What Health Care System?

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The above title is meant to convey at least two aspects of our current discussions on health care: We don't have a national system, and we have the opportunity to design one, for which there are several models.

Those nations that do have national health care systems conform to one of three major structural models. From greater to lesser diversity and complexity, and from lesser to greater government involvement, the models are:

1. Universal health insurance is provided by "social insurance funds" or "sickness funds" that are highly regulated and not-for-profit. They also permit a limited role for private insurance in filling gaps in coverage. Examples: Germany, France, Japan, the Netherlands, and Switzerland.
2. There is a government-run insurance plan that covers everyone, and most physicians are in private practice. It functions like Medicare, and Canada is a well known example. Other examples are the Scandinavian countries, Australia, and Taiwan.
3. The health care delivery system is government-owned and care is delivered as a government service by salaried physicians. Our best known example is the Veterans Administration Health System. The U.K., Spain, and Cuba have such systems.

It isn't the economic and social efficiency of these models that Americans notice. We most notice the political context each brings with it. The first two models represent socialized insurance; only the third is socialized medicine. The only role for profit making in any of these is the "gap coverage" in the first. The ill-fated 1993-94 Clinton Health Reform Plan was modeled after the first of these models too. The Veterans Administration Health System is the only fully integrated, complete health system we have in America, and that permits it to better employ IT and to excel at quality assurance better than all the others.

In America, health care is seen as a commodity to be purchased, but all of these national models recognize health care as a social good to be shared, so they are universal. Donald Light has studied these healthcare systems and identified ten benchmarks that foster a "justice-based" health care system. These benchmarks include: universal participation regardless of health condition, risks and ability to pay; minimizing non-financial barriers; comprehensive and uniform services; equitable financing through community-rated contributions and ability to pay; value through clinical and financial efficiency; public accountability; and choice of providers.[1] About our "system," he has this to say:

> "… one could say that most societies have approximately the health care system that reflects what their business, professional, and political elite

> have wanted. This implies that we are unlikely to attain a health care system too much more ideal than the society in which we live. In the United States, we developed a health care system that reflected the priorities of the elite political and business: minimal governmental involvement or regulation, maximum free choice for patients and providers, the unfettered pursuit of high-tech subspecialty medicine, private voluntary insurance, and a capitalist dream of protected high-growth markets. These features led to a health care system with a high percentage of unnecessary tests, prescriptions, and procedures; by far the highest administrative costs in the world; the highest prices and costs in the world; a neglect of public health, prevention, and primary care; and one of the greatest misfits between health care needs and health care services."[2]

The society in which we live was created out of the most progressive thinking about human rights extant over two centuries ago, directed toward forming "a more perfect union." We haven't done that for health care, and we cannot do it without "the consent of the governed." Do Americans even realize that the rest of the world desires our leadership and expects us to develop a sound health care system for our own benefit as well as theirs?

Making Universal Health Care Universal

The Commission on Social Determinants of Health (CSDH), a commission of the World Health Organization (WHO) composed of an eminent group of 19 independent policy makers, academics, former heads of state, and former ministers of health, delivered a long-awaited report[3] to the WHO on August 28th. Launched in March 2005, its mandate was to investigate and report on evidence to guide action on social determinants of health to reduce health inequities. Among the worst causes of poor health and inequalities between and within countries identified by the CSDH are unemployment, unsafe workplaces, urban slums, globalization, and lack of access to health systems. In its report, the CSDH recommends that all nations provide universal health care based on assured access to primary health care, and that it be funded by general taxation and/or mandatory universal insurance. It expresses concern over the growing commercialization of services that threatens the sustainability of health care systems. "(The) toxic combination of bad policies, economics, and politics is, in large measure, responsible for the fact that a majority of people in the world do not enjoy the good health that is biologically possible," according to the CSDH.

Health equity through action on the social determinants of health should be a principal measure of the performance of governments according to the report. "We rely too much on medical interventions as a way of increasing life expectancy" explained Sir Michael Marmot, CSDH chair. "A more effective way of increasing life expectancy and improving health would be for every government policy and programme to be assessed for its impact on health and health equity; to make health and health equity a marker for government performance." Prof. Marmot is head of the epidemiology and public health

department at University College, London. He has been selected to be the Keynote Speaker at the American Public Health Association's Annual Meeting and Conference in San Diego in October.

Health equity is a key concept for the CSDH which states that "health equity depends vitally on the empowerment of individuals to challenge and change the unfair and steeply graded distribution of social resources to which everyone has equal claims and rights. Inequity in power interacts across four main dimensions – political, economic, social, and cultural – together constituting a continuum along which groups are, to varying degrees, excluded or included."[4] The report finds that the good health of the Nordic countries is rooted in commitment to universalist policies such as equality of rights to benefits and services, full employment, gender equity and low levels of social exclusion. Prof. Marmot said: "Central to the Commission's recommendations is creating the conditions for people to be empowered, to have freedom to lead flourishing lives. Nowhere is lack of empowerment more obvious than in the plight of women in many parts of the world. Health suffers as a result. Following our recommendations would dramatically improve the health and life chances of billions of people."

Guided by its ideal of social justice, the CSDH report issues four recommendations addressing political empowerment, including:

> "National- and local-level government ensure the fair representation of all groups and communities in decisionmaking that affects health, and in subsequent programme and service delivery and evaluation." (14.3)

The report sums up the relation between health determinants and health inequity as follows:

> "The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of peoples lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life. This unequal distribution of health-damaging experiences is not in any sense a 'natural' phenomenon."

The CSDH reports that in the U.S., 886,202 deaths would have been averted between 1991 and 2000 if mortality rates between whites and African Americans were equalized.[5]

Dr. David Satcher, former U.S. Surgeon General and a member of the CSDH, said: "New Orleans and its experience with Hurricane Katrina illustrate why we need to target social determinants of health – including housing, education, working and learning conditions,

and whether people are exposed to toxins – better than any place I can think of right now."

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[1] Donald W. Light, "Fostering a Justice-Based Health Care System." *Contemporary Sociology*, Vol. 29, No. 1 (Jan., 2000), pp. 62-74.

[2] Ibid, p.62.

[3] *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health.* (WHO, August 2008). Accessible at: http://www.who.int/social_determinants/final_report/en/index.html.

[4] For definitions of its key concepts, see: http://www.who.int/social_determinants/final_report/key_concepts/en/index.html.

[5] It contrasts this to the 176,633 lives saved in the U.S. by medical advances in the same period.