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"The Healing of America" and the Next Steps for American Healthcare

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Abstract

An exploration of three healthcare systems—France, United Kingdom, and Canada—and what can be learned for them. Elements from the three national systems are combined into a proposal for reforming the American healthcare system into a devolved single-payer system.

Keywords

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Comments

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By Carter Hanson

Section 1: Global Perspective

France

Regarded as one of the most effective and efficient providers of healthcare in the world, the French system functions as a variation of the Bismarck Model, which is "a system of private doctors treating patients who buy health insurance—from a government health plan, and from private insurers—to cover most of the cost" (Reid 50). This is similar to the American healthcare system in its prioritization of the private sector over a larger role for the government in providing and insuring healthcare. Like the United States, in France, doctors are privately employed and patients must pay out-of-pocket for everyday doctors' visits. Additionally, French citizens receive health insurance through—and split the premium with—their employer. However, unlike the U.S., the vast majority of out-of-pocket costs paid for visiting the doctor are reimbursed by the patient's insurer, and "premiums are dirt cheap" (53).

The French, like much of the rest of the developed world, have made it a top priority to ensure that all citizens have access to affordable and effective medical treatment: "The French health insurance system covers every resident of France and guarantees everyone a roughly equal level of treatment" (53). They achieve this by enforcing the individual mandate, making it "illegal to opt out…" (53) of health insurance.

Health insurance is provided in France by "sickness insurance funds," which are nonprofit insurance plans. The fact that insurance providers are nonprofit is a significant improvement on the American system because, by removing the profit incentive and replacing it with a directive to keep as many people healthy as possible, sickness insurance funds can't turn patients down for preexisting conditions, and are far cheaper for customers and more

administratively efficient than a for-profit insurance company. Additionally, the "Carte Vital," which is essentially an ID card that allows doctors to access a patient's medical history by simply scanning the card into their computer, makes the French system one of the most efficient in the world.

Some patient choice is still preserved in the French system: "the French can also buy supplemental health insurance, either form nonprofit cooperatives… or from for-profit insurance companies…" (53). Many people do purchase this, as the price is extremely low, and it is often used to cover the "Medi-Gap," which is coverage for treatments not covered by sickness insurance funds.

However, the vital problem with the French healthcare system is that it is not cost-effective. The French system simply costs too much for the treatment it provides and the sickness funds are underfunded: "Most of the sickness funds run up operating deficits year after year" (55). As this continues, sickness funds have turned to the government for help and "now operate more like branches of the Health Ministry…" (55). Fundamentally, though "on paper… France is a multi-payer health care system," in reality, the government has a very large role: "In practice, France acts like a single-payer system..." (54).

Canada

Canada uses a modified single-payer system called Medicare which has the provincial and territorial governments function as both healthcare provider and insurer, with oversight from the federal government. By having a single entity control treatment and prescription drug costs, the Canadian government is able to wrestle a great amount of negotiating power away from the private sector, replacing the profit incentive of the health insurance industry with the mandate of the government to provide effective health services to the Canadian public: "Canada shows again that a coordinated system of payment (whether it's single-payer or thirteen-payer) has enough negotiating clout with health care providers to get serious control over costs" (141).

Like France, Canada established its healthcare system on the principles of universality. Like France's individual mandate, all citizens must be covered by some kind of insurance. In Canada, this takes the form of Medicare, which fulfills this national value universally: "The fact that anybody who needs health care can get it, without payment, satisfies the basic collectivist spirit of the nation. No Canadian dies because he can't afford a doctor; no Canadian goes bankrupt from medical bills" (128).

Unlike France, Canada doesn't have semi-privatized (albeit nonprofit) sickness insurance funds; instead, provincial governments provide insurance: "Each province's health insurance system must be operated by a public body on a not-for-profit basis" (135). This has a lot of benefits for the Canadian public such as a level of transparency in pricing and service that could not be offered if health insurance was provided by private funds, even nonprofit ones. Additionally, with the insurance provider being the same as the price determiner, prices for Canadians are much lower than for their American counterparts. Administrative costs are also

extremely low as the entire insurance industry has been replaced with an expanded government health service, meaning that the paperwork that governs claim negotiations, corporatist bureaucracy, and advertising is unnecessary. Though Canada has no "Carte Vital" or equivalent, the system has become more accessible in other ways such as by mandating that "every resident of the province must have the same access as everybody else to treatments and drugs covered by the plan" (135).

One of the most unique—and positive—aspects of the Canadian system is its devolution of control over the fringes of health coverage to the provinces and territories. The federal government in Ottawa determines much of what must be covered by Medicare and decides how most of the process should function. Each province and territory then builds its own Medicare plan, following the federal rules and guidelines and exercising its discretion with the rest: "Some provinces pay 100 percent of every doctor and hospital bill; other require patients to make a co-pay or pay a deductible before the government insurance kicks in" (134). The variation between provinces is, in practice, very little, but provinces do differ on how—or if—they cover non-standard medical treatment such as mental, dental, and optical.

Private insurance is preserved in Canada, as "most Canadians… also have private health insurance to pay the tab for things that aren't covered by the system…" (136). Thus a problem arises: because of the devolution of health coverage to the provinces, and their panoply of plans, and the continuation of private supplemental insurance, an inequality emerges between those who can afford supplemental insurance and those who cannot, and those who live in provinces that provide supplemental for free and those who do not. This has dire consequences for a nation

that prides itself on its equity: “The result would be ‘two-tier medicine,’ a term that is as pejorative in Canada as ‘socialized medicine’ is in the United States” (137).

United Kingdom

The National Health Service (NHS) of the United Kingdom functions as a Beveridge Model, which is a national single-payer healthcare system. The Beveridge Model is supremely universal and cost-effective, all the while providing some of the best healthcare in the world. Reid, reflecting on his time using the NHS, writes, "The availability and quality of the care we had in Britain were about equal to what we had at home—better, in one sense, in that British doctors still make house calls" (120).

The goal of the NHS is to provide all British citizens with equal access to healthcare for as little cost as possible. To this end, the system has been remarkably successful: "In the NHS, there is no insurance premium to pay, no co-payment, no fee at all" (104). Furthermore, the system has remained very cost-effective: "[The NHS]... has proven to be an unusually cost-efficient means of providing quality health care to everybody" (105). However, the NHS is not completely universal, as a small portion of the British public still has to pay for prescriptions and some dental and optical are not covered by the NHS.

One way that the NHS is able to remain so cheap is by limiting what treatments are covered by the national health insurance plan. This is achieved by a government entity called the National Institute for Health and Clinical Excellence (NICE). In the past, NICE has received criticism from the British public and press for some of the decisions it has made regarding what the NHS covers. However, the function of NICE is necessary for any healthcare system, not just single-payer systems. Indeed, every healthcare system has some form of NICE, but in the American system, large health insurance corporations fill this role, without the transparency of NICE (54).

Some private supplemental insurance is permitted in the British system: private insurance can be purchased to cover treatments excluded by the NHS's plan, as determined by NICE. However, the NHS is very popular and covers such a wide variety of treatments, that few actually purchase supplemental insurance (105). The private sector is also preserved to some extent within the NHS as doctors remain private contractors, not government employees (114).

Section 2: Solutions to our Immense Problems

No one should die because of a lack of healthcare in the richest nation in history, especially in a nation that has the best medical treatment available anywhere in the world; this moral principle must drive our vision of a better healthcare system. The current American healthcare system is critically flawed: 28.5 million Americans were uninsured in 2017 (Berchick), many more are underinsured, and as many as 45,000 Americans die from a lack of healthcare every year, according to a study from Harvard Medical School (Wilper).

On an elementary level, it is morally and unambiguously wrong for someone to die from a preventable ailment when the means to save them is nominally available, and the only thing obstructing their survival is their socio-economic tier. No one should go bankrupt from being ill; that this is possible is a definitive moral self-decapitation on the part of our nation. Thus universality is the foundational principle of the American dream—and an essential *human right*, paramount to the success of any nation, not just in terms of that nation's healthcare system, but in terms of that nation's ability to provide basic sustenance for all people and, therein, for it to be just.

In this vein, I propose a national single-payer healthcare system, similar to the NHS in the United Kingdom, though partially devolved to the states, like the Canadian Medicare system. Single-payer is unique in its ability to achieve the goal of universal coverage as, unlike any other healthcare model, there is very little or no ability for the wealthy to get better health services than the poor. Indeed, healthcare can only ever be truly universal if everyone pays the same amount out-of-pocket; and the only cost that every American citizen can afford to pay out-of-pocket is $0.

My resolution, a modified single-payer system, would replace much—but not all—of the health care industry with a combination of federal and state government entities that would act as both insurer and provider. Like the UK, doctors would remain private but would act as contractors for the government health services.

Supplemental private health insurance would still exist, covering treatments outside of the government plans. What the federal government covers would be determined by a public body similar to the UK's NICE (The National Institute for Health and Care Excellence). The government plan would probably exclude a variety of non-exigent treatments for health problems, similar to Canada, as well as traditional medicine and some (very) limited dental and optical. Treatments that the federal plan does not cover can be covered by state governments, like in Canada; thus each state would have its own government entity which determines what the health system will cover outside of the federal plan. If a state extends coverage beyond the federal plan, the state budget will have to pay for it. The federal government, however, incentivizes healthcare extensions by partially subsidizing the extension. The federal plan and the body similar to NICE would also be completely transparent, which would be an improvement on the current American system.

Prescription drug costs would be tightly regulated by the government and would be universally covered by the federal healthcare plan, similar to the other health services that fall under the federal plan. To improve accessibility and administrative efficiency, the Carte Vitale would be instituted in the new American system, either as a part of legislation reforming the Social Security Card system or through legislation creating a new, fully encrypted card, like in France.

Doctors are paid for the effectiveness of treatment and receive bonuses for preventive care, in a system similar to the UK's capitation payments and the Index of Quality Indicators. However, doctors would get paid less overall, though not as low as in some countries like Japan.

"Carter Care" would be paid for through a large tax increase, particularly on the wealthy. Though taxes will increase, the overall cost of healthcare will decrease, like in every other developed nation that has adopted a national healthcare system. Furthermore, in the long run, the system will pay for most of itself because it is preventative, and it is cheaper to cure an illness before it becomes a major problem than when it is one.

Single-payer, I admit, is a very progressive policy, and unlikely to become the healthcare standard for the majority of Americans. However, precedent tells a different story, particularly in the passage and success of Obamacare. Despite every barrier that was put in the way of the Affordable Care Act—the dismal history of American healthcare reform, the general antipathy for reform, the poor rollout, and the Republican Party—Obamacare was ultimately successful, insuring 25 million Americans. After it was passed, the ACA endured the onslaught of Republican repeal efforts from 2009 to 2018 and every time the GOP held another repeal vote, public opinion of the ACA improved, and the Overton Window shifted farther left—to the point that the Public Option became mainstream and Single-Payer multiplied in popularity. By enacting Single-Payer, as in the case of Obamacare, the Overton Window will shift, and with it popular opinion—so much so that once passed, Single-Payer will be here to stay.

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