

Transcript
Comparative Health Systems, Part 1

Lecture companion to Chapter 4.

1. Welcome to Comparative Health Systems, part 1. The lecture is a companion to Jonas & Kovner's Health Care Delivery in the United States, Chapter Four, Comparative Health Systems.
2. The presentation objectives include:
 - Compare U.S. health outcomes to other countries
 - Compare U.S. health spending to other countries
 - Review the concept of health care as a right throughout the world
 - Define classifications of national health systems
3. The lines in this chart show the life expectancy of males and females as compared to the median OECD countries. The blue line shows that U.S. women; the red line is U.S. men. This chart shows that, compared with other OECD countries in the early 1990s, the U.S. life expectancy was similar to the average of the OECD countries, especially for females, but the other countries have improved more than the United States over the last 20 years. We are not expected to live as long as other industrialized countries, on average.
4. And these disparities between the U.S. and other OECD countries are rising. Life expectancy at birth in the U.S. declined in 2016 and 2017, according to the CDC's National Center for Health Statistics. Many reasons are to blame, not the least of which are the opioid epidemic and increased suicides.
5. According to the World Health Organization, we are in the top tier for life expectancy at 60 years old. However, our 23 year life expectancy at 60 years old ranks only thirtieth in the world.
6. And this chart is probably most telling about the state of affairs with the U.S. healthcare system. The vertical axis is life expectancy measured in years, and the horizontal axis shows our per capita spending. As you can see from the red line, the U.S. has diverged from life-expectancy of the rest of these OECD countries' gains since 1980. The costs meanwhile, have continued to skyrocket. In other words, we get very little in terms of value from our healthcare system.
7. The US has the 12th highest infant mortality rates among these countries. India, South Africa, Indonesia, Columbia, Brazil, Mexico, Turkey, China, Costa Rica, Chile, and Russia have higher rates. Countries like France, Germany, United Kingdom, and Canada, all outperform the US in infant mortality.
8. The Commonwealth Fund is a private, independent research organization that also makes grants to improve health care practice and policy. This chart is from its publication called on "Health System Performance Based on Measures of Quality, Efficiency, Access, Equity, and Healthy Lives." As you can see, the United States ranks last overall compared to ten other industrialized countries - Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United Kingdom, according to the Commonwealth Fund report.

Last you say? How is this possible? I thought we had the best health system in the world.

9. According to many people's values, the U.S. health system is excellent. Read these quotes from prominent politicians. They believe that the United States has the best healthcare system in the world. So what gives? According to the Commonwealth Fund values of "quality, efficiency, access, equity, and healthy lives" we rank last. But are there other values?? What about the value of medical treatment? How does our healthcare system do for patients after diagnosis or when stricken with illness?
10. Cancer offers an opportunity to make an international comparison since the illness is common; every industrialized country collects good data, and cancer is a research and treatment priority.

This chart from the August 2008 issue of *The Lancet Oncology* shed light on our performance in providing treatment. While France excels in treating women's and Japan in men's colorectal cancer, the U.S. clearly leads other nations in overall survival for colon cancer. The vertical bar on the right of each graphic shows the contribution (%) of each continent to the total number of cases analyzed, and the red vertical line represents mean survival for the 22 European countries that participated in a cancer study.

11. Again, with breast cancer we are second in 5-year relative survival from the period of 2005 and 2009. The U.S is in the red box, trailing only Cyprus in breast cancer survival rates.
12. This chart shows percent of patients whose waiting time for a specialist appointment was four weeks or more. It includes OECD countries. What you see is that Canada and the UK have much higher proportion of patients waiting more than 4 weeks. This is rationing care through supply. For example, Canada has physician to population ratio 22% lower than U.S. I will present more on Canada and the UK health systems in the next lecture.
13. However, this chart from your textbook reveals that we are not satisfied with our U.S. healthcare system, despite viewing the local health care services more favorably than the other OECD nations, such as Australia, Germany, and Japan. In my opinion, this chart points to the confidence in medical treatment acumen, but not in the overall results of our country's healthcare system. Maybe I reading too much into it.
14. Here's another look at our healthcare spending in terms of a percentage of our gross domestic product, a measure of our total economy. As you can see, we spend much more than other countries in proportion the total economy – over 17% of our GDP is spent on health care. Most other comparable countries are around 10% of GDP.
15. There are many suggested explanatory factors for the higher level of U.S. health spending, and all are probably true to some extent. Some of the more popular explanations include higher staff to patient ratios, adoption of newer technologies sooner, administrative complexity, and our lack of waiting lists. However, according to other analysis by [Anderson, et al. \(2005\)](#), "It's the Prices Stupid!" That is, the prices of health care workers' salaries (including physician salaries), medical equipment, and pharmaceutical and other supplies, are more expensive than in other countries. While on most of health services utilization, the United States uses less services than the OECD median, U.S. system tends to deliver more of the really expensive services, such as coronary angioplasties and kidney dialyses. It is true that the U.S. government has relatively limited power to

control prices of healthcare. We'll talk about single payer price list controls in relation to Japan in the next lecture. Also, many mention malpractice litigation and/or defensive medicine as the culprit for higher healthcare spending, but [Anderson et al. \(2005\)](#) found that it was a small part of our problem. Finally, in the lectures on healthcare finance, we discussed the incentives associated with fee-for-service payment schemes. That is, [literature](#) shows that providers have the incentive to deliver more health services because they are paid for each one. This may be true, but it is hard to imagine this is the reason for our high costs, as many other lower cost countries also rely on the fee-for-service payment system for physicians. I will mention several in the next module.

16. The first question for a society to answer when determining whether to have nationalized health care is whether they view health care as a right or not. For example, in the U.S. we consider education from kindergarten through high school a right, and as a result we fund education through taxes. However, we do not view owning a car as a right. Only if one has the funds to purchase a car is one able to obtain a car.

According to [Eleanor Kinney \(2001\)](#), a right to health can be understood as a continuum. At the very least, it means a right to conditions that protect population health. Although, maybe it also includes the basic civil rights to access health care services. At a maximum, perhaps, it could mean medical care for all.

There is a right to health under international law. The [1948 Universal Declaration of Human Rights](#) by the UN General Assembly set the right to health as a common standard for all humanity. The Declaration sets forth the right to a "standard of living adequate for the health and well-being of himself and his family, including . . . medical care and . . . the right to security in the event of . . . sickness, disability . . . or other lack of livelihood in circumstances beyond his control."

Interestingly, it is possible that the United States does not meet this basic human standard, according to [Alicia Ely Yamin \(2005\)](#). She argues that we should hold the government accountable for violating this basic human right, as evidenced by the great racial and ethnic disparities in terms of our health outcomes in the United States. We will discuss racial and ethnic disparities more in the lecture on Population Health.

17. Why should we study different health care systems? First, many countries have constructed programs that predate U.S. programs by decades. There is a wide variation in programs and experiences that's worth discovering in and of itself. Second, even with implementation of the ACA, the U.S. system has some huge holes in coverage compared with many other systems. Also, most health outcomes are better in other countries, while they spend less of their GDP on health care. As a general principle it is always a good idea to understand other approaches to provide important clues to assessing our own system. As you'll learn, many industrialized countries either provide health care directly through the government or publicly funded health insurance with comprehensive coverage (or both).
18. Some countries support private insurance market approach with a state subsidy. Countries with traditional sickness insurance are Germany, Austria, Belgium, France, Luxembourg, and the Netherlands. Those with national health insurance are Canada, Finland, Norway, Spain and Sweden. These are called single-payer systems. Countries with national health services where the government also provides health care delivery are Denmark, Greece, Italy, New Zealand, Turkey and the United

Kingdom. Mixed systems contain elements of both traditional sickness insurance and national health insurance. Countries with mixed systems include Australia, Iceland, Ireland, Japan, Switzerland, and the United States.

19. Here are the take-aways from this lecture. First, the U.S. ranks poorly on many measures of health outcomes, such as equity and life expectancy. However, U.S. outperforms others in many medical intervention-oriented health outcomes. U.S. spends vastly more on healthcare. And finally, there are many different types of national healthcare systems in world.
20. In the next lecture, we will review four different health systems, including the United Kingdom, Germany, Canada, and Japan. I will conclude with thoughts on the comparable components of the U.S. system.