2.3. Health systems

2.3.1. USA

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The costs of health care

Since the 1960s, the cost of health care in the United States has risen faster than that of other sectors of the economy and far faster than that in other industrialised countries (**Figure 1**). In 2005, total health spending in the USA was US$ 2,000 billion equal to US$ 6,697 per capita and 16% of Gross Domestic Product (GDP). It is predicted that, by 2015, health spending will double (US$ 4,000 billion, or, about 20% of GDP). As the previous Report[1] illustrated, there are two main reasons for this disproportionately high health care spending in the USA: a) the high costs of products and health services; b) the extremely fragmented nature of the Health System.

A recent article published in Health Affairs[2] suggests another interpretation to explain the gap between US health spending and that of other countries. Analysis of the differences between disease prevalence and differences in the treatment rate for these diseases in the US and in other countries suggests that one explanation

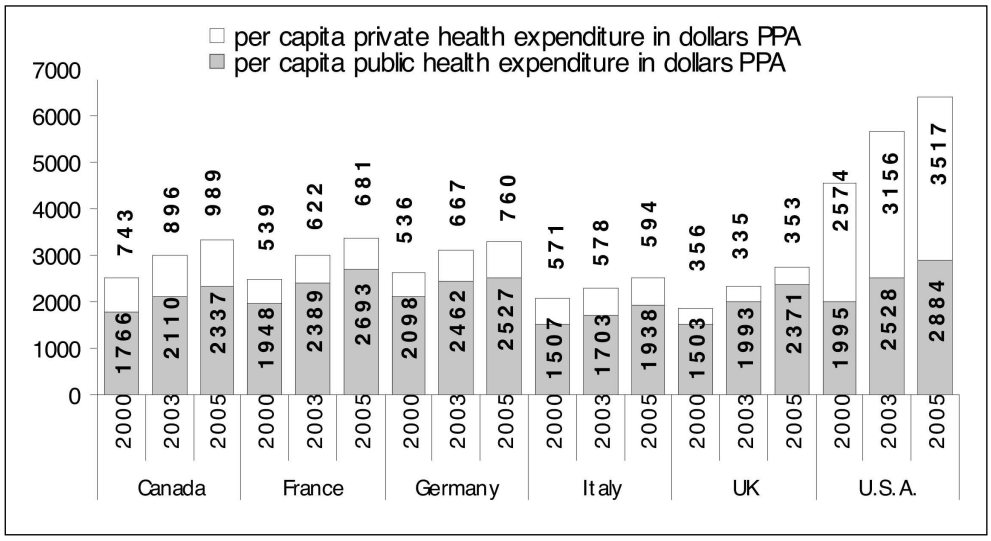

Figure 1. Public and Private health expenditure per capita: USA and other selected countries. US$ PPA. Years 2000-2003-2005.

Source: OECD Database 2007

for the gap could be the different levels of health services consumption and, consequently, of the resources required to finance them. The article gave the results of two parallel studies on the state of health of subjects aged 50 years and above in the USA (*2004 Health and Retirement Survey* - HRS) and in 10 European countries (2004 *Survey of Health, Ageing and Retirement in Europe* - SHARE). **Table 1** shows the differences regarding the prevalence of 10 diseases and of two risk factors, obesity and smoking. With the exception of osteoporosis, the prevalence of these diseases is clearly higher in the USA than in Europe, sometimes even twice as high: **cardiovascular disease** 21.8% (USA) vs. 11.4% (Europe); **diabetes** 16.4% (USA) vs. 10.9% (Europe); **obesity** 33.1% (USA) vs. 17.1% (Europe).

The data on **obesity** are certainly the most striking and, in some aspects, shocking. Indeed the speed with which this condition is spreading among the US population is both astounding and scandalous, as are the dramatic consequences of its spread in terms of co-morbidity and the effects on expected life-span.

In the space of two decades (1980-2000) the prevalence of obesity among the adult population (aged 20-74) has gone from 15% to 31% (with women of Hispanic origin at 40% and afro-American women at 51%). Among the over 65s (all on the Medicare Public Health programme) obesity increased by five percentage points between 1997 and 2002. Co-morbidity associated with obesity and severe obesity (BMI >35) was also studied; for example: the probability of being affected

Table 1. Prevalence of chronic conditions and risk factors in adults aged 50 and over. USA and 10 European countries*, 2004.

	USA	*Europe*	*USA/Europe difference*
Heart Disease	21.8	11.4	10.4
High blood pressure	50.0	32.9	17.1
High cholesterol	21.7	19.6	2.1
Stroke/Cerebrovascular disease	5.3	3.5	1.8
Diabetes	16.4	10.9	5.5
Chronic Lung disease	9.7	5.4	4.3
Asthma	4.4	4.3	0.1
Arthritis	53.8	21.3	32.5
Osteoporosis	5.0	7.8	-2.8
Cancer	12.2	5.4	6.8
Obese	33.1	17.1	16.0
Current smokers	20.9	17.8	3.1
Former smokers	31.7	25.2	6.5
Never smoked	47.3	57.0	9.7

* Austria, Denmark, France, Germany, Greece, Italy, The Netherlands, Spain, Sweden, Switzerland.
Source: K.E. Thorpe, D.H. Howard, K. Galactionova, Differences in disease prevalence as a source of the U.S.-European care spending gap, Health Affairs, w 678, 2 October 2007.

by diabetes among the normal weight population was 12.7%, among the obese population 34.3% and among the severely obese population 42.8%[3]. This rapid rise in obesity – and in the co-morbidity associated with it – is seriously affecting the life expectancy of the US population; average life-span, which had been rising steadily for the past two centuries has now stopped rising[5].

It has been calculated that if the US over-fifties population had the same health profile (and the same treatment) as the European population of the same age group, the total saving in resources would be about US$ 100-150 billion per year.

High cost, low performance

The US Health system is famed for being very expensive and very unjust because of the increasing numbers of people who have no health insurance cover: in 2007 about 47 million US citizens were without health care cover for the whole year (15.8% of the population)[6]. Between 2000 and 2007 the number of persons uninsured rose steadily at a rate of about one million per year and it has been estimated that in the period 2006-2007, more than 89 million US citizens were without any health cover for at least one month[6]. It should be added that a further 25 million people were under-insured in this period, that is, with a health insurance that offered no protection in the event of serious illness (+60% with respect to 2003)[7]. This latter was to a large extent caused by the tendency among firms (especially small firms) to stop paying employees' insurance contributions because of their steadily rising costs: between 2000 and 2005 the costs of such policies rose by 73% while, in the same period, inflation rose by 14% and the real value of wages by 15%. In 2005, the average annual costs of insurance for a family was US$ 10,728 and, for a single person, US$ 3,991. Faced with these rising costs firms reacted in one of two ways: either a) transferred part of the burden of insurance payments onto their employees, by means of high levels of deductible and/or cost-sharing; or b) as mentioned before, simply stopped paying contributions for their employees. Indeed, between 2000 and 2006 the percentage of US citizens covered by insurance paid by their employer fell from 63.6% to 59.7%.

While the poor performance of the US health-care system in the fields of equity and accessibility is already well-recognised, performances on other variables, for example level of health, quality of treatment and efficiency, are equally poor too.

The *Commonwealth Fund* analysed the situation by means of a nation-wide survey which looked at a large number of indicators and compared them with benchmarks (optimal reference values) based either on data from other countries or from US centres of excellence (hospitals, insurance companies, States, regions etc.)[8].

The US health system scored 66 overall when measured on a scale of 100, (with 100 optimal), this score can be broken down as follows: State of Health, 69; Quality of treatment, 71; Accessibility, 67; Equity, 71; Efficiency, 51.

Table 2 shows a selection of the indicators used in the survey and clearly illustrates how the indicators of efficiency consistently scored lowest.

Table 2. Performance of the US Health System. Health status, quality of care, access, efficiency.

Indicators	*National data USA*	*Benchmark*	*% National data USA over benchmark*
Long, Healthy and Productive life			
Mortality amenable to health care (deaths per 100,000 population)	115	80 **a**	70
Infant mortality (deaths per 1,000 live births)	7.0	2.7 **a**	39
Healthy life expectancy at 60 years			
Males	15.3	17.4 **a**	88
Females	17.9	20.8 **a**	86
Quality of care			
Adults-received recommended screening or other preventive interventions (%)	49	80 **b**	61
Children-received all recommended doses of five key vaccines (%)	79	89 **c**	89
Diabetics with HbA1c level < 9% (%)	74	89 **b**	83
Adult with hypertension with PA < 140/90 mmHg (%)	29	75 **b**	39
Heart failure patients-received written instructions at discharge (%)	50	87 **d**	58
Adults with chronic conditions-given self-management	58	65 **a**	89
Accessibility			
Adults (ages 19-64) insured all year (not underinsured) (%)	65	100 **e**	65
Adults-no access problem services due to costs (%)	60	91 **a**	66
Families spending < 10% of income (or <5% of income in cases of low income) in out-of-pocket for medical costs and premiums (%)	83	100 **e**	83
Efficiency			
Hospital admissions for diabetes (x 100,000 population.)	241	137 **c**	57
Went to ER for condition that could have been treated by regular doctors (%)	26	6 **a**	23
Medicare hospital 30-day readmission rates (%)	18	14 **f**	75
% of national health expenditure spent on health administration and insurance	7.3	2,0 **a**	28

a: other Countries; b: insurances; c: States; d: hospitals; e: income group; f: regions.
Source: Bibliog. Ref. 8.

An inequitable system

The US health system is notorious, above all, for its inequity and its contradictions. It is a system which, on the one hand is costly, iniquitous and inefficient and, on the other, is extremely rich in professional scientific and technological resources; a fragmented system which lacks effective federal coordination and which, especially in recent years, has seen a proliferation of autonomous health policies adopted by individual States.

This letter, sent by two readers to a well-known columnist of the New York Times, Paul Krugman, offers a perfect picture of the "unequal" and almost "anarchic" situation within the US health system.

"My husband and I decided to move to California to live in a rural area. My husband has had heart problems and could not risk being without health care cover for a long period of time. Being admitted to hospital without health insurance would have been financially catastrophic. This affected our decision about where to move to. We had to choose a forward looking State where my husband would not be refused health cover and where, because of his existing health problems, there would be no delay in registration for such cover. Currently we are living in Massachusetts, which has excellent laws on health care and assistance, and we are buying a plot of land in Vermont where there is guaranteed health care cover. The health care policy will cost us 1,100 dollars per month, but at least we will not have to live in fear of having to face enormous, unexpected hospital treatment bills. It is comforting to know that our neighbours, who are less well-off than we are, do have access to health care services even though they are either self-employed or employed in small firms. The health care crisis is serving to discourage people from setting up businesses, because anyone who has health problems in a State where there is inadequate health care cover is forced to work for companies that are large enough to be able to offer health insurance cover. Individuals are thus like vassals in a feudal system, which implicitly means their freedom is being curtailed".

Letter to Paul Krugman, 9 July 2007.

The history of the US Health Care system is studded with attempts – all of which, from Roosevelt (1935) to Clinton (1994) have failed – to introduce diverse forms of national health insurance schemes. The failure of the Federal government to offer viable solutions to the problem has induced some States to institute reforms at the local level, trying out new models and new organisational structures. The type of reform varies widely from State to State, and is influenced by the political and fiscal realities of each; by the demographic and economic situation; by the dynamics of the insurance market and by many other factors which can and do affect a State's ability to act. The report "*State of the State 2008*" in *Academy Health*[9] gives an overall picture of the reforms carried out by individual States, placing them in three categories:

1. **Total reforms**: activated or proposed: in particular the reforms which are already in place in three states – Massachusetts (2006), Vermont (2006) and Maine (2003), where almost "universal" health care coverage has been set up – and which other States, such as California, New Jersey, Pennsylvania and New Mexico, are working towards achieving;

2. **Major reforms**: in 2007, various States, for example Washington, Oregon, Illinois, Indiana and Maryland, carried out reforms concerning not only an increase in insurance cover, but also innovations in the private sector, such as supply mechanisms, subsidies to pay for insurance cover and changes in the insurance market itself;
3. **Incremental reforms**: States such as Hawaii, Connecticut and Missouri have approved reforms which aim to increase health insurance cover in target populations: children, the elderly and the chronically ill.

One of the main methods used by States to increase health cover is to extend the reach of the Medicaid programme (a public programme designed to help specific categories of poor people). They are extending its reach by broadening the categories eligible for the programme, by increasing its benefits and, by making the application and admissions procedures leaner, less complex, to name but a few of the options chosen. In 2007, more than half the States in the USA used the Medicaid programme to increase the levels of health insurance cover and, in 2008, no State either reduced or set limits on the programme.

The Massachusetts Reform. This reform, enacted in April 2006, was promoted by the Republican Governor, Mitt Romney, who sought to set up universal health insurance cover, for all residents in the State, as from July 2007. Expansion of cover, setting up a structure to facilitate contacts between individuals, firms and insurance companies, a new system of subsidies, and the requirement that all people must have health insurance are the key elements of the reorganisation of the Massachusetts Health insurance system[10]. Companies with more than ten employees were now obliged to provide health insurance for their workers and those firms that decided not to offer such cover had to pay a fixed sum of US$ 295 to the State for each uninsured employee. At the time there were about 515,000 people with no health insurance in Massachusetts and, of these, around 39% obtained health cover through private insurance schemes, 38% obtained it by using State subsidies to pay the premiums, and 17% obtained it through the expansion of the Medicaid programme. However, about 6% of the population still had no medical cover[11].

The California Reform. The State of California watched the progress of the Massachusetts reform with great interest and, already in early 2007, the Republican Governor Schwarzenegger, introduced a bill to guarantee health insurance cover to all Californian citizens[12]. All those whose income was 100% of the poverty line were insured through the federal *Medi-Cal* programme*. However, both mothers with an income between 250% and 200% and adults with an income between 250% and 100% of the poverty line, could apply for subsidies to pay health insurance premiums through a common health insurance purchasing pool[13].

* 100% of poverty line is the income threshold below which an individual, or a family, is considered poor. Currently this threshold corresponds to an annual income of about US$ 10,000 for a single, US$ 14,000 for a family of two people, US$ 17,000 for a family of three people, etc. For instance, "*200% of the poverty line*" indicates an annual income of US$ 20,000 for a single.

The New Jersey Reform. New Jersey has recently decided to seek universal health insurance for its citizens. About one million and a half of the State's resident population (1 in 5) currently have no health insurance cover. Senator Joseph F. Vitale maintains that the first step to overcoming the gap would be to enrol all children in the current "NJ Family Care" programme which seeks to help families who earn up to 350% of the Federal poverty line – about 74,000 dollars for a family of four; another possible measure could be that of making health insurance compulsory for all. But unlike in Massachusetts, where many individual insurance plans are available on the private market, in New Jersey, there will be just one health insurance plan which is to be administered by the State: "we do not wish to follow the Massachusetts model: we need a permanent and lasting solution, not an emergency measure"[14], commented Senator Robert W. Singer.

While on the one hand, these reforms will benefit some US residents, on the other, they increase the disparities between States in terms of insurance cover, insurance services, costs and benefits. In particular, the States where a large proportion of the population is below the poverty line are still those where a larger proportion of residents remain without health insurance. **Figure 2** shows the uninsured rate for each State: in some it is still as high as 20% of the total population. There are other disparities too: for example in two States, New York and Illinois, the Medicaid programme includes rehabilitation treatments, while Medicaid in nearby New Jersey and Pennsylvania does not cover these services. There are

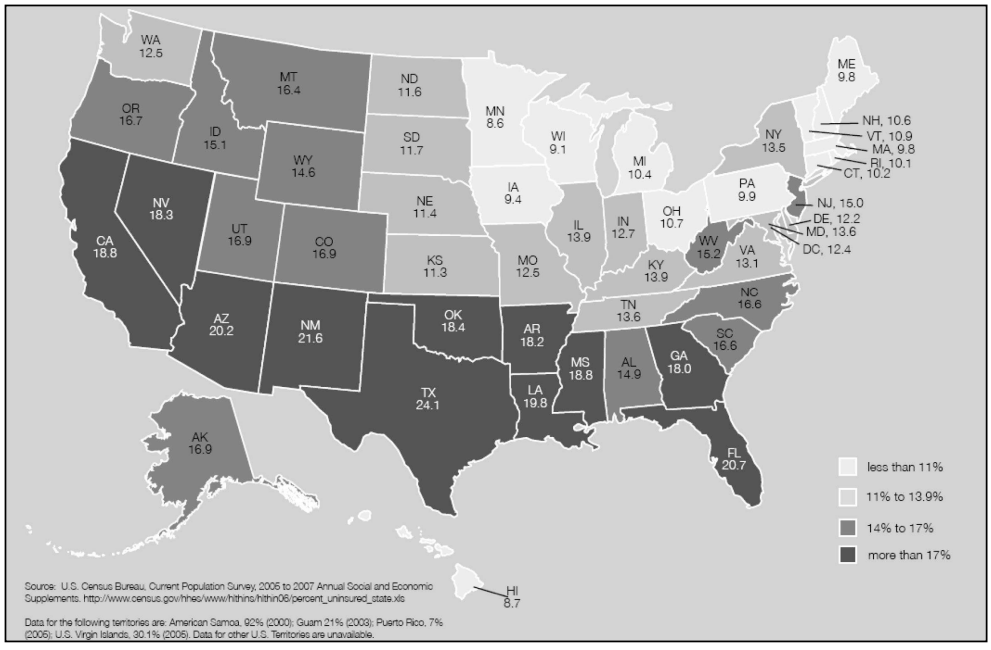

Figure 2. USA. Percentage of uninsured by State. Average for years 2005-2006
Source: US Census Bureau - 2007.

marked differences too in the cost per year of insurance premiums: for example, in Arkansas people pay 9,190 dollars per year while in New Hampshire they pay 11,385 dollars.

Barack Obama and his health care reform

As Jonathan Cohn, a journalist with New Republic, wrote in his book "*Sick: the untold story of America's health care crisis and the people who pay the price*"[15] – the US system did not develop from a carefully planned political programme, rather it is the result of a series of unconnected decisions that, when they were taken, seemed innocuous but which, in the end, have had a profound impact on US society. If this trend continues, by 2020, the United States will be consuming twice the current quota of its GDP allocated to health care and, consequently, will have to raise taxes in order to pay for it. The problem is how to find a workable solution. After the 1993-1994 Clinton reform failed, even the idea of a universal health insurance reform seemed to disappear from the national government agenda: the presidential elections of 2008 could offer an opportunity, for the first time since the mid nineties, of making changes in the health insurance system at the Federal level.

President Barack Obama, during his electoral campaign, argued that he would "*have the opportunity and obligation to turn the page and start anew with respect to the previous, failed, health policies*"[16]. Moreover, Obama declared: "*... if you already have a health insurance policy then nothing will change, except the premiums. They will be lower. If, however, you are one of the 45 million Americans who have no health insurance, you will be covered once my programme becomes law*". Obama's strategy focuses on an incremental type of reform strategy: making health insurance for children compulsory; setting up a new public health insurance scheme for those who are not covered by Medicaid, establishing a National Agency to help both individuals and companies to choose better quality, lower cost, i.e. affordable, policies and to encourage firms to insure employees through a "play or pay" scheme. The Clintons' failed attempt to reform health policy has taught us that it is important not to frighten Americans, and to leave in place, unchanged, anything that does function. "People who argue that there must be radical changes in the health system, think like this on the basis of their reading of a mixture of facts and reasoning which should be able to persuade Americans that a universal health system is efficacious, efficient and equal. Unfortunately, these are changes that must be made in the world of politics and public opinion, where values and perceptions carry more weight than facts and reasoning and where, should the facts not fit the values and prevailing climate of public opinion, they will tend to be rejected. This is especially true in the field of health services where people's behaviour is often highly contradictory, largely because it is so strongly influenced by a unique mixture of personal experiences, anecdotes and political propaganda and, also, by a set of values that often rigidly determines what is "Good" and what is "Bad""[17].

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