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Health care has become a universal pain

By SCOTT CANON
The Kansas City Star

In Britain, famously, they wait.

To replace a hip, for instance, means months before surgery.

Spaniards and Italians have single-payer health care systems, but they leave it to the cities and villages, not the capitals, to run things. The Greeks demand all medical bills be covered by universal insurance, but let doctors hit up patients for more.

The Swiss are required to buy health insurance, and virtually all do.

Health care systems around the world vary like cuisine, reflecting customs and history. Some ingredients travel better than others.

"The same thing doesn't work for everybody," said Michael Tanner, who has analyzed the world's varying systems for the Cato Institute, a group that largely figures the less government the better.

"Even here, it's not just one way," he said. "What works in Minnesota is not necessarily what works in inner-city Kansas City or Texas."

As a nation, we pay more per capita — through government programs and out-of-pocket — for health care than almost any other country, but without achieving better health.

We aren't the only ones looking for a better way. Foreign health plans also struggle to make ends meet, to improve care, to keep private and to tame public bureaucracies.

"Ultimately, all health care systems ration care. It's a finite commodity. There's not an infinite amount of doctors, hospitals or money," Tanner said. "I think those countries that have markets at work give consumers greater influence over making those rationing decisions."

Public health specialist Alyssa Schabloski says governments must step in when markets don't work, as in areas like health care, where consumers don't understand the choices.

"We've got those markets here," she said. "Yet we spend more than anybody else, but our results are worse."

Waits for care in places like Canada and the United Kingdom might seem maddening to us, said Schabloski, who wrote a report for the Insure the Uninsured Project, but that doesn't necessarily mean a worse ultimate outcome.

Both Schabloski and Tanner say no nation has yet landed on the ideal or easily transplanted plan, but possibilities exist abroad.

Both, for instance, have good things to say about France.

"Whether it would be successful in the United States is another story," said Schabloski. "You still want to look."

Health care in other industrialized countries defies easy categorization. Experts note that all, in their way, leave many people unsatisfied, either because they cost too much, cover too little, or are so gummed up with regulation that they leave the sick neglected.

Single payer

Canada's Medicare system may be the single-payer setup most familiar to Americans. The country's provinces plan and evaluate care. They pay doctors and hospitals on a fee-for-service system similar to U.S. Medicare and Medicaid. While provincial plans vary slightly, they are all primarily tax-funded.

The plus is that everyone is covered, the country devotes a percentage of its gross domestic product to health care

far below that of the United States (less than 10 percent, compared with 15 percent), there's virtually no consumer cost at the time of service, and essential care is widely available.

But Canada has its bottlenecks. Virtually any care that can be delayed is put off, for months. And as costs have risen, the private health care providers paid by the government have begun to game the system by cherry-picking pricey, low-risk services, such as MRI scans and outpatient surgeries.

Boosters of the single-payer approach see the wait lists as just another form of rationing that exists in every system.

"Bringing that here might require a change in people's expectations of getting something right away all the time," said Cathy Schoen at the nonpartisan Commonwealth Fund, which studies health care and other social issues.

"It wasn't popular (in Canada) at first, but that changed," she said. "Cultural beliefs matter, but culture also changes."

Taiwan, Australia, Sweden, Spain, Italy, Norway, Portugal, Greece and New Zealand use similar approaches with the same results. Japan has a government-run, employer-based system with high co-pays to discourage overuse. Often private insurance systems form alongside the public system to reduce waits or give access to a broader range of elective care.

Some Greeks skip care when they can't afford the gratuities doctors demand. More than one in 100 Portuguese are on waiting lists for surgery and risk losing insurance for going to the doctor too often.

Swedes pay half what we do for health care, but need hard-to-find referrals to see a doctor outside the patient's own, tiny regions. In Norway, a fourth of patients wait more than three months to be admitted to the hospital.

National Health Service

Great Britain is as close to socialized medicine as anywhere today.

The National Health Service relies on taxes that average out to about $3,000 per person a year. Administration eats up about 7 percent of spending — compared with 30 percent here.

Doctors work as private contractors to the government, and consumers can choose any physician they want within their regions and pay virtually nothing for a visit.

About one in 10 Brits, the country's wealthiest, buy private supplemental insurance for better hospital beds and quicker access to specialists and non-emergency procedures.

Only recently have the British begun paying about $14 for most prescription drugs.

The greatest pressure inside the country is not to dump the system, but to find the money to reduce waiting lists.

Managed competition

The U.N.'s World Health Organization in 2001 ranked France's health care the best in the world based on its universal coverage, the freedoms it grants to patients and caregivers, and its responsiveness to people's needs.

How do they do it? For starters, they spend a lot of money. At 11 percent of GDP, their costs are greater than just about everywhere but the United States.

The French system grew gradually out of insurance funds built first by trade groups, then copied by ever-larger classes of workers. Today it's a combination of public and private doctors and hospitals paid by a mix of public and private insurance funds.

French consumers draw from three large insurance funds: one for salaried workers, one for farm workers and one for independent professionals. Since 2000, the coverage has been universal.

Nearly nine in 10 Frenchmen buy supplemental policies to help cover co-pays.

That said, the system is stretched, and funding — drawn from sin taxes, income taxes and employer contributions — is a nagging problem made more acute by the country's aging population.

"The social insurance model comes out of this concept of social solidarity that other countries feel stronger than we do," said Gregory Stevens, who studies health research at the University of Southern California Medical School. "We've got this long history (in the United States) of fighting for freedoms and being left alone. But at some point we agreed that education is important for everyone. We haven't gone there yet for health care."

Switzerland has adopted a model like the French, leaving insurance in private hands but imposing strict rules on getting everyone covered and on what services must be provided.

Some experts compare the Swiss system to Massachusetts, where people are required to get health coverage but at prices that government has made affordable — and with penalties for the minority (less than 1 percent in Switzerland and about 2 percent in Massachusetts) who attempt to skate by without insurance.

Swiss consumers choose among roughly 70 HMO-style plans that compete on price. But government oversight takes place at the canton, or state, level. That makes reforms cumbersome and slow. And the out-of-pocket expenses paid by patients are second highest in the world.

Israel uses a similar plan. It's paid for with payroll taxes and government subsidies that support four HMO-like plans. By law, there are no premiums. High co-pays means about half the population buys into supplemental plans to hedge against those costs.

The German way

Berlin has tried to squeeze more competition into the model even as it broadened to universal coverage in 2007.

Germans must buy into either state-run or private health plans, and about 85 percent take the public option. Those state plans are paid with income-based premiums, 7 percent from the worker and 7 percent from the employer.

The country tries to control costs by limiting what's available. Prescriptions, for instance, are kept relatively cheap — 10 percent of the cost capped at about $20 — but there are limits to the number and types of drugs that can be prescribed under the plan.

In return for paying heavily, Germans get quick and unfettered access to the doctors they want and never have to pay more than 2 percent of their income on co-pays.

But costs are rising, partly because preventive care has been largely neglected.

In 2006, the Netherlands broke from the German model to adopt a sweeping overhaul aimed at putting more competition in the mix.

Now it pools insurance risk by mandating that everyone get coverage, but gives them a choice of 14 private insurers.

The Netherlands spends two-thirds the proportion of its GDP on health care as Americans and ranks toward the middle, rather than the bottom, on the WHO ratings of health care performance among industrialized countries.

The nation has a few who refuse to pay premiums, and is contemplating withholding the money from paychecks or welfare payments.

In the 47 U.S. states mandating auto insurance, notes Cato's Tanner, the number of drivers without it exceeds those who lack health insurance. We're simply not as compliant here, so mandating health insurance might not work.

Yet others say some lessons overseas could work in the United States. The right penalties for failing to get insurance, such as extracting back premiums from people when they show up for care or garnisheeing wages, could make Americans as compliant as the Dutch or the Swiss.

"If we made a genuine effort to make things happen," said Schoen of the Commonwealth Fund, "we could do it."

Why now?

Politicians have been talking about the need to overhaul the U.S. health care system, to move closer to universal coverage, at least since the days of the Truman administration.

So why is the pressure for reform seemingly so urgent this year?

The Obama administration hopes to capitalize on the president's popularity before it wanes.

Waiting until 2010 would put it in an election year, which would give both Democrats and Republicans more reason to make the debate more partisan.

Presidential chief of staff Rahm Emanuel has joked that a politician should not let a good crisis go to waste, and reasoned that skyrocketing health expenses and disappearing insurance are a crisis made for reform.

President Barack Obama has Democratic majorities in the House and Senate that might not last another election cycle.

The faltering economy has left many jobless without health insurance and the still-employed struggling to make ends meet between rising premiums and co-pays, giving more political momentum for reform.

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