

Analyzing Evolutionary Healthcare Models Across the Globe

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ABSTRACT

The present state of research into varying forms of healthcare is limited if existent. Discussions are limited to the state of different healthcare policies and their overall effects but have not effectively attempted to compare proposals in regards to US applicability. This article aims to bridge that gap and build off existing pieces of research to effectively produce concrete analysis on various forms of healthcare. Irrespective of one's opinion on the status of healthcare, there is no denying the current system is in need of change. Via analyzing proposals in across the globe this paper discusses respective benefits in conjunction with the harms. The goal of this paper however is not to *determine* the best healthcare policy as that answer will inevitably not arise at any point in time but rather to discuss what forms of benefits we might see as a result of various policies.

Introduction

1.11 million, the number of deaths in the United States from Covid 19. This catastrophically high number highlights what should have been an already apparent truth in the US: status quo health care and pandemic response is unsustainable. While many scholars reach the same conclusion, being the necessity of reform, the question of what to implement is yet to reach a conclusion, even among experts. This paper thus aims to analyze a variety of different nations, their health care policies, and their respective pandemic response to dissect numerous different potential alternatives to the current United States health care model. While health care policies play a role in nations' economic vitality as well, this paper will prioritize the consequences in relation to quality of care. This includes but is not limited to pandemic preparedness, doctor-patient trust, wait lines, presence of innovation, and of course, accessibility. The nations to be analyzed within this paper include Germany, Canada, and The United Kingdom, due to their diversity in health care standardization. This includes single payer health care, the National Health Service, and private options. To limit ambiguity, this article will some important terms that will be used throughout the course of this paper. Single Payer health care refers to a system of health care in which the government funds all health care providers and reimburses them, usually funded through an increased tax on constituents of a nation. The National Health Service, present in Britain, is a great example of single payer but differs in that even the providers of health care are government affiliated. Within a single payer model, health care providers themselves can still be private corporations but under Britain's NHS, the entire process is nationalized under government control.

The State of US Health Coverage

First, analyzing the defective nature of status quo healthcare in the United States, we can look to Allison Galvani's recent study analyzing healthcare's impact on Covid-19 preparedness in the United States. She finds that 26.4 percent of lives lost during Covid in the United States would likely have been prevented if universal healthcare was guaranteed (Galvani 3). This number is corroborated by her analysis of the US population in

which 14 percent of US adults report they would not seek care even if they noticed common symptoms related to Covid-19. Now, these numbers provide us with alarming insight into how fundamentally flawed status quo healthcare is. The privatized nature of healthcare turns it into a commodity, rather than a guarantee. This deters broad swaths of the US population from seeking care under the impression that access to care will have to come at the expense of having food on the table, or being able to pay rent. The question then becomes, why is healthcare inaccessible and what is resulting in the absurdly high population of uninsured citizens.

This is answered by Patrick Drake of the KTF's recent paper which used data from the American Community Service to ask American adults the reason they are uninsured. Out of the uninsured adults surveyed, 64 percent reported the reason was due to the cost of healthcare being unaffordable (Drake 1). Access to basic necessities such as health should never impose a dichotomy on individuals yet in the United States, it does. Now, many point to the existence of cost-sharing documents as a potential solution to the overwhelmingly high costs of health care that exist in the United States. Cost sharing, under the Affordable Care Act, allows low income individuals to pay a "small" out of pocket cost in exchange for the government paying the remainder. In essence, this splits the cost of healthcare between families and the government to reduce the overall cost. While in theory this makes practical sense, there is an arduous and painstaking literary process required to interpret cost sharing applications that deters low income families from signing on.

There are 8.1 million Americans with incomes between 11,770 and 29,425\$, being the eligibility requirement to qualify for cost sharing, but a recent study found that only 5.9 million are currently signed on. This means that 2.2 million, or 29 percent, of low income families are currently denied access to health care due to the overwhelmingly difficult process required to apply for cost sharing (Carpenter 4). Carpenter's analysis required using American Health Census data from databases that tracked a) healthcare enrollment rates, b) cost sharing usage among low income populations, designated by Census data and c) geographic proximity's impact on healthcare usage. From here we see that while the Affordable Care Act attempts to equalize health care and provide affordable options for low income families, still health care remains broadly inaccessible within the United States.

Canadian Quality of Care

Next, it is important to view this in terms of quality of care. Yes, particular populations may be denied health care in the status quo but the question turns to whether or not an alternative means of health of care can effectively respond to these qualms. Proponents of privatized health care often argue that scaling up health care to a universal standard results in "overuse" of health care in which the healthcare system gets overwhelmed. To this, we can look to Canada as a glowing case in study of the effects of universalizing health care. In 2016, Paul Geyman published a study in which he analyzed health care data provided from the CDHC over the last 25 years starting from the 1970s. His analysis attempted to answer a simple proposition: does single payer healthcare require overusage?

The results were clear as day. In analyzing Canada's system, being single payer, he found that there was just a 5 percent increase in health care usage, almost all of which being primary, necessary care (Geyman 7). This has broad implications on the way we interpret single payer health care. First, it corroborates Galvani's study results in revealing that implementation of single payer does result in at-risk patients getting necessary care. Second, it reveals that there is no "overheating" effect of single payer that results in too many patients using the system at once. In effect, the increase in health care usage is taken up by patients who are in desperate need of the system which at the end of the day, is the goal of health care. Analyzing Canada, it is important to go a little further. Proponents of maintaining the status quo of health care often point to the increased wait times that arise as a result of single payer health care. This seems to be the most stringent criticism that exists of any alternative health care system. There is weight to this argument given that as an institution, Canada has suffered from longer wait times however this conflates cause with correlation. Andrew Torrance in 2017 published a

study in which he compared United States health care to that of Canada through viewing the infrastructural capacities of both systems. He analyzed trends in health care related to the total revenue spent on healthcare and how relatively accessible both systems were. His aim in the study was to discover whether implementation of healthcare in the United States would result in significant rationing (aka wait times) in the same manner that it did in Canada. His conclusion was that the Canada example is non-telling of how the United States single payer would operate. In Canada, the total amount of money spent on health care procedures is not even half as much as that of the US. As a result, the money directed towards paying for different procedures is far lower meaning that the supply is in turn exponentially lower which is what results in patients needing to wait to get access (Torrance 6).

Additionally, the analysis of single payer in Canada often attempts to reach a monolithic decision while ignoring valuable complexity. Colleen Flood and Bryan Thomas in 2017 conducted a study in which they compared the wait times in Canada for non-essential procedures against the more essential ones such as surgery, or radiation. They additionally chose to separate Canada into different provinces in order to yield a more accurate result of what Canadian wait times look like across the board. They found that across all provinces for radiation therapy, 9 out of 10 patients were able to garner access in a time frame of less than a month which is the expected time frame for radiation therapy (Flood and Thomas). Flood and Thomas study along with Torrance's point towards a brighter conception of single payer health care. While often singled out as an unrealistic, overly radical system that is bound to reproduce the harms it attempts to solve, in actuality it has yielded empirical results and criticisms seem more directed towards the infrastructure of a nation, rather than the health care itself.

Germany and The Public Option

Moving from the single payer model, many have advocated for the usage of a public option as the middle ground between private and public care. The public option health care system has been utilized in different ways by many different nations most notably, Germany. The method holds as follows: health care is best when there is both a public and private option. Public health care can thus be taken advantage of by those in desperate need of public services to guarantee some access to health care and the private system of insurance can still be maintained. Public option essentially splits health care into two separate sectors: the private and public. Rather than imposing a dichotomy in which individuals have to access insurance to receive health care, there is a choice that presents both options to individuals to ensure there is some level of universal access. In theory, this sounds like the perfect middle ground and has been actualized by some nations. Germany, for example, has competing private health insurance systems for those that can afford it or for those that have their health care covered by employers.

They simultaneously offer a public option for those that have neither and have seen meaningful results. Most notably, results have come in the context of costs. Chase Madar, a New York attorney in health care analyzed the year by year change in percent of American GDP dedicated to health care. As of 2017, that number was 18 percent. Close to one-fifth of the total GDP is spent just on our health care industry by funneling money into private insurers that prioritize monopolization over access. Germany in contrast, as Madar finds through his statistical analysis of spending in relation to GDP, directs just 11 percent of their GDP on health care (Madar). Now, money alone may not be the sign of a positive health care system unless it can transfer into noticeable tangible results. The European Observatory on Health Systems and Policies, who conduct an annual report on European nations and their health care trends through the years, find that German life expectancy has risen to 81 years as of 2020. This is a positive, 3 year trajectory and one of the top average life expectancies across the globe (European Observatory). Another positive trend beyond just life expectancy, is the accessibility of the system. The total out of pocket costs that individuals are forced to pay in the German system to fund health care is just 13.6 percent.

Taking low cost sharing numbers with high life expectancy displays the vitality of the German trend and is needed insight into the alternative potentialities of health care. Many view the American system as being the only “realistic” option for health care yet seemingly this is a view from nowhere as there quite literally is no real empirical backing that justifies this proposition. Still however, criticisms of the “public option” exist and cannot be dismissed. The Congressional Budget Office in 2017 conducted a study in which they scored the proposal of a public option proposal based on the way it could be added to the Affordable Care Act which lays out the scripture for effective health regulation in the United States. The CBO’s analysis, as described by Adam Gaffney, scores the program immensely low, finding that the 28.6 million who are currently uninsured “would not budge” (Gaffney 5). We cannot only view this CBO report as a point to consider, but *the* point to consider. The CBO did not estimate that a large portion of uninsured people would remain uninsured, they estimated that almost *all* uninsured people would remain without access to health care. The CBO additionally analyzed the potential applications of public option specifically in a US setting making their results far more applicable to the infrastructural capacity.

For individual patients, this would have a variety of implications. First, patients would be unable to differentiate between different forms of care thereby deterring any *and all* services. When patients are unaware of differing options, they are deterred from securing care meaning all in all harms persist. The second potent criticism of the public option relates to admin costs. Before delving into studies, the importance of administrative costs must be made clear. Administrative costs occur when healthcare providers have bureaucratic struggles with managing payments from numerous different insurers. While this may seem like a small concern, for rural hospitals the absence of a standardized payment system can eat close to 80 percent of healthcare budgets. Not the provision of health care, not the payment of workers, but the managing of funds from different providers eats up 80 percent of costs. Dr. Woolhandler studied at the CUNY school in public health administration and attempted to analyze the effects of the public option on administrative costs. While a single payer system would cut administrative costs down to 0, as the system in it of itself centralizes payment directly from the government meaning there is just one outlet, the public option still maintains the numerous different providers that small hospitals have to manage. Woolhandler finds that a public option would forgo “84 percent of the administrative savings available through single payer” (Woolhandler 6). Woolhandler and Gaffney offer the most insightful criticisms of a public option that seem to follow a common line. While theoretically perfect, the idea of dividing health care into an option seeking a middle ground suffers from the *worst* of both worlds rather than the best of both.

Swiss Health Administration: Universally Non-Universal

An additional alternative to health care this paper will analyze is the Swiss model. Switzerland maintains what many like to refer to as the “universal non universal model”. They offer a set of 82 different private insurance options of which some include basic plans and others include supplemental treatments of higher care. Here is the catch, while each option is *private* in nature, it is **compulsory** that each person purchases one of the treatment plans that are offered. Thus, the system is universal in that all individuals are mandated access to healthcare as a law but non universal in that accessing said health care requires purchasing it. In theory, this system seems like the inverse of the public option: totally undesirable. It would seem ridiculous to propose a system that compels individuals to sign onto health care, yet in reality, it is substantially different. As described in paragraph 1, the problem with American health care is not *just* the cost of health care but the financial illiteracy that deters many Americans from signing on to cost sharing alternatives and the perceptive risk that the process is too time consuming.

When individuals are given a choice between accessing health care or not, if the costs are even perceived to be too high then most will choose to obviate from signing on to health care. This is exactly why within the United States, the uninsured rate is so high as individuals are inclined to believe they will survive without

healthcare and thus avoid paying the fee. Switzerland, takes away this choice. A recent PBS study analyzed two Americans who traveled to Switzerland with the sole goal of analyzing their health systems and both reported needing to pay 16 percent of their income on purchasing a health care plan. (PBS 3) This seems repressive but that same PBS study found that Switzerland has the lowest unavoidable death rate being the death rate of individuals that could be avoided by health coverage. In comparison, the United States has the highest of any nation.

Yet still, the obvious criticism of this system is obvious for a reason: healthcare is too expensive. Switzerland's population and infrastructure may be well equipped to handle a system of such compulsion, but whether the United States is, remains unknown. To date, no quantitative assessment has evaluated the potential usage of Switzerland's system in the United States and until then its potential applications are limited.

Conclusion

The purpose of this paper is not to find or evaluate an objective solution to the problem of healthcare in the United States. On the contrary, what becomes obvious is the relative success of alternative options across the globe and the, put simply, failure on the part of the United States to respond to emerging health concerns. Switzerland, Germany, and Canada are examples of nations that have proposed three separate models of health care. The compulsory system in Switzerland, public option in Germany, and single payer system in Canada have all yielded both positive and potentially concerning results in one way or the other but what is important is their prioritization of access over monopolization. These systems have all outperformed the United States in their intent which albeit matters less than actual results, is a great measure of the future potentials of any system. The United States alternatively, fails both in intent and results. When evaluating the application of any other health care system and its potential in the United States, there are various angles that must be accounted for as this paper displays but status quo health politics seem to operate under a facade that genuinely deems American health care as efficient. Breaking out of this mindset and confronting the failure of American health care is necessary to actualize change and ensure equitable access and cost savings which at the end of the day, is not debatable.

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