americans. However, there are other industrialized countries that have managed to establish a health care system highly regulated by the state, which provides the entire nation to have access to health care. The first country that will be analyzed and compared to the United States in this research paper will be Canada, considering that the geographical proximity has allowed these two developed countries to become trading partners while having some differences in terms of government policies, demographics, health care systems.

The Structure of the Canadian Health Care System

Canada's current health care system dates back to 1947 when publicly funded universal hospital insurance was funded in the province of Saskatchewan. By 1972, many of the provinces in Canada had adopted Saskatchewan's model and offered a public health care plan to its people. The most important change in Canadian health care came in 1984 with the Canada Health Act (CHA). The CHA aimed to control provincial institutions and health professionals' behavior in order to regulate price and supervise how the system is financed. Health Care in Canada is for the most part publicly financed as approximately 70% of the total health care expenditures in the country come from public funds. In fact, 98.6 and 90.3 percent of physicians and hospital services are paid through these funds[46]. These public insurance programs are financed mostly through personal income and consumption taxes levied by both the federal and

provincial government. The only sector in which private insurance pay for most of the health services is the Dental care area, as provincial governments finance less than 5 percent of all services[47]. The following table shows the percentage of total spending by source of funds. A high percentage of the public health care spending in Canada is incurred in physician and hospital services as well as drugs. Private health care has a high percentage of spending in dental services.

Table 5.

Table 3: Health Care Expenditures in Canada by Source of Funds, 2005

	Total Health Care Spending	Public Health Care Spending	% of Total Spending	Private Health Care Spending	% of Total Spending
Total	141,241	99,073	70.1%	42,168	29.9%
Physician Services	18,536	18,280	98.6%	256	1.4%
Hospital Services	40,363	36,464	90.3%	3,899	9.7%
Drugs	23,340	9,099	39.0%	14,241	61.0%
Dental Care	9847	449	4.6%	9398	95.4%
Other Health Professional	5,361	678	12.7%	4,683	87.3%
Other Institutions	14,759	11,077	75.1%	3,681	24.9%
Other	29,035	22,026	79.3%	6,009	20.7%

Source: CIHI (2007)
All figures in 000,000's

Nonetheless, the CHA created several criteria that represent the principles and values for Canadian health care, all of which are valid and used in present times: public administration, comprehensiveness, universality, portability, and accessibility. Public administration ensures that a non-profit public authority administers each provincial plan.

Comprehensiveness guarantees that every plan must cover all insured health services provided by hospitals, physicians or dentists. Universality ensures that all residents of a province are entitled to the insured health services. Portability means that Canadians can transfer their coverage between provinces, and accessibility makes sure that citizens can have access to insured hospital, medical and surgical-dental services.

Unlike the United States, each Canadian province is responsible for health care within their jurisdiction. This created a sense of fragmentation since the Canadian health care system is controlled by the provinces but coordinated by the federal government with the provinces' consent[48]. The majority of hospital and physician care is publicly insured in Canadian provinces, but some of the medical goods and services are not. For example, health care services provided by private practitioners are reimbursed by public insurance and at much lesser degree by private insurance[49]. In addition, most of the hospitals in Canada are private non-profit institutions that are funded by provincial departments of health and governed by a board of trustees. Canadian citizens also have the option to choose their general physician and change from one to another as desired. However, if an individual wishes to be seen by a specialist, each province has a "gatekeeper" system in which people can have access to a specialist only through referral of their general physician. Both the general physician and the specialists are paid by the provincial

departments of health according to a fee schedule that is arranged and discussed with the physicians' professional associations[50].

There are other goods and services that are not funded publicly, but nonetheless provincial governments have found solutions to ensure that all their citizens receive the health care needed. For example, pharmaceuticals and long-term care are two of the goods and services that are not covered by the CHA. However, most citizens do have insurance for these goods as the provinces have mandates or programs to cover seniors or catastrophic drugs needs[51]. These types of insurance programs come from private health care insurance companies that offer their employees health benefits besides the ones that are given by their province. Unlike the United States, private insurance only accounts for 12 percent of health care expenditures in Canada. Some scholars argue that the limited role of private insurance companies promotes equal access and necessary health care to the people, instead of giving certain privileges to those who are willing to pay for private health goods and services.

Issues with Universal Health Care in Canada

However, having universal health care does create some challenges in the system that need to be addressed. Waiting times have increased for common, high profile services such as orthopaedic surgery, eye surgery, and diagnostic imaging and cancer treatments. The people

affected by these waiting times have advocated for the implementation of further private health plans and private financing in order to give the best possible attention to their patients. Some of the other policy challenges also include shortages for selected services, a misdistribution of some health professionals, an out-moded primary care delivery system dominated by physicians in solo or small group practices, and dated information systems that do not allow information sharing in order to create an efficient health record for the people[52].

For these reasons, private health insurance has become increasingly common in Canada and even more so among those people whom large companies employ. In order to supervise the market for private insurance, provincial governments regulate the provision of private health insurance and private health care services. Through these policies, provincial governments have indirectly limited the growth of private insurance through regulation of physicians and the fees they charge for private services. For example, a physician is required to decide whether they will support their entire practice through private (out-of-pocket) payments by patients or by public funds given by the province. Even if a physician decided to opt out of the public funded payment plan, some of the states do not allow these physicians to charge more for their services than the arranged fees for those enrolled in public plans. Therefore, the provinces have created little to no incentive for physicians to opt out of public plans, therefore giving more control to provincial

governments and allowing them to regulate the cost of health care services.

Health Care in Britain

Like Canada, England has also created a health care system that allows all of its citizens to receive health care goods and services. The United Kingdom was one of the first nations in Europe to implement a publicly funded National Health Service (NHS), one that is still active today and that has become an icon of national identity for Britain. In 1948 that the U.K. National Health Service Act was enacted, encouraging three main principles for its publicly funded health care system: Equal access to medical care, availability of comprehensive preventive and curative care, and provide the service at no cost at the point of service[53]. Throughout the years, the NHS has been able to fund its health care system by general taxation. This means that all individuals in the country contribute to a public health insurance system, resulting in coverage for everyone. Since the NHS funding comes from general taxation, individuals' contributions are determined by income, rather than their health condition. The NHS has also established itself by having government dominance in the administrative and fiscal areas of health policy making and implementation of health care in the region[54]. By the 1950's, the NHS introduced co-pays for health services such as dentistry, optometry and prescription drugs, creating a complete medical system that covers the needs of all citizens by using public funds. Besides providing universal

health care to the country, one of the most important achievements that the NHS has accomplished throughout time has to do with its ability to control costs. By the end of the 1980's, the government decided to reform the health care system in order to improve services while reducing costs. The government addressed some of the ways in which spending could be controlled by giving more power to the government and letting it decide the course of the NHS.

The result of this reform was the creation of an internal market within the NHS that would take advantage of the way in which markets naturally tend to seek out efficiencies[55]. These reforms were announced in the 1989 White Paper *Working for Patients* and aimed to establish a split in the market between purchasers and providers of health care services. In this case, the purchasers were all the general practitioners and district health authorities that worked with their patients' interests. General practitioners were still working for the NHS and were paid on the basis of the number of people who were registered with their practice instead of a fee-for-service basis[56]. On the other hand, the providers were hospitals that provided specific services, those that could be sold to purchasers of health care. This division would then encourage providers to compete with one another in order to obtain more purchasers. Ideally, providers would concentrate on an area of expertise and would therefore be able to provide these specific services at a cheaper price than other hospitals.

This competition would reduce costs and create incentives for purchasers to save costs as general practitioners were allowed to keep a certain proportion of the saved costs for themselves. General practitioners would then shop for the best medical services available in a marketplace offering different prices and services. As a result of the development of the internal market, administrative costs increased and patients had fewer options of medical services since general practitioners began negotiating their services with a small number of providers in order to save costs. In addition, hospitals that wanted to reduce cost by getting rid of inefficient or low demand services, were not able to eliminate them as these were required to have a minimum amount of services and emergency departments in their facilities. In the end, the 1990's reforms did not bring immediate noticeable change. This was due to the fact that both providers and purchasers (GP and hospitals) were run under the NHS, meaning there was no real competition because one single player controlled the marketplace.

The Private Health Care Market in Britain

Besides having a well-established public health care system, Britain had a very small private market that co-existed with the public one. In 1991, approximately 17% of total health expenditures came from the private market[57], some of which included dental services that were not

covered by the public system. With the inclusion of a private market, health care in the United Kingdom became organized into four categories. The first category was health care that was publicly provided and publicly funded. This accounted for the great majority of medical practices, including general practice, emergency care, maternity care and non-elective surgery. The second category consisted of publicly provided but privately financed health care. This category was made up mainly of "pay-beds" services, where public hospitals would provide their facilities to consultants that would treat patients on a private basis and for which the patients had to pay for their services. Services such as dentistry were also covered in this category, as dentists would use public facilities to provide their services to customers willing to pay for their services. The third category consists of privately provided but publicly financed health services such as long-term care for the elderly and the mentally ill. It also included services such as elective surgery that was delivered by private providers. The last category consists of privately funded and privately provided health care, including a small number of elective surgeries and medical procedures, and pharmaceutical services[58].

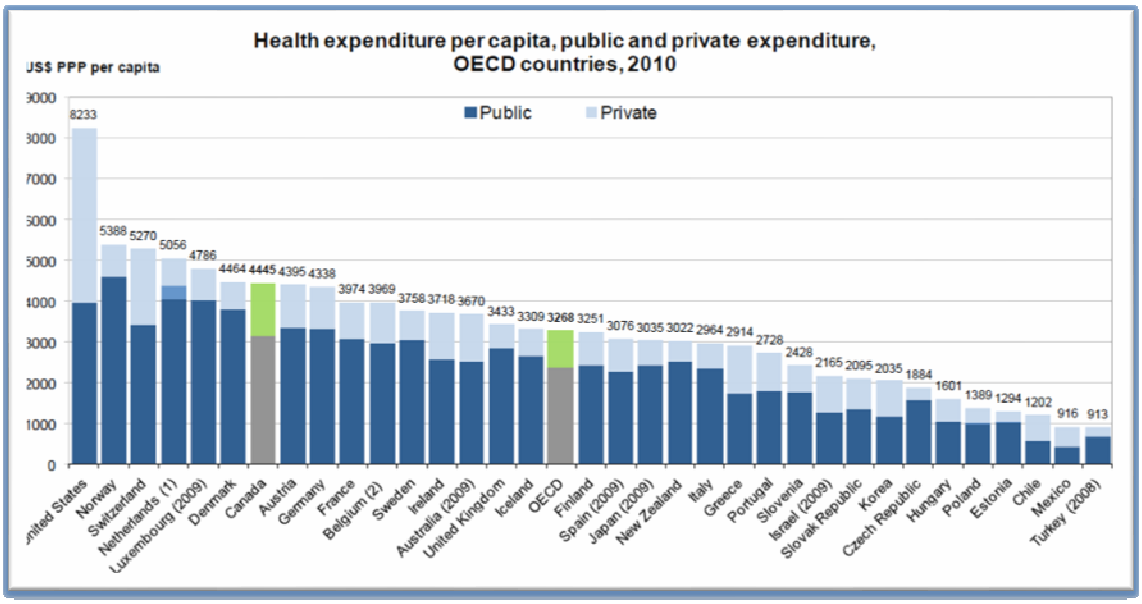
Two decades after the reform took place, evidence suggested that there had not been significant changes to the system. Nonetheless, the evidence also showed that there were no signs of failure from the system. Looking to improve, in 2003 the NHS decided to raise taxes and fund new initiatives in the health care system. As a result, medical schools

increased their enrolment by over half; more nurses were hired; hospitals were built and electronic information technology systems were put into place[59]. Recent health care indicators have shown that these initiatives have had positive outcomes, as there have been substantial drops in waiting times for diagnosis and treatment at both the primary and secondary levels. In addition, patients are treated more quickly in emergency rooms, there are more screening for major diseases taking place, and there are fewer individuals dying from cancer and heart disease[60]. Even with the initiatives taken in 2003, health spending in the United Kingdom was affected by the financial crisis in 2008 as it's health spending to GDP ratio increased and continues to rise to this date. Nonetheless, the UK's spending per capita remains at a level a little over 40 percent of that in the U.S. at approximately $3,433 per capita[61].

The Importance of the Single-Payer System

Evidence shows that both Canada and the United Kingdom, having a single-payer system to cover health care services, have been more efficient at reducing cost in comparison to the United States[62]. Table 6 shows the health expenditures per capita in all OECD countries. In the case of the United Kingdom, their expenditures per capita are $3,433, compared to Canada's $4,445, and the United States' $8,233.

Table 6.



In Canada provincial governments are responsible for all payments, thereby creating a monopoly in health care where the governing bodies decide how to administer most services. England adopted a similar approach with the creation of the NHS, with the exception that they were employing general physicians and contractors, a task that provincial governments in Canada avoided.

One of the most important advantages that the single payer system has is the ability of the governing body to negotiate the prices of health care services. For instance, Canadian Medicare is able to pay physicians on a fee-for-service basis that is previously agreed on by the provincial medical association. Having the ability to budget and plan health care costs in advance result in savings for both the Canadian and British system. Physician's fees and hospital budgets are negotiated on a yearly

basis by government and medical representatives. Planning costs through a single payer system also allows allocating costly technological equipment by need, reducing the cost of maintenance and maximizing the use of these machines[63]. In addition, having a single payer system results in a reduction of administrative costs as all the billing and paperwork is managed by one entity. The United States, however, has more than 1,500 different payers[64], making it significantly harder to administer costs. Canadian physicians submit a simple and standardized form in which they list the services provided to the patient, and then provincial government proceed to reimburse these physicians for their services[65].

The idea of having a macro-management approach in the health care system suggests that this is more efficient and cost-effective than having multiple payers of health care like in the United States. By giving one entity the power to control health care (whether it is provincial governments or the NHS) it is possible to avoid health care inflation and therefore manage and delivery funds in a more organized and controlled manner. Nevertheless, the idea of having a single-payer system in the U.S. has not resonated with many organizations and has created much controversy. The Republican party in the United States has made it clear throughout the debate on the Affordable Care Act that imposing a single payer system would result in government control over citizens' lives, giving federal and state governments more power than what they should have. In addition, the Republican Party has a set conservative ideology in

which they believe people should not be obliged to pay more taxes or fees if they opted out of buying insurance. American's belief in a free market and the regulation of it without much government involvement has made it extremely difficult for the people to believe in the benefits of regulating health care costs and services through the government. In addition, special interest groups have created a strong advocacy force in order to avoid the single payer system. Companies in the pharmaceutical industry, the Health Insurance Association of America, and wealthy lobbyist groups have spent their resources opposing the implementation of universal health care, as this would impose regulation on their prices.

Part III

The Value of International Comparisons

In order to evaluate the effectiveness of each country's health care, and which offer better services at lower cost, several indicators need to be taken into consideration. First of all, its important to understand that Canada, Britain, and the United States have had different approaches to the administration of health care, including the rationale for creating each system. For example, the British NHS was a postwar creation, showing signs of the centralization and expansion of government authority, as well as austerity[66]. The NHS represents a major change in the delivery and administration of health care in the world, giving control to the state and

decreasing the role of private finance by reorganizing the system into a set of geographically based hierarchies[67]. Its underlying purpose was to have a central organization that would be able to control and administer medical costs, providing health care to the entire population. Unlike the British system, the Canadian and American health care systems were established in later years when the health care financing model had been more developed. It was during the 1960's, that the model adopted was one of state-sponsored insurance that "expanded the role of the state vis-à-vis private finance and reduced reliance on market mechanisms for the financing of health care, while leaving in place a health care delivery system consisting of a myriad independent units"[68]. The difference was that the Canadian system adopted a universal coverage approach for all its medical and hospital services, while the United States restricted coverage to certain population groups: the elderly, the disabled, and recipients of public assistance. Those who did not qualify for government programs in the United States had to look for ways to get health insurance. Insurance companies worked with corporations and companies to create a plan in which they would provide their employees insurance through their employers. This trend is still reflected in the present, where most health insurance in the U.S. is primarily employee based.

In Canada and Britain, physicians and field professionals played an important role in the decision-making process and were much more

involved in the system, as they were able to negotiate with the state the prices for their services. The United States took a different approach by allowing private markets to be the predominant force for resource allocation as well as the delivery of health care. As all three systems became more established towards the 1990's, it became clear that each on of them had taken a specific approach on the provision and delivery of health care. Britain had given the state and its actors the power to create a hierarchical mechanism in which all health care related expenditures were controlled by the state. The United States was relying on private finance and market mechanisms, while Canada had a single payer system that gave power to each province to manage their health care, in addition to medical profession and collegial mechanisms.

Canadian health care administration shifted from the federal government to provincial government, Britain continued to control their internal market by having both the provider and the purchaser supervised by the state, while the United States growing health insurance business allowed for multiple opportunities to shift costs and cost-bearing risks. The reliance of the U.S. on market mechanisms and private finance in the health care arena has become a problem that countries like Canada and Britain do not have to face since most of the control is given to the state. This suggests that having federal or provincial government intervention in the health care arena can help to regulate costs, and most importantly to keep the nation's citizens healthy. Nonetheless, even thought health care

costs are an indicator used to measure the quality of health care in a country, there are other signs that need to be taken into consideration when determining which is the best health care system. The chart below[69] shows the general health status by age groups between Canada and the United States. In all the age groups, a higher percentage of Canadians reported feeling "excellent, very good, or good" in terms of health, while a higher number of Americans reported feeling in a "fair or poor" health condition.

Table 1
General health status by age group, Canada and United States, 2002/03

	Canada		United States	
	%	95% confidence interval	%	95% confidence interval
18-44				
Excellent/Very good/Good	94.0*	92.7, 95.2	91.5*	90.3, 92.8
Fair/Poor	6.0*	4.8, 7.3	8.5*	7.2, 9.7
45-64				
Excellent/Very good/Good	87.1*	84.8, 89.3	82.8*	80.9, 84.7
Fair/Poor	12.9*	10.7, 15.2	17.2*	15.3, 19.1
65+				
Excellent/Very good/Good	72.7	69.2, 76.1	71.1	68.2, 73.9
Fair/Poor	27.3	23.9, 30.8	28.9	26.1, 31.8
All‡				
Excellent/Very good/Good	88.3*	87.3, 89.3	85.4*	84.8, 86.1
Fair/Poor	11.7*	10.7, 12.7	14.6*	13.9, 15.2

Data source: Joint Canada/United States Survey of Health, 2002/03
Notes: Household population aged 18 and over.
Missing data ("I don't know", "not stated", "refusal") have been excluded from the analysis.
‡ Age-adjusted percents calculated using the projected 2000 U.S. standard population.
** Statistically significant difference between Canada and U.S. ($p < 0.05$).*

Joint Canada/United States Survey of Health, 2002-03 — Statistics Canada, Catalogue 82M0022-XIE

It is important to understand that health care systems around the world are different and that there is no exact formula or universal model that can be put in place in order to have a successful health care system. Each country must create a system based on its needs, availability of services and funds, and demographics. Nonetheless, international organizations have tried to rank and evaluate nations' performances on

the health care arena by measuring different variables. There are qualitative and quantitative difficulties when trying to rank health care systems in the developed world, as the structure and procedures for each country are different, making it complicated to compare one to another.

Comparing Country Characteristics

There are specific characteristics in health care systems around the world that international organizations and governing bodies approved, all of which aim to provide a standard of what an ideal health care system should be. Some of these characteristics are: economic advancement, availability of basic health services, technology. In terms of economic advancement and health care expenditures, the most common way of comparing countries is through their GDP per capita. Countries measure the cost of health care by calculating the percentage of the total GDP per capita that was spent on health care. The reason that this economic indicator focuses more on expenditures than on economic growth is because, in most cases, improvement of health conditions is linked to economic progress[70]. Besides looking at the cost of health care in a country in relation to their income level, indicators such as the availability of physicians, hospitals, and public health services are also important

measures of access to health care. A country's availability of basic services can be measured by looking at specific services such as immunizations, number of physicians, and number of hospital beds. Technology can also be used to measure a country's health care quality by looking at the type of technology they use for their surgical procedures, and the use of it in the medical arena.

Besides having these indicators, it is also important to measure the outcome that developed health care systems can have on the population. In order to measure the performance of these systems, there are certain measurements of health systems that focus entirely on the outcome of these health services. These outcomes are generally categorized by system outcomes and by patient and population outcomes. Within the health system outcomes, some of the measurements include: percentage of the population covered by insurance, efficiency and effectiveness of the health care delivery system, and the kinds of benefits available to those who have insurance. For the patient outcomes, the performance of a system is based on measurements such as: life expectancy, infant mortality, and causes of deaths[71]. There are also indicators that measure patients' satisfaction and the way in which they perceive they are treated by the health care system. These are useful to have a reference of what the overall population feeling is towards health care, and what areas could use improvement.

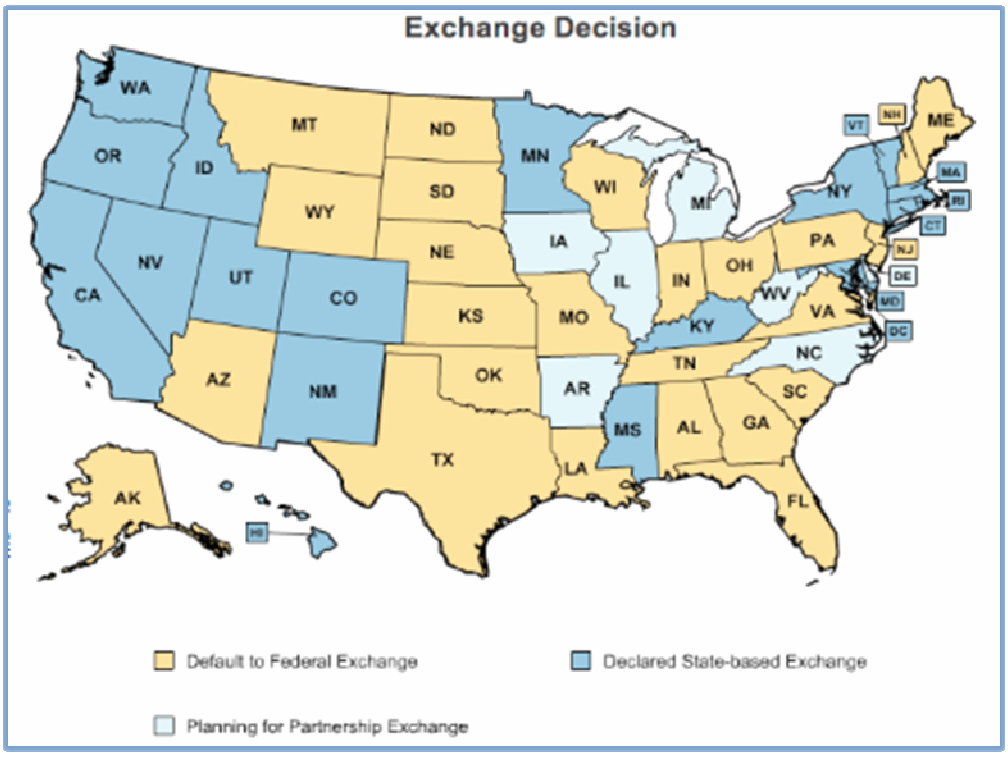
However, patient satisfaction surveys and indicators have to be used carefully, as they can be highly subjective. For instance, patients in Canada indicated that they were unsatisfied with the health care provided by the provincial government as access to health care was becoming increasingly difficult due to the long waiting times. Nonetheless, the World Health Organization has rated Canada as having the best overall quality of life, based on a number of social well-being measures[72]. The subjectivity of patient information can be useful to make improvements within the country, but can become a challenge when trying to use them to compare patient satisfaction at an international level. In order for these surveys to be accurate, patients in each country would need to experience different health care systems in order to have a point of comparison other than their own system.

Each country seems to have an "amorphous but potent set of values (most often some articulation of 'choice' or 'equity') that simply seems to matter a great deal to the citizens of that particular country"[73]. In the case of the United States, opponents of the Patient Protection and Affordable Care Act (ACA) argue that health insurance should not be required by the state, as citizens should have the power and free choice to decide what they want or do not want to buy. Even though the ACA aims to address many of the issues of the current health care system in the U.S., some citizens continue to disapprove of the measures that have been taken in order to achieve these goals. The Republicans have portrayed the PPACA

as unconstitutional, claiming that it will increase health care costs, insurance premiums to rise, hurt the quality of health care, creating nearly $570 billion in tax hikes, and adding over $500 million to the debt[74].

However, these claims by the Republicans contradict the findings by experts in health care who argue that if the Patient Protection and Affordable Care Act had not been passed, by 2019 18.5 percent of the total population of the United States would be living without health insurance[75]. This means that approximately 62 million Americans would be uninsured by 2019. With the approval of the ACA, every employer with more than fifty employees can choose to offer health insurance coverage to their workers or to pay a tax to the federal government. In addition, the individual mandate of the ACA will require by 2014 that all U.S citizens and permanent residents obtain health insurance coverage; those who are not eligible for health insurance through their employers will be guaranteed an option through the Health Benefit Exchange (HBE)[76]. The HBE is an organization in charge of providing affordable health insurance options to families and individuals who do not obtain it through their employer by looking for compatible health insurance coverage depending on a family's needs and income. HBEs will have to be operated by either a state government or a non-profit organization, providing the best health insurance option for buyers. Interestingly, the Republican discourse has influenced many states to opt out of creating a state run health insurance

exchange. The following maps highlights those states that have enrolled, opted out, and planning a partnership for this exchange:



Today, there are twenty-five states in the country that have opted out of federal HBEs. One of the requirements for HBEs is to offer at least two options for health insurance, one of them being provided by a non-profit insurer[77]. Those individuals who decide not to obtain health insurance coverage will have to pay a tax penalty that will not exceed 2.5 percent of their taxable income. Furthermore, the ACA will extend coverage to people in the United States with incomes below 133 percent of the federal poverty line (FPL). With these regulations in place, it is expected that health insurance coverage will be provided to 32 million people by 2019. Half of these new insurance holders will be enrolled in

Medicaid while the other half will be either covered by their employers or by HBEs affordable programs[78].

Even knowing the positive aspects that the ACA will bring, there are still groups that are opposed to this health care reform in the U.S., mostly because they consider the implementation of it as a restriction of their right to exercise their free will. One of the reasons why evaluating or ranking health care systems around the world is complicated is because of cases like the one in the U.S., where the government is working to implement a program to improve health conditions in the country, but some of its citizens believe that by doing so the government is going against the norms and values for which they stand. There are, then, a number of ideal situations for health care systems that can be measured in order to determine the quality of health care in a country, but not a universal or definite one that all systems can be evaluated with.

Nonetheless, comparing information among countries can benefit all the different systems because their features can be examined and evaluated in order to find patterns of efficient and successful policies. By comparing health care systems, it is possible to determine which elements of financing, delivery, or other variables are producing results and then can be adjusted to different health care systems to meet their demands. The World Health Organization (WHO), the World Bank, and the Organization for Economic Cooperation and Development (OECD) have studied and established different ways in which it is possible to measure

the health care services and quality in a country. These examinations of high quality, universal access and reasonable cost can help determine what areas can be improved in a country's system and which can be used as a model for others[79]. However, not all health care characteristics are comparable among countries. Having information reported in different formats can affect the outcome of the study, as this provides less accurate information to work with. Even though this problem is more evident when comparing developing countries to developed countries, there are still a number of comparisons that present a challenge to organizations such as WHO or the World Bank who compile this data. For example, financial comparisons can be questionable since exchange rates among national currencies are used to convert each cost or expenditure to a common set of numbers[80].

In order to compare health care systems at a financial level, researches also have to take into consideration aspects such as the purchasing power parities (PPP) can be a useful indicator to measure health care expenditures since it takes into account the differences in prices for services between countries, instead of just looking at the amount spent in services. Besides financial comparisons, making health status comparisons can also be an arduous task for researches since the data is subject to different variables. Indicators such as child mortality or life expectancy are two common health care performance indicators among countries, but even these can be insufficient as there are variables

such as historical, cultural, political, demographic and social differences that can't be measured in these indicators.

Nevertheless, having international comparisons can be useful to countries that are developing new policies or that are looking to improve their current system by implementing ideas that have been proven successful in other countries and shaping them to their needs. In addition, these comparisons allow policy makers to identify essential components of the health care system and the different influences that cased each system to evolve to its present state[81]. Cultural influences, political system, environmental conditions, demography of the population and the social organization of health care are just a few of the components of health care that can be useful in determining what the best policies or health care programs for a country can be.

Conclusion

This research paper has explored two of the main problems in the health care arena in the United States, looked at two universal health care foreign models, and analyzed the different criteria and obstacles when comparing health care systems. By studying the current situation of the uninsured and elderly population in the United States, it has become clear what the problems regarding cost, quality, and access of medical services are and how they need to be addressed. In addition, comparing foreign health care models that have addressed some of these issues has been

helpful to find solutions that could be implemented in the U.S. One of the biggest problems in the U.S, if not the biggest, is the increasing cost of medical services. Having the highest spending per capita among OECD countries, the United States must make changes in the health care system to be able to provide for its citizens in the years to come.

Canada and Britain have both addressed the problem of having an uninsured population by creating a universal health care system in their countries. Due to the structure of the health care system in the United States, implementing universal health care over a short period of time would not only have an economic impact on the private insurance market but would go against the beliefs of many Americans who do not approve of the government controlling like Canada and Britain do. The Republican Party has been a major actor in this debate, as they are strongly opposed to any sort of federal intervention or supervision that gives government more control over the economy. Republicans are against the Affordable Care Act, claiming that government-run universal health care leads to inefficiencies, long waiting periods, and often substandard health care[82]. However, the research in this project shows that even though countries with universal health care do face problems such as longer waiting times, the overall health of its citizens is better than in the U.S., while at the same time reducing the cost. The Republican discourse in the health care arena emphasizes the importance of having consumer choice instead of government intervention. They support the private practice model of

medicine instead of the socialized medicine model in the form of a government-run universal health care system. This retrogressive mentality continues to impose obstacles to the improvement of health care in the country as Republicans have and will continue to obstruct the implementation of the ACA. The United States congressional system can be counterproductive in an area such as health care, as the procedures to get new laws approved require more time and approvals than in a parliamentary system like the one Canada and Britain have in place.

One of the reasons implementing universal health care in Canada and Britain was easier than what it has been in the United States has to do with the type of government implemented in the country. With a parliamentary system, the elected party has much more freedom to go through its agenda without opposition. In the case of health care, having a parliamentary system would allow health care reforms to be implemented in a faster manner than in a congressional system. In a congressional system, like the one in the United States, the passage of a law or reform has to go through committees, votes in both houses and a number of protocols that delay, and in some cases obstruct entirely, the implementation of these reforms. In the case of health care reform, having a congressional system has had a negative impact as republicans are constantly opposing changes in the current system. In addition due to the way in which federalism operates in the U.S., provisions of the ACA can also be delayed or blocked at the state level.

The ideal of a perfect and flawless health care system is a utopia, for there will be tradeoffs in any model that is implemented. Universal health care models will have longer waiting times and some inefficiency, but they guarantee coverage and medical attention to its entire population. The private insurance market model used in the U.S. could be successful if every individual in the country had insurance, but unfortunately there are still over 60 million people without it who are subject either to lack of medical services or expensive medical bills. It is clear that the health care model is in need for a change, and that even the best models can't solve some of the problems the current system has. Empirical data shows that if present trends continue, health care in the United States will face a crisis where the Medicare fund will run out, people will continue to be uninsured and the cost of medical services will increase. In order to improve the system, the solution has to come first from the political sphere where all the parties come together and understand that the old private practice and insurance model is no longer cost-efficient or manageable.

[1] Donald A. Barr, *Introduction to U.S. Health Policy: The Organization, Financing, and Delivery of Health Care in America*. Baltimore: The Johns Hopkins University Press, 2011. Preface

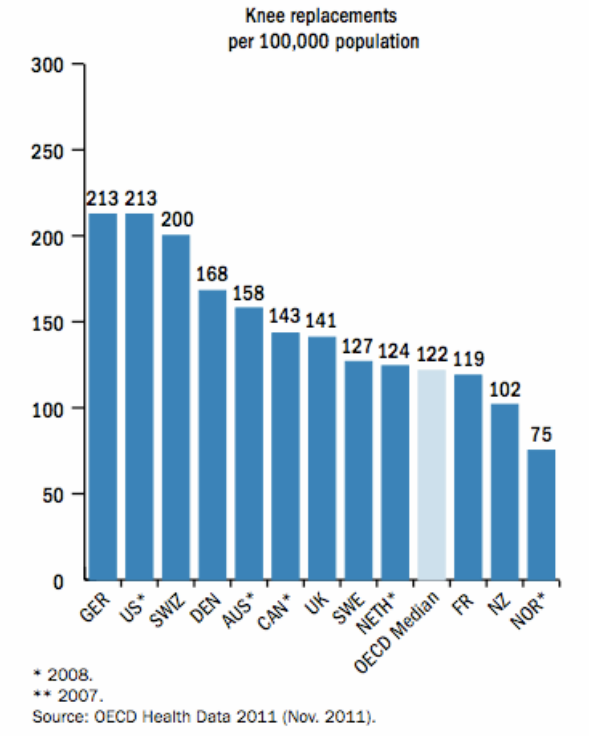
[2] Squires, David A. *Explaining High Health Care Spending in the United States: An International Comparison of Supply, Utilization, Prices, and Quality.* The Commonwealth Fund, May 3, 2012. Vol. 10 http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/May/1595_Squires_explaining_high_hlt_care_spending_intl_brief.pdf

Exhibit 2. Health Spending in Select OECD Countries, 2009

	Population (millions)	GDP per capita[b]	Total health spending		Health spending, by source of financing		
			Per capita[b]	% GDP	Public	Private	Out-of-pocket
Australia	22.0	$39,924	$3,445[a]	8.7%[a]	$2,342[a]	$476[a]	$627[a]
Canada	33.4	$38,230	$4,363	11.4%	$3,081	$646	$636
Denmark	5.5	$37,706	$4,348	11.5%	—	—	—
France	62.6	$33,763	$3,978	11.8%	$3,100	$587	$291
Germany	81.9	$36,328	$4,218	11.6%	$3,242	$424	$552
Japan	127.5	$32,431	$2,878[a]	8.5%[a]	$2,325[a]	$99[a]	$454[a]
Netherlands	16.4	$41,085	$4,914	12.0%	—	—	—
New Zealand	4.3	$28,985	$2,983	10.3%	$2,400	$184	$399
Norway	4.8	$55,730	$5,352	9.6%	$4,501	$43	$808
Sweden	9.3	$37,155	$3,722	10.0%	$3,033	$69	$620
Switzerland	7.7	$45,150	$5,144	11.4%	$3,072	$504	$1,568
United Kingdom	60.9	$35,656	$3,487	9.8%	$2,935	$188	$364
United States	306.7	$45,797	$7,960	17.4%	$3,795	$3,189	$976
OECD Median	***10.7***	***$33,434***	***$3,182***	***9.5%***	***$2,400***	***$193***	***$559***

[a] 2008.
[b] Adjusted for differences in cost of living.
Source: OECD Health Data 2011 (Nov. 2011).

[3] Squires, Pg 11
[4] Barr, Pg 24
[5] Barr, Pg 24
[6] Barr, Pg 24
[7] Squires, Pg 1



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[9] Squires, Pg 7

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Exhibit 9. Diagnostic Imaging in Select OECD Countries

	MRI machines			CT scanners			PET scanners	Mammographs
	Devices per million pop., 2009[c]	Exams per 1,000 pop., 2009[c]	MRI scan fees, 2011[d]	Devices per million pop., 2009[c]	Exams per 1,000 pop., 2009[c]	CT scan (head) fees, 2011[d]	Devices per million pop., 2009[c]	Devices per million pop., 2009[c]
Australia	5.9	23.3	—	38.7	93.9	—	1.1	24.3
Canada	8.0	43.0	—	13.9	125.4	$122[e]	1.1	—
Denmark	15.4	37.8[a]	—	23.7	83.8[a]	—	5.6	17.0
France	6.5	55.2	$281	11.1	138.7	$141	0.9	—
Germany	—	—	$599	—	—	$272	—	—
Japan	43.1[a]	—	—	97.3[a]	—	—	3.7[a]	29.7[a]
Netherlands	11.0	43.9	—	11.3	65.7	—	4.5	—
New Zealand	9.7	—	—	14.6	—	—	0.5	26.4
Switzerland	—	—	$903	32.8	—	$319	3.0	33.2
United Kingdom	5.6[a]	—	—	7.4a	—	—	—	9.0
United States	25.9[b]	91.2[b]	$1,080[f]	34.3[b]	227.9[b]	$510[f]	3.1[a]	40.2[a]
Median (countries shown)	***8.9***	***43.0***	—	***15.1***	***122.8***	—	***1.1***	***17.3***

[a] 2008.
[b] 2007.
[c] Source: OECD Health Data 2011 (Nov. 2011).
[d] Source: International Federation of Health Plans, *2011 Comparative Price Report: Medical and Hospital Fees by Country* (London: IFHP, 2011).
[e] Nova Scotia only.
[f] U.S. commercial average.

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