Critical thinking on health care policy

Countries, United States

Universal healthcare is a contentious topic in the United States. On one side, people argue the benefits of a single-payer system where individuals are covered by the government as the ultimate insurer. On the other side of the debate are those that argue that the government mustn't intervene in the healthcare marketplace at any cost. Healthcare consumes approximately 16% of the American GDP. This is due to a number of factors including: the high costs associated with long term advanced treatments such as dialysis and chemotherapy, as well as the fact that physicians earn more in the United States than in other countries. Ultimately, the United States spends more per capita on health care than any other country in the world (Khan, 2013).

Jonathan Cohn, in an article in The New Republic, writes a tome refuting conservative claims that the high cost of American health care results in the most advanced and innovative treatments (2007). Using the example of Deep Brain Stimulation for the treatment of Parkinson's Disease, he points out that many advanced treatments come from countries with socialized medicine. Indeed, the vast majority of medical research that comes out of America is not funded by the private sector, but rather takes place under the auspices of the National Institute of Health and its huge levels of government funding. Simultaneously, Mr. Cohn, acknowledges the unique position of private enterprise in America and cites the development of computerized tomography by General Electric as a major victory of private enterprise in the medical field. Ultimately, the question arises regarding what would national health insurance actually cover in America and what previously covered treatments would then be purely out of pocket? Without wading into

speculation, the conclusion is that some beneficial treatments would no longer be covered, but a greater good would be achieved by giving everyone coverage.

In contrast to the Cohn article, Paul Krugman and Robin Wells in their article The Health Care Crisis and What to do About it (2006), also suggest the benefits of a single payer or universal health system. The problem with health care in their eyes is that a very small percentage of the population consumes the vast majority of health care dollars expended in the US. Approximately 20% of the population consumes 80% of the medicine dispensed and astonishingly 1% of the population consumes more than 20% of all dollars spent. The reasons for this are obvious: a young healthy individual may go for several years without seeing a physician, while an elderly person with a host of chronic diseases will go to the doctor frequently and require costly constant treatments. Cancers, Kidney Dialysis, and Heart Failure account for an astonishingly high proportion of our health care spending, and these are diseases and treatments that are typically only used by older individuals. They further cite many attempts at cost control by the previous Bush administration, but state that they would hardly put a dent in the overall expenditures because no one would be willing to take the political risk of angering older voters on Medicare. Going through the history of the present system in America, the authors ultimately conclude that a single payer system a la the Canadian model is the remedy for American healthcare – furthermore, they believe that the development of such a system is inevitable.

In America, the government pays approximately 50% of all healthcare costs.

This may seem like a lot, but compared to other western countries, this is actually a very small percentage. Indeed, in Western Europe, advanced systems of national health insurance have developed where every individual is covered for medical care. The French system is illustrative of this fact. Approximately 85% of healthcare costs are borne by the state, and the total expenditure approximates 11% of GDP. Furthermore, France is considered to be a good medical system with minimal wait times for necessary or elective procedures. The French system requires a moderate pay-in of approximately 5. 25% of gross income and supposedly covers 80% of healthcare costs. The remaining percentage is either paid out of pocket, in an attempt to have the consumer control costs, or covered by supplemental insurance that any individual may buy (Clarke & Bidgood, 2013).

Indeed, the French model of a single-payer government system looks very attractive to the uninformed, but, a) this will require a massive overhaul of medicine in America, from medical schools to the hospitals, and b) it seems that most of the people who have “ researched” French medicine, haven’t the faintest of clues about how the system actually works. The French system currently reimburses a generaliste (a family practitioner) 23 euro per visit and 27 for a specialist. However, a physician is entitled to charge the patient what he wants (Thomson & Mossialos, 2004). If a physician wants 100 euro for the visit, the patient is ultimately required to pay the balance of the bill. France has some excellent physicians, however, they are also very expensive. Prof. Marescoux of the University of Strasbourg is a world leader in innovative surgeries. He performed the Lindbergh Procedure: the world’s first tele-surgery, as well as the world’s first scarless surgeries. Prof.

Marescoux charges 1000 euro for a consultation, and then a substantial amount for a surgical procedure he actually performs (Personal communication, July 11, 2013, interview of Prof. Marescoux's secretary). In fact, French national insurance only guarantees that you will be admitted into the hospital and looked after be interns (physicians straight out of medical school), or externes (medical students) – often times, medicine dispensed by the untrained resembles torture (Personal communication, July 11, 2013, interview of French medical student). French outcomes tend to be good and life expectancy in France is higher than in the United States. Furthermore, stories of sick and bankrupted individuals are few and far between. Unlike in America, where medical education can cost upwards of 200, 000 dollars, medical education in France is free. Thus, there are many institutional issues that make the French system possible, but unworkable presently in America.

Interestingly, US development aid promotes universal healthcare throughout the world by funding the systems of various countries (Garrett, 2012). These expenditures started during the Marshall Plan in Europe and continued through today through the funding of various developing countries. This is made all the more ridiculous considering the patchwork of private health insurers in America and the fact that 26% of Americans have faced serious financial hardships as a result of health care expenditures. A lack of health insurance means that individuals in America will often forego a doctor visit which could have detected and cured disease at a much earlier state for significantly less cost. Instead, the patients often wait until the disease is severe and then appear in the emergency room for the most expensive

possible treatment that America has.

Universal coverage seems to offer a panacea for the healthcare crisis in America. Proponents argue that in the long term it would reduce costs and be the most moral system, providing everyone with access to medicine when they need it. These goals are noble, but unworkable in the current system we have. Expenses in America come from a variety of sources, either the absurd price of education, the high toll that lawsuits take on physicians, and the high costs of advanced systems that are primarily developed in the US. Reining in the spending in many areas is required before we can seriously consider universal health coverage; otherwise we will be punishing physicians and researchers for their hard work and dedication to the field. Somehow, the United States must come to terms that for all the expenses, we are simply not producing the results that we'd hope for (Khan, 2013)

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