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POLICY BRIEF

Do socialized health care systems in other countries offer a model for the United States?

By Dr. Roger Stark, Policy Analyst,
Center for Health Care

July 2019

Key Findings

1. The United States has a complex health care delivery system composed of private and government funded insurance plans.
2. Other countries have a much more uniform health care delivery system that began with planned, top-down government control.
3. The United States spends far more on health care than other industrialized countries.
4. Looking to other countries to solve our health care delivery system problems may not be reasonable. Other countries are smaller than the U.S. and have more homogenous populations.
5. The demand for health care far outstrips the money budgeted for it in all other countries and rationing of medical care by the government is common. Some patients are denied care to save money.
6. Just as in the U.S., every other country faces the demographic problem of an aging population and a decreasing work-force to pay taxes for their seniors' health care.
7. While the U.S. does spend more on health care than other industrialized countries, the U.S. also leads the world in financing medical innovations.
8. While universal health insurance coverage is the goal of other countries, the critical point is utilizing the best mechanism to allow the greatest number of Americans access to health care.
9. Just like in all other economic activities, the private free-market offers the best solution to provide the greatest access to health care and to control costs.

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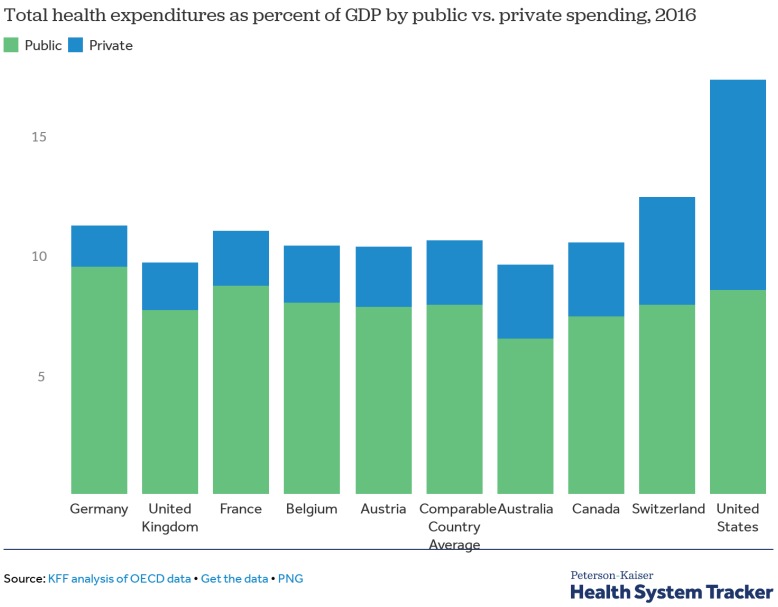
Introduction

The United States has a complex health care delivery system composed of private and government funded insurance plans. Half of all Americans receive their health insurance from their employer or their spouse's employer. Over forty percent of Americans receive their health insurance from the government, through Medicare, Medicaid, the Veterans Administration, the Affordable Care Act exchanges, and the Native Health Service. The remainder of Americans are either uninsured or obtain health insurance through the private individual market.

The United States spends far more money per-person on health care than other industrialized countries. Last year, overall medical spending in the U.S. totaled $3.5 trillion or 18 percent of the national gross domestic product.[1] Switzerland was the second highest spender at 11 percent of GDP.[2]



Supporters of the Affordable Care Act, also known as Obamacare, promised universal health insurance coverage, while claiming to bring down overall spending on medical care in the U.S. After nine years of experience with the law, the reality is

1 "National Health Expenditure Data," Centers for Medicare and Medicaid Services, CMS.gov, December 11, 2018, at https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html.

2 "How does health spending in the U.S. compare to other countries?," by B. Sawyer and C. Cox, Peterson-Kaiser Health System Tracker, December 7, 2018, at https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#item-u-s-similar-public-spending-private-sector-spending-triple-comparable-countries.

quite different. Only 40 percent of those who were uninsured when the law passed in 2010 now have health insurance. Costs continue to increase and all Americans, except those in the Medicaid entitlement, pay more for health care now than when the Affordable Care Act passed.

The U.S. is now at a health care crossroads. Progressives on the left are strongly arguing for greater public-sector control, through a single-payer, government-run system or through incremental moves toward such a system. A Medicare or Medicaid buy-in, dropping the age of Medicare eligibility, and a public option are gaining traction in the national debate. The private alternative revolves around more consumerism, with measures that give patients more direct control over their health care dollars and medical decisions.

Other countries' health care systems are frequently cited as providing the solution for the U.S. It is not clear, however, whether systems in other countries offer a workable health care model for Americans. This Policy Brief examines the health care delivery systems in the other leading industrialized countries and looks at the possible applicability of these systems in the U.S.

Background

The current U.S. health care system developed through policy actions taken at three separate and specific points in time. In 1943 during World War II, the government placed wage and price controls essentially on the entire economy. Employers were not allowed to compete for new employees based on offering higher wages because of the government controls. The federal government did allow employers to provide health care benefits instead of higher wages, and in addition allowed employers to deduct the cost of that health insurance from their company income taxes. The result was to make the purchase of health insurance cheaper for companies than it is for individuals and families. This was the beginning of the employer-paid model which is now firmly established in the U.S.

The second important date is 1965, when the Medicare and Medicaid entitlements were passed into law. Twenty percent of Americans are now in the Medicaid program and seventeen percent have Medicare insurance.[3]

The third action occurred when President Obama signed the Affordable Care Act (ACA) into law in 2010, further entrenching government control over the U.S. health care delivery system. The ACA expanded Medicaid by 10 million people and provided taxpayer subsidies for 10 million individuals purchasing insurance in the health benefit exchanges.[4]

The U.S. consequently has a non-uniform health care delivery system with multiple entitlement and private insurance plans. Other countries have a much more uniform health care delivery system that began with planned, top-down government control.

3 "Health Care Coverage in the United States," by E. Berchik, E. Hood, and J. Barnett, United States Census Bureau, September 12, 2018, at https://www.census.gov/library/publications/2018/demo/p60-264.html.

4 "Since Obamacare Became Law, 20 million more Americans Have Gained Health Insurance," by Bloomberg, fortune.com, November 15, 2018, at http://fortune.com/2018/11/15/obamacare-americans-with-health-insurance-uninsured/.

The United States health care ranking among other industrialized countries

The most commonly quoted publication that ranks countries' health care delivery system is a World Health Organization (WHO) study from 2000.[5] The U.S. ranked 37th out of 191 countries in the report, behind Greece, Morocco, and Columbia.

The paper's authors placed a ranking-number on five separate health care delivery system criteria and then added the results of those five to get a total number for each country. From the paper itself:

" …country attainment on all five indicators (i.e., health, health inequality, responsiveness-level, responsiveness-distribution, and fair-financing) were rescaled… Then the following weights were used to construct the overall composite measure: 25% for health, 25% for health inequality, 12.5% for the level of responsiveness, 12.5% for the distribution of responsiveness, and 25% for fairness in financing. These weights are based on a survey carried out by WHO to elicit stated preferences of individuals in their relative valuations of the goals of the health system."

The WHO-selected criteria of health inequality, distribution of responsiveness, and fairness in financing give an advantage to countries with either a single-payer system or countries with some form of universal health insurance coverage. In other words, because the U.S. does not have a top-down, government-run health care system, America began the rankings with a 62.5 percent handicap. We ranked very well in the health and level of responsiveness categories.

The tragedy is that the ranking of 37th is used repeatedly in health care debates and does a disservice to the excellent medical outcomes and overall responsiveness of the current U.S. health care system. The high quality of the U.S. system is confirmed by the strong desire of many sick people from around the world to travel to the United States for treatment.

In another flawed publication, the Commonwealth Fund has serially tracked the health care delivery systems of eleven first-world counties. The U.S. has ranked last in all of the Fund's reports for the past fifteen years.[6] As with the WHO study, the U.S. is severely penalized in the rankings for not having some form of socialized universal health coverage.

The Fund's studies also rank the U.S. poorly for medical outcomes – specifically infant mortality, longevity after age 60, and preventable mortality. However, there are explanations for these results.

The U.S. records every birth, whereas many other countries record a "live" birth only if the infant has survived a certain number of days or weeks. Longevity after 60 in the U.S. varies by only one to two years compared with other countries. And finally, preventable mortality reflects patients that actually sought medical help. If a patient died at home or of "natural causes" this is not reflected in the overall results.

5 "Measuring Overall Health System Performance For 191 Countries," by A. Tandon, C. Murray, J. Lauer, and D. Evans, World Health Organization, 2000, at https://www.who.int/healthinfo/paper30.pdf.

6 "Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally," by K. Davis, K. Stremikis, D. Squires, and C. Schoen, the Commonwealth Fund, June 16, 2014, at https://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror-wall-2014-update-how-us-health-care-system.

Again, for treatment of specific disease entities such as heart failure, diabetes, and many forms of cancer, the U.S. results are enviable by world standards.

Health care in other countries

Great Britain

Great Britain established a comprehensive government health care system in 1948. The National Health Service (NHS) essentially gives every citizen cradle-to-grave coverage. The national system provides open access to primary care, although the general practitioner may not be of the patient's choosing. There are very modest co-pays and basically no hospital charges. The entitlement is financed through general taxes as well as a small payroll tax on workers. About ten percent of the population has private insurance and many physicians combine government entitlement work with private practice.

Health services are planned and approved by regional government agencies called Clinical Commissioning Groups. These commissions determine the value of specific treatments, who can receive them, and the number of these procedures that the NHS will provide in any given area of the country.[7]

Like many nationalized health care systems, it is difficult for people in need of care to turn their theoretical legal entitlement into access to actual health care service. Most rationing under these systems takes the form of long waiting lists. Wait times for diagnostic and specialty care in Britain became so long that the government ruled in 2010 no one should have to wait more than 18 weeks (four-and-a-half months) for treatment.[8]

Over the past year, 250,000 citizens have waited more than six months for planned treatments within the NHS, while 36,000 British have waited nine months or more.[9] Twenty five percent of cancer patients did not start their treatment at the recommended time. This is reflected in poor survival times for the common cancers of breast and prostate.

Wait times are less in the private sector and offer an alternative for those patients with the financial resources to seek private care.

Medical and administrative inefficiencies are rampant, and chronic shortages, with resulting rationing, are commonplace. Some British families have filed lawsuits claiming medical neglect of elderly parents or grandparents who died waiting to receive care. Heavy workloads are causing older doctors to retire early. The country faces a shortage of both physicians and nurses.

In spite of these problems, most British citizens have a positive, if not enthusiastic, opinion of their health care delivery system, seeing it as a source of national pride.

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7 "BrItain's Version of 'Medicare For All' Is Struggling With Long Waits For Care," by S. Pipes, Forbes.com, April 1, 2019, at https://www.forbes.com/sites/sallypipes/2019/04/01/britains-version-of-medicare-for-all-is-collapsing/#27c4b71436b8.

8 "Happy birthday to Great Britain's increasingly scandalous National Health Service," by Scott Atlas, MD, Forbes.com, July 5, 2013, at http://www.forbes.com/sites/ scottatlas/2013/07/05/happy-birthday-to-great-britains-increasingly-scandalousnational-health-service/.

9 "BrItain's Version of 'Medicare For All' Is Struggling With Long Waits For Care," by S. Pipes, Forbes.com, April 1, 2019, at https://www.forbes.com/sites/sallypipes/2019/04/01/britains-version-of-medicare-for-all-is-collapsing/#27c4b71436b8.

Germany

Germany was the first country to institute a comprehensive form of socialized health care, starting in 1883. Today, health insurance is mandatory for all German citizens and is financed through employer and employee contributions as well as the general tax fund.[10] Because of ever-increasing costs, the contribution from the general tax fund is increasing. Accident and long term care insurance are separate, but are part of the overall health care delivery system.

Anyone earning less than $71,000 a year is automatically placed in one of 118 government insurance or "sickness" funds. Eighty five percent of all Germans are enrolled in the government plans. People who earn more than $71,000 can choose to enroll in one of 42 private insurance funds, although 75 percent of these higher-income individuals have chosen to remain in the government plans.

Private insurance plans pay providers more than the government funds and consequently doctors will give private patients priority.[11] Deductibles can vary, but all funds are tightly controlled by agencies composed of government officials and providers.

Although 84 percent of Germans say they are satisfied with their health care system, there is a growing egalitarian movement to eliminate the private insurance funds and place everyone in a single, socialized government plan.

Switzerland

Switzerland has had mandated health insurance since 1996. The country uses a model of government "managed competition" with an individual mandate to purchase health insurance. It is not employer-based and relies on "private" insurers who must honor guaranteed issue rules (they must sell to anyone regardless of pre-existing conditions) and community rating (all people except for smokers are placed in the same risk pool).[12] All hospitals are private, but heavily regulated by the government.

Individuals pay approximately 30 percent of their health care expenses out-of pocket and the government subsidizes nearly one third of the cost of covering all Swiss citizens. "Private" insurance covers the balance.

Insurance companies set payments to doctors in a cartel fashion and compete on policy price and benefits. Basic benefit packages are determined by the government. Because of organized special interests, the political influence of the government is constantly expanding the mandatory basic benefit package, putting upward pressure on insurance prices.

Because employers are not involved and because the Swiss pay a high percent out-of-pocket, patients are well informed about the full cost of their health care. This has

10 "The German Health Care System," by M. Blumel and R. Busse, International Health Care Systems Profile, The Commonwealth Fund, 2016, at https://international.commonwealthfund.org/countries/germany/.

11 "Why Germans Love Their Health Insurance," by S. Kimball, Handelsbatt Today, May 15, 2017, at https://www.handelsblatt.com/today/politics/handelsblatt-explains-why-germans-love-their-health-insurance/23569646.html?ticket=ST-1005727-3KxYSepLAcxYJgml7M1k-ap6.

12 "Health care reform: lowering costs by putting patients in charge," by R. Stark, MD, Policy Brief, Washington Policy Center, June, 2015, at https://www.washingtonpolicy.org/library/docLib/Stark-_Health_care_reform_and_alternatives_to_the_Affordable_Care_Act.pdf.

led to a greater degree of informed consumerism in health care than exists in other countries.

Eighty one percent of Swiss citizens say they have a "positive" impression of their health care system.[13] Wait times are not an problem, yet because the list of government-mandated benefits in any insurance plan continues to grow, the Swiss are paying more and finding fewer options for health insurance.

Japan

Japan socialized its health delivery system in 1961, when the country required everyone to join a health insurance plan directed by the government. The entire system is essentially a pay-as-you-go plan. Retirees, the self-employed, and the unemployed are covered by the National Health Insurance Plan (NHIP), and workers are enrolled in one of the various employee plans. The NHIP is funded by the government and the employee plans are equally funded by employers and workers. Monthly premiums differ based on salary.

Waiting to receive health care services is not currently a problem, but over utilization is rampant leading to exploding costs.[14] Since 1995, when extrapolation of spending trends revealed that by year 2025 Japan would be consuming 50 percent of its GDP for medical care, the Japanese system has undergone gradual reform. Seniors must now pay an increasing fixed premium and worker co-pays have gone from 10 percent to 20 percent. Likewise, physician reimbursement has been adjusted downward and continues to be reevaluated.

Canada

The Canadian federal government passed the Canadian Health Care Act (CHA) in 1984. It is a pure single-payer system. Every Canadian is covered by the plan and theoretically has full access to medical care. The provinces administer the plan with funding provided by federal taxpayers. Government officials determine what procedures are medically necessary based on aggregated data and statistics.[15]

The CHA is a pay-as-you-go plan, which depends on having enough younger workers to pay for the health care of older and sicker individuals. Seventy-five percent of Canadians have supplementary insurance for things such as drugs and eye glasses that the CHA does not cover.

The supply of health care is overwhelmed by the demand in Canada leading to severe shortages. Consequently medical care is severely rationed through the use of long waiting lists and through limits placed on the number of certain medical procedures. Wait times vary by province and medical specialty, but on average 29 percent of adults who became ill waited two months or more to see a doctor and 18 percent waited four months or more in 2018. Specialty care in Canada is even harder

13 "Swiss are happy with their health – more or less," by J. Wurz, Health Monitor 2016, swissinfo.ch, June 24, 2016, at https://www.swissinfo.ch/eng/health-monitor-2016_swiss-are-happy-with-their-health-more-or-less/42249778.

14 "Japan's buckling health care system at a crossroads," by T. Otake, The Japan Times, February 19, 2017, at https://www.japantimes.co.jp/news/2017/02/19/national/japans-buckling-health-care-system-crossroads/#.XQl_W4hKjIV.

15 "Is a Single-payer Health Care System Right for America?," by R. Stark,MD, Policy Note, Washington Policy Center,May 2017, at https://www.washingtonpolicy.org/library/doclib/Stark-Single-Payer-Health-Care-System-5.22.2017.pdf.

to access. In 1993, the median wait time in ten provinces across 12 medical specialties was 9.3 weeks. By 2018, that number had increased to 20.0 weeks or five months.[16]

In Canada, health care costs have skyrocketed and now represent the largest expense for every province's budget. Ontario, for example, spent 43 percent of its budget on health care in 2010. Estimates show that Ontario will spend 80 percent of its budget on health care in 2030.

Almost 90 percent of Canadians live within driving distance of the United States. For those Canadians who can afford it and do not want to wait, quality health care is available in the U.S. without waiting. In reality, Canada has a two-tiered health care system, with the U.S. providing timely care for those willing and able to travel and pay more.

France

France's current health care system began in 1945 and "statutory" health insurance, as defined in law, is compulsory. Funding is through a combination of employer and employee payroll tax (50 percent), mandatory and dedicated income tax (35 percent), and taxes on drug manufacturers, alcohol and tobacco (15 percent). Private insurance covers only deductibles and some co-pays.[17]

Available treatments, pricing, and co-pays are determined by the government. Doctors may be government employees or may be in private practice. Sixty five percent of hospitals are government-run, 25 percent are private for-profit, and the remainder are private not-for-profit (most of these are cancer facilities).

Wait times vary by patient location and doctor specialty, but can run from six to eighty days.[18] For example, the wait to see a dentist averages four weeks, a gynecologist six weeks, a cardiologist seven weeks, and a dermatologist 11 weeks. When the French believe the wait is too long, over half will seek another doctor and a third will forgo being seen at all by a provider. The French attribute the long wait times to a lack of physicians.

France is struggling with increasing costs, a doctor shortage, and an aging demographic.[19] The response of elected officials to these problems is to impose more government regulation and control.

Singapore

Singapore is a city-state made up of 5.8 million people. It is a relatively new country, having established sovereignty in 1965. It has a booming economy and ranks as one of the most expensive cities in which to live.

Its health care system is truly two tiered, with 30 percent of spending occurring in the public sector and 70 percent in the private sector. Both private and public

16 "Waiting Your Turn: Wait Times for Health Care in Canada, 2018 Report," by B. Barua and D. Jacques, Fraser Institute, December 4, 2018, at https://www.fraserinstitute.org/studies/waiting-your-turn-wait-times-for-health-care-in-canada-2018.

17 "The French Health Care System," by I. Durand-Zaleski, International Health Care System Profiles, The Commonwealth Fund, 2016, at https://international.commonwealthfund.org/countries/france/.

18 What are the average waiting times to see doctors in France?," by B. McPartland, The Local, October 19, 2018, at https://www.thelocal.fr/20181009/what-are-the-average-waiting-times-to-see-doctors-in-france.

19 "Macron announces changes to France's health care system," by S. Corbet, Medicalxpress, September 18, 2018, at https://medicalxpress.com/news/2018-09-macron-france-health.html.

sectors are heavily controlled by the government and health insurance is mandatory.[20] Hospitals offer five levels of care, where the most expensive rooms are single-patient with air conditioning, private doctors, and other amenities. The least expensive level places patients in wards with seven or eight other patients who are all treated by government-employed physicians.

The government mandates that all workers set up three savings accounts; one for housing, education, and investments, one for retirement, and one for health care spending (this account functions like a health savings account).

The government also offers a second, non-mandated insurance plan for catastrophic medical problems. The cost of this insurance is very inexpensive and most citizens have it. It kicks in after the deductibles and co-pays paid by the patient are exhausted.

A third program is a safety-net plan that begins when the patient has exhausted his health savings account. The amount of financial support given to a patient depends on income, social situation, and is decided at a very local level.

Sweden

Sweden has a universal health care system that is overseen by the federal government, but administered on a local level by county councils.[21] Health care in Sweden began as a socialized system in the 18th century, but the specific administration through county councils began in 1928.[22] Local taxes pay for 70 percent of costs and the national government pays for 20 percent. Private insurance accounts for less than one percent of overall costs and patients cover the balance of health care expenses. The government controls costs through a budget ceiling and through a national committee that "promotes the efficient utilization of (health care) resources."

Doctor office visits and most pharmaceuticals are paid for out-of-pocket. The federal government sets ceilings for these charges. Children and adolescents receive free care. The overriding goals of Sweden's health care system are "equal access," "care based on need," and "cost effectiveness." The government determines the effectiveness of various treatments and "some" expensive treatments are covered. The government has the ability to deny treatment if officials determine a particular level of patient care is unjustified.

Most doctors are employed by the county councils which also manage the majority of hospitals. Private hospitals exist, although they contract with the local county council.

Swedish law states that no patient can wait longer than 90 days, although the law has little real meaning since 30 percent of patients wait longer. In addition to long wait-times, many parts of the country face a doctor and nurse shortage.[23] As the

20 "What Makes Singapore's Health Care So Cheap?," by A. Carroll and A. Frakt, The New York Times, October 2, 2017, at https://www.nytimes.com/2017/10/02/upshot/what-makes-singapores-health-care-so-cheap.html.

21 "Facts about Sweden's health care system," Swedish Health Care Academy, at https://www.swedishhealthcare.se/about-sweden-and-swedish-healthcare/swedens-healthcare-system/.

22 "Health care systems in transition," World Health Organization, 1996, at http://www.euro.who.int/__data/assets/pdf_file/0016/120283/E72481.pdf.

23 "Swedes enjoy world class health care – when they can get it," by G. Hodan, Medical press, September 3, 2018, at https://medicalxpress.com/news/2018-09-swedes-world-class-healthcarewhen.html.

population ages, wait times are becoming longer and the number of citizens frustrated by the shortcomings of the system grows.

Italy

Officials in Italy nationalized their health care delivery system in the 1970s. Every citizen has health insurance through the government, although private insurance and doctors are available mainly in the larger cities such as Milan and Rome.[24]

The system is financed by local and national taxes and treatments are free at the point of service.[25] There are small out-of-pocket expenses for pharmaceuticals and modest co-pays for some doctor visits. The largest problem facing Italian officials is financial – staying within budgets.

The majority of Italians are not pleased with their health care system. On a scale of one (worst) to ten (best), Italians rate the socialized system at 3.7 and the competency of their government-paid doctors at 4.6.[26] There is a wide divergence of medical outcomes and overall satisfaction with Italian health care. Citizens in the wealthy north of Italy seem to do much better than those living in regions in the impoverished south.

Generalizations about health care in other countries

Looking to other countries to solve our health care delivery system problems may not be reasonable. Other countries are smaller than the U.S. and have a more homogenous population. What the people of one country favor may not be applicable or acceptable to people living in a different society.

One fact does remain, though. In all other countries examined, the demand for health care far outstrips the money budgeted for it. The results of this supply/demand mismatch are chronic shortages followed by strict rationing of health care. The rationing can take many forms – from long waits, to denying the elderly access to certain procedures, to allowing individuals with political influence to "jump the que" and receive priority attention from providers.

The United States spends 18 percent of its annual economy on health care. Other industrialized countries spend between eight and eleven percent of their GDP on health care. Yet each of these countries is experiencing greater demand and rising costs.

Just as in the U.S., every other country faces the demographic problem of an aging population and a relatively decreasing work-force to pay taxes for their seniors' health care. This age mis-match is creating health care budget problems for most other countries.

Further, the legal system in other countries is not as active or contentious as it is in the United States. Lawsuits contribute a higher percent of overall health care costs

24 "Health Care in Italy," International Living, at https://internationalliving.com/countries/italy/health-care-in-italy/.
25 "Italy: health system review," by F. Ferre, et. al., NCBI, PubMed, 2014, at https://www.ncbi.nlm.nih.gov/pubmed/25471543.
26 "Italians are Unhappy with Health Care in Italy," by A. Roe, Italy Chronicles, October 9, 2012, at http://www.italychronicles.com/italians-unhappy-healthcare-italy/.

in the U.S. than in other countries.[27] Hospitals and doctors in the U.S. pay much higher malpractice insurance rates and are more vulnerable to lawsuits than in other cultures. In addition, the practice of "defensive medicine," ordering unneeded tests and procedures to guard against litigation, adds to costs in the U.S.

Canada has a true single-payer, nationalized system which is totally funded by taxpayers. In reality, it is a two tiered system in the sense that Canadian officials allow their citizens to travel to the U.S. for privately-funded health care. All other industrialized countries have mandated universal health insurance coverage, but allow some form of a private sector to compete with government plans. These are not truly free-market systems because the government retains firm control of the practice of medicine in the private sectors.

The U.S. leads the world in medical innovations

While there is no question that the U.S. spends more on health care than other industrialized countries, the U.S. also leads the world in financing medical innovations. We pay three times as much for drugs as patients in other countries, where government officials have negotiated prices with pharmaceutical companies.[28] The U.S. also leads the world in medical and biologic research which is the foundation for the development of innovative medical devices.[29]

By paying higher prices, the reality is that patients in the U.S. finance the research and development of new life-saving and life-extending drugs and medical devices for the rest of the world. The health care budgets in other countries are dedicated almost exclusively to patient care rather than research, and these socialized systems rely on medical innovations and drugs developed in the U.S.

Health care as a "right"

Supporters of more government-control of the U.S. health care system have what they believe is a fair-minded egalitarian view point; that everyone has a "right" to health care. Supporters argue that people in other countries accept this "right" as a fact and have enshrined it in law. This is a fundamental belief and is often used in health care reform discussions. Unfortunately, the term "right" is rarely defined and often mis-applied to government programs.[30]

A political "right" is a quality inherent in the human person, like freedom of speech or freedom of conscience, which legitimate governments work to protect.

A mis-understanding of a "right" to health care holds that someone else is required to provide you with a particular good or service. Does it mean that your neighbors, through the government, are obligated to provide all health care for you? Does it mean that anyone can demand the government to pay for hospitalization, for prescription

27 "The cost of medical malpractice lawsuits in Washington state – Lessons from Texas reform," by R. Stark, MD, Policy Note, Washington Policy Center, April, 2016, at https://www.washingtonpolicy.org/library/doclib/Stark-Update-on-the-cost-of-medical-malpractice-lawsuits-in-Washington-State-Lessons-from-Texas-reform.pdf.

28 "The global burden of medical innovation," by D. Goldman and D. Lakdawalla, Brookings Institution, January 30, 2018, at https://www.brookings.edu/research/the-global-burden-of-medical-innovation/.

29 "The Most Innovative Countries in Biology and Medicine," by M. Herper, forbes.com, March 23, 2011, at https://www.forbes.com/sites/matthewherper/2011/03/23/the-most-innovative-countries-in-biology-and-medicine/#1dfeaedb1a71.

30 "Why health care is not a 'right'," by R. Stark MD, Op-Ed, *The Washington Times*, April 30, 2017, at https://www.washingtontimes.com/news/2017/apr/30/health-care-is-not-a-right/.

drugs, and for specialty treatments such as organ transplants? Does it mean that every American has a right to the skill and knowledge of all physicians and providers regardless of the cost to others?

These questions lead to other questions. How does society pay for health care for all? Who gets to decide who should receive health care and how much? Who gets to decide what the health care budget should be? Who should have the power to make health care decisions for us?

Rather than confront these issues, do proponents of health care as a right mean everyone should have health insurance? The problem with this belief is that simply having health insurance does not guarantee timely access to actual medical care. As we have seen from other countries, all citizens may have government-paid health insurance, but that doesn't mean they receive care. Some countries deny care to the elderly and the very sick, and the long wait times for treatment would be unacceptable to Americans.

Instead of arguing that health care is a right, the goal should be timely access to health care. The government should exist to guarantee this access to medical care, just as the government establishes rules and laws to guarantee access to food, shelter, and clothing in free markets.

What the U.S. can learn from health care systems in other countries

Is there some combination of measures from other countries that the U.S. can utilize in reforming our health care delivery system? Although the overall systems vary, the common factor for all other countries is government-mandated health insurance. Even those countries that have a component of "private" health care continue to mandate that every citizen have health insurance.

While universal health insurance coverage is a worthy goal, the critical point is utilizing the best mechanism to allow the greatest number of Americans access to health care. The Canadian single-payer system does not guarantee timely access. The American experience with the Veterans Administration hospital system, a comprehensive government-controlled, single-payer health care program, reveals unacceptable wait times and huge inefficiencies. Fundamentally, these systems ration health care by waiting lists and limited money. The quality of care veterans receive is variable.

A liberal Congress tried to force universal health insurance on all Americans through the Affordable Care Act. This was doomed to fail, however, because the same law required all insurance plans to contain expensive and unwanted benefit mandates. The law compounded this insurance regulation problem by forcing companies to sell health insurance to people after they had become ill. Young and healthy individuals have made a reasonable economic decision and have opted to not buy health insurance that they don't want and can't use until they become sick.

Switzerland has a comparatively large private health care sector and patients are responsible for 30 percent of their own health care costs. Consequently, a certain degree of health care consumerism exists in Switzerland and the country has been

fairly successful in holding down costs. Unfortunately, as officials increase the number of benefit mandates required in insurance plans, health care costs are rising.

Singapore has a multi-tiered system with different levels of care depending on the patient's ability and willingness to pay more. This is similar to the system in the U.S. before the passage of Medicare and Medicaid, when private hospitals and doctors treated paying patients and charity hospitals and residents-in-training cared for indigent patients.

The United States is a melting-pot of diverse cultures with a strong tradition of respecting freedom of choice. While smaller countries with a more homogenous population can require that everyone must have health insurance, the majority of Americans object to such a government mandate. Advocates argue that people must have auto insurance to drive a car, but the point is that people have other alternatives and are not forced to drive. Also, the car insurance system does not achieve universal coverage. Even with the auto insurance mandate, an average of 14 percent of drivers nationally do not have automobile insurance.[31]

Conclusion

Just like all other economic activities, the free-market offers the best solution to provide the greatest access to health care and to control costs. People freely making their own health care decisions and using their own health care dollars would give Americans the best chance to utilize their "right" to access health care, with tax-funded safety-net health programs provided for those who can't afford it.

At the end of the day, health care is an economic activity with suppliers and consumers like any other activity, albeit with the most personal of interactions between patient and provider. Public policy should work towards putting patients in charge of their health care, reducing the role of government, and focusing on access, not simply universal health insurance.[32]

31 "How many drivers don't have auto insurance?," autoinsurance.org, Accessed June 1, 2019, at https://www.autoinsurance.org/how-many-drivers-dont-have-auto-insurance/.

32 For an in depth discussion of patient-centered health care and solutions, please see: "Health care reform: lowering costs by putting patients in charge," by R. Stark, MD at https://www.washingtonpolicy.org/publications/detail/health-care-reform-lowering-costs-by-putting-patients-in-charge.

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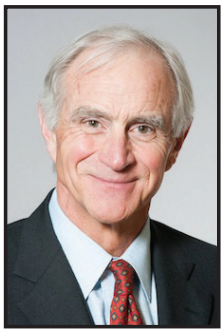

Dr. Roger Stark is the health care policy analyst at Washington Policy Center and a retired physician. He is the author of two books including *The Patient-Centered Solution: Our Health Care Crisis, How It Happened, and How We Can Fix It*. He has also authored numerous in-depth studies on health care policy for WPC, including *The Impact of the Affordable Care Act in Washington State, A Review of the Medicaid Program: Its Impact in Washington State and Efforts at Reform in Other States, What Works and What Doesn't: A Review of Health Care Reform in the States,* and *Health Care Reform that Works: An Update on Health Savings Accounts*. Over a 12-month period in 2013 and 2014, Dr. Stark testified before three different Congressional committees in Washington DC regarding the Affordable Care Act. Dr. Stark graduated from the University of Nebraska's College of Medicine and he completed his general surgery residency in Seattle and his cardiothoracic residency at the University of Utah. After practicing in Tacoma he moved to Bellevue and was one of the co-founders of the open heart surgery program at Overlake Hospital. He has served on the hospital's governing board. He retired from private practice in 2001 and became actively involved in the hospital's Foundation, serving as Board Chair and Executive Director. He currently serves on the Board of the Washington Liability Reform Coalition and is an active member of the Woodinville Rotary. He and his wife live on the Eastside and have children and grandchildren in the area.