A U.S. Healthcare Retrospective
Within a Global Community

Historical Paper

Barry Hubert, MBA, FACMPE

August 4, 2017

This paper is being submitted in partial fulfillment of the requirements of Fellowship in the American College of Medical Practice Executives.
INTRODUCTION

Health care: like every other integral institution, it is embedded in a nation's culture, economy, and politics. The political scientist Margaret Levi has appropriately compared the development of such institutions to climbing an old tree. As the journey progresses, the climber is compelled to make choices about which branch system to follow. While it is possible to turn around or perhaps leap to another branch, the climber will continue on the original branch past the point of no return (Dutton, 2008).

This metaphor for how a nation's health care system evolves tells us that history matters, singular moments possess narrative power and that radical reversals may be hard to achieve. It doesn't mean, however, that while our health care journey differs from other countries that we shouldn't learn from them.

The objective of this historical paper is to trace the evolution of managed care in the U.S. and to investigate how it compares with other key industrialized nations, namely France and Germany. The presentation will reflect the cultural, economic, and political forces that have shaped the U.S. system from World War I to the present day. It is supported by a salient analysis from the literature of the cost and quality of the U.S. system when compared to generally-accepted global benchmarks.

At the conclusion, the paper will reflect on global best practices that are not conveyed through mainstream media and are not typically considered in the healthcare debate. The hope is that through a broader understanding of global best practices, the modern manager will be better equipped as an organizational leader, healthcare strategist and legislative advocate in the new value-based frontier.
"If you go back to 1960 or thereabouts, corporate taxes were about 4 percent of G.D.P. I mean, they bounced around some. And now, they're about 2 percent of G.D.P." Yet reflecting back 50 years ago on our industry "health care was 5 percent of G.D.P., and now it's about 17 percent. When American business talks about strangling our competitiveness, or that sort of thing, they're talking about something that as a percentage of G.D.P. has gone down, while medical costs, which are borne to a great extent by business has swelled. Medical costs are the tapeworm of American economic competitiveness." So declares the revered American businessman, the "Oracle of Omaha", Warren Buffett (Sorkin, Andrew Ross. "Forget Taxes, Warren Buffett Says. The Real Problem Is Health Care." The New York Times. The New York Times, 08 May 2017. Web. 16 May 2017).

Being a manager in today's U.S. health system is arguably more challenging than ever. The system is based largely on health insurance in various shapes and forms. The companies that have built and sustained that foundation work tirelessly to maximize returns for their shareholders, often by paying less for the services provided by medical groups, while simultaneously transferring sizable financial responsibility to the consumer of that care. As these companies trim costs at both ends of the delivery chain, practice overhead steadily rises year over year. It's an unsustainable cycle.

There is a humorous adage in the construction trade that there are three factors to any project. You can have fast service, high quality, or low cost. The problem is – you can only pick two! With healthcare, the growing expectation for medical managers is to deliver all three with the utmost excellence.
The United States has the reputation of being the best in clinical research and first in medical technology, so it gets high marks in those quality measures. It has some of the shortest patient wait times, so it is without peer in fast service; yet the U.S. system consistently highest among first-world nations for spending (Cain U.S. Insurance Agents, 2017). Paradoxically, the U.S. is also among the lowest ranked regarding key public health outcomes and continues to wrestle with the idea of delivering essential medical services to its population at a sustainable cost (Peterson Foundation, 2015).

Take a step back and compare the U.S. health system to shopping at the grocery store. Here, customers know what they will pay exactly for eggs, milk, and sugar. It would be foolish to spend a wildly different amount than what other customers pay for the same product. Yet it's easy to feel that the U.S. health system is rigged in this respect. Even when the consumer wants to find out basic price information, it's hard and at times impossible to uncover and doesn't reflect the best in free market conditions (Bartlett and Steele, 2006).

Do medical managers in the U.S. today have the historical perspective they need on how the current system came to be? Do they know how it compares to the systems of other wealthy developed countries who reap better health outcomes for the healthcare investment? In a nation proud of individual exceptionalism, is it possible to pause and learn from other countries on this crucial topic? Perhaps stakeholders, medical managers included, would do well to better understand how the U.S. system came to be and to learn from the experience of other countries.

**TYPES OF HEALTH SYSTEMS**

Before exploring the evolution of the U.S. health care system, it is helpful to offer a working definition of the primary types of systems found around the world.
**Single provider** systems are characterized by a government centrally funding health care, employing the care providers, and operating the care facilities. The United Kingdom (U.K.) is the prime global leader in this category.

The U.K.’s National Health Service was established in 1948 and fashioned after the landmark Beveridge Report of 1942. The three core principles conveyed in the report were (1) equal access to care (2) provision of comprehensive preventative and curative care, and (3) services to be provided at no cost to the patient at the point of service. It remains the oldest and largest single provider system in the world (Fried and Gaydos, 2012).

**Single payer** systems exist where one entity, typically the central government, collects, funds and pays for the care. Think here of Medicare for everyone. Proponents of this system say that because there is one large entity that purchases and manages resources, it is more cost-effective.

Most experts categorize the system in Canada as single payer. Care is rendered by both public and private practitioners using both public and private facilities. All citizens have basic coverage from the time of birth, 30% of whom purchase additional private insurance to supplement the coverage provided by the government. Canada, as evaluated by outside agencies, has contributed well to positive health outcomes at lower overall cost. In recent surveys, Canada spends 11.2% of GDP on health care while the U.S. spends 17.6% of GDP (Martin and Galea, 2017).

**Multi-tiered** systems exist where some costs are paid by the government, some by individuals, and some by employers. Creating treatment plans and obtaining approvals vary considerably because medical policies can be unique for every insurance provider. The systems of the U.S., France, and Germany are multi-tiered. These will be studied in more detail later in this paper.
**Universal Health Care (UHC).** UHC is a characteristic of a health system in which all residents have access to affordable, high-quality healthcare. It can be funded through a variety of financing arrangements involving both public and private sectors; therefore, UHC can be fundamental for any of the systems mentioned above. The U.K., Canada, Japan, France, Germany and most European countries have some form of UHC (Fried and Gaydos; 2012).

Countries with UHC typically have higher and sometimes drastically higher tax rates than the U.S. They are often simpler since doctors and patients have a good idea of what is covered and how the process works, which usually saves time in administration and decision making. These systems typically have streamlined systems for sharing medical information, such as a common electronic health record.

While an understanding of these various systems is necessary to a meaningful study, none of them exists in a theoretical vacuum. Each nation's healthcare system is an active reflection of its core values.

Canada is a federal parliamentary democracy and constitutional monarchy. Its health system reflects a national determination to take care of its citizens at moments of vulnerability, and to place well-being over wealth. "Health Canada is committed to improving the lives of all of Canada's people and to making this country's population among the healthiest in the world as measured by longevity, lifestyle and effective use of the public health care system."

The U.K. is a constitutional monarchy where the reigning monarch does not make open political decisions. Such decisions are considered by the Prime Minister and the Cabinet. The constitution for the U.K.'s National Health Service (NHS) reflects its core values, "The NHS belongs to the people. It is there to improve our health and well-being, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most." ("The NHS Constitution for England." The NHS Constitution for England - GOV.UK. N.p., n.d. Web. 01 Aug. 2017.)

Nordic countries are governed under Nordic Social Democracy, a combination of free market capitalism, a comprehensive welfare state, and collective bargaining at the national level. In this system, the government is viewed as a benevolent force whose role is to care for society. It maintains a belief in universalism in the context of welfare policy, and that services should be made available to all individuals. Consistent with these values, the government provides public education, healthcare, pension rights, public housing support, and other social programs to promote improved welfare. This belief is reflected in the willingness of the citizenry to be taxed for the common good, up to 50% of income.

Nordic countries have a centuries-old tradition very different from the U.S. As far back as the 1500s, church and state bureaucracies joined forces to provide for the common welfare. In the U.S. colonies, churches provided this welfare support. WWII brought people in the Nordic countries together and minimized individualism, paving the way for the modern day social contract. By contrast, U.S. history going back to colonial rule under King George III weaved a suspicion of government in the societal fabric (Bradley and Taylor, 2013).
Experts call this sense of common value *solidarity*, something that still eludes the health care discussion in the U.S. A Google search for "U.S. health system values" produces numerous hits, but all from disparate sources with viewpoints that differ on what the foundational principles are for the U.S. health system.

The rest of the world takes interest in the recent political battle in the U.S. over the Patient Protection and Affordable Care Act (ACA) signed into law during the Obama administration, and the "repeal and replace" pursuit of the American Health Care Act (AHCA). They view the debate as odd. For these countries, UHC is seen as a mundane fact of life and virtually a right of citizenship (Martin, Danielle, and Sandro Galea. "What Canada can teach the US about health care reform." STAT. STAT, 27 Mar. 2017. Web. 16 May 2017.).

The managed care debate is nothing new. It goes back over 100 years.

**MANAGED CARE IN THE UNITED STATES**

**The Early Years (Before 1970)**

The concept of health insurance was introduced in the modern industrial world by Chancellor Otto van Bismarck's plan to provide "social" insurance for the working men of Germany in 1883. The system was organized through independent sickness funds in order to stabilize incomes and provide funeral benefits for the country's workers, which equated to about one-third of the population. Employees paid two-thirds of the cost; employers paid one-third. Bismarck's goal was to wean the country off of socialism, but the initiative was so successful in raising the health level of workers that by WWI, ten European nations had adopted some form of compulsory health insurance, including the National Insurance Act passed by the British Parliament in 1911.
In the early twentieth century within the U.S., non-government reformers, including socialists, trade unionists, and progressives, along with a few political leaders, promoted the concept of health insurance. The first health plan proposals followed the German and British models, aiming to improve worker health on the grounds of industrial efficiency and social equity. The plans were to be funded by employers (40%), workers (40%) and the state (20%), and found champions in the American Association for Labor Legislation (AALL) and Theodore Roosevelt's Progressive Party.

Roosevelt campaigned for president at the turn of the twentieth century by saying, "Of all the questions which can come before this nation, short of the actual preservation of its existence in a great war, there is none which compares in importance with the great central task of leaving this land even a better land for our descendants than it is for us. Let me add that the health and vitality of our people are at least as well worth conserving as their forests, waters, lands, and minerals, and in this great work the national government must bear a most important work." (R, /. T. "Teddy Roosevelt and Healthcare." Teddy Roosevelt. N.p., 11 Sept. 2014. Web. 16 May 2017.)

While the AALL system was initially successful, the defeat of Theodore Roosevelt by Woodrow Wilson brought an end to progressivism. The insurance industry fought the idea, and physicians differed on the structure. The entry of the U.S. into WWI brought an end to the discussion as more pressing matters faced the nation. ("The Origins of Managed Health Care - Jones & Bartlett Learning." N.p., n.d. Web. 16 May 2017.)

The first modern health insurance plan was developed in 1929 by Justin Ford Kimball, vice president of Baylor University. He expanded care from work-related accidents to general hospitalization, which at the time encompassed the three most common surgical visits: OB
deliveries, appendectomy, and tonsillectomy/adenoidectomy. The plan attracted national attention to the point where a number of similar plans, later known as Blue Cross plans, expanded on the idea.

The American Medical Association (AMA) formed the Committee on the Economic Factors Affecting the Organization of Medicine to examine the problems leading to the rising costs of medical care. This, in turn, led to the formation of the Committee on the Cost of Medical Care (CCMC) (Bradley and Taylor, 2013).

The CCMC released this list of majority recommendations in 1932:

- Comprehensive medical service should be provided mainly by organized groups of practitioners, organized preferably around hospitals, encouraging high standards, and preserving personal relations.

- All necessary public health services should be extended to the entire population, requiring increased financial support, full-time trained health workers with security of tenure.

- Medical costs should be placed on a group payment basis through insurance, taxation, or both; individual fee-for-service should be available to those who prefer it, and cash benefits for wage loss should be kept separate.

- State and local agencies should be created to study, evaluate, and coordinate services, with particular attention to urban-rural coordination.
• Professional education should improve for physicians, health officers, dentists, pharmacists, registered nurses, nursing aides, midwives, and hospital and clinic administrators.

Even though the CCMC recommendations were not adopted, they did effect change. While medical insurance was considered but ultimately not included in the Social Security Act of 1935, the act provided federal grants to the states for public health service programs – the essence of the majority's second recommendation. In 1937 the campaign for voluntary group prepayment of hospital costs consummated in the formation of the Blue Cross program, representing elements of the majority's first and third recommendation. Blue Shield formed in 1939 to cover physician services.

Kaiser Foundation Health Plans started in 1937 by Dr. Sidney Garfield as part of the vision of his friend and industrialist, Henry J. Kaiser. At that time, large corporations provided housing, schools, churches, and entertainment to their employees in what was termed "welfare capitalism." This reached its apex with the Great Depression, which became a turning point in the history of American social politics. The Kaiser plan financed medical care for workers who were constructing an aqueduct in the southern California desert, and later for those building the Grand Coulee Dam in Washington State.

While the U.S. was being innovative in creating insurance plans at the local level, multiple European countries were developing national and compulsory insurance plans managed governmentally. Germany's led the way in 1883, with a plan originally designed for low-income individuals, Austria followed in 1888, Hungary in 1891, Denmark in 1892, Norway in 1909, Britain in 1911, and the Netherlands in 1913.
During the administration of Franklin Delano Roosevelt (FDR), the Farm Security Act collaborated with the U.S. Public Health Service to enroll people into prepaid medical cooperative plans. The program was initially circumscribed to rural, very low-income areas, and by 1942 there were 650,000 people participating. Rural physicians saw the value because it guaranteed them payment and kept their communities healthier. Only licensed physicians were eligible for reimbursement which promoted professionalization and secured these doctors a patient base (Bradley and Taylor, 2013).

The period from 1943 through 1946 was a turning point in the redefinition of social and economic relations in U.S. Medicine. It was during this time that Medicine became redefined as a business that served consumers, subject to free enterprise regulations. It moved from a paternalistic doctor-patient relationship to contractual equality and mutual responsibility. Social services were channeled primarily to governmental and non-profit agencies.

In this new era, numerous health plans were developed. In 1944 in response to needs of the City of New York in desiring coverage for its employees, the Health Insurance Plan (HIP) of Greater New York was created. In 1947, consumers in Seattle organized 400 families who contributed $100 each to form the Group Health Cooperative of Puget Sound.

Efforts continued at the highest level of the federal government to establish a national health system featuring UHC. As World War II (WWII) wound down, the Truman administration turned to domestic issues and in 1945 began work on a national health insurance plan that would provide coverage to all Americans and be paid for by a tax of four percent on the first $3,600 of wages and salaries. Truman argued that the system was not socialized medicine, because individuals could choose their doctors and hospital. The AMA opposed the proposal, labeling it "the red menace", and joined forces with the American Hospital Association (AHA) to back the
alternative Hill-Burton Act which, when it ultimately triumphed in 1946, provided abundant subsidies for hospital and nursing home construction over the next 25 years (Bartlett and Steele, 2006).

In 1954, the first Independent Practice Association (IPA) model Health Maintenance Organizations (HMOs) were formed and contracted with private practice fee-for-service (FFS) physicians to compete with group HMOs.

President Lyndon Johnson's landslide victory over Barry Goldwater in 1964 resulted in a dominant Democratic majority in both houses of Congress. Johnson pushed through Medicare to cover the elderly and Medicaid to cover low income individuals in 1965, cashing in his dominant political capital and taking advantage of a democrat-controlled legislature. Unions became one of the primary proponents of Medicare, wanting a program based on Social Security eligibility and funded by payroll taxes instead of income taxes. Eligibility based on Social Security participation destined high-income union members to be eligible. Funding through payroll taxes meant that the costs would be disproportionately borne by lower income, nonunion workers. The fact that many healthcare expenses would be paid by the government program rather than employer insurance plans indicated that wages for workers could be negotiated upward (Bartlett and Steele, 2006).

Once Medicare and Medicaid were introduced, medical costs began a startling ascent. From 1950 to 1965 per capita health care spending increased less than eight percent per year. After 1965, that rate grew to 14 percent per year. From 1965 to 1970, government spending at the state and federal level rose 20.8 percent annually.
The Adolescent Years (1970 – 1985)

The key health insurance event of the 1970s was triggered in December 1963, when the Studebaker Corporation closed its U.S. automobile factory in South Bend, Indiana, and abandoned workers with an underfunded pension plan. Congress responded to this and other pension concerns in 1974 with the Employee Retirement Income Security Act (ERISA).

The significant boost to the HMO movement was the enactment of the HMO Act of 1973 under President Richard Nixon. The Act authorized start-up funding and, more importantly, ensured access to an employer-based health insurance market. HMO plans that requested federal qualification did so for four main reasons: (1) Qualification represented a "seal of approval" that was useful in marketing. (2) The Act required employers to offer an HMO option. Qualification meant that your HMO would be on the list. (3) The Act allowed HMOs to override some state laws, vital in some markets. (4) Only qualified HMOs were eligible for non-profit grant or for-profit loan funding ("Health Maintenance Organization and the HMO Act of 1973." N.p., n.d. Web. 16 May 2017).

A core principle of managed care was the plan's role in medical decision making. The HMO would oversee and approve physicians' decisions (admit patient, how long to keep the person in the hospital, whether to order diagnostic tests), therefore limiting high cost activity.

After Vietnam, Alain Enthoven in the Carter administration developed a "Consumer Choice Health Plan" to encourage competition in the private sector. He foresaw government creating numerous HMOs that could then compete for consumers' business, creating a system of opposing health plans in which doctors and consumers could benefit from using resources wisely (Bartlett and Steele, 2006).
In many service areas, doctors and hospitals collaborated to form integrated delivery systems (IDS). Advances in computer technology allowed statistical evaluation of services provided by physicians. While this allowed assessment of quality, it also allowed the systems to vary payment based on capitation and risk-sharing. Technology also revolutionized the processing of medical and drug claims.

In 1982, Blue Cross and Blue Shield merged. Today, the Blue Cross Blue Shield (BCBS) Association is a consortium of 37 medical associations from across the U.S.


*Innovation*

Interest in market influences on healthcare took on new momentum under the Reagan administration, which worked to bring market forces to bear on healthcare. At the center of the conversation was the appropriate role for government. With communist countries falling in quick succession in the early 1990’s, proponents of small government involvement were emboldened in their argument. The tough question was how to find the right balance in healthcare between some government role, which hardly anyone rejected however much they disagreed on its extent, and the place of a private sector, evoking similar disagreement. Consensus on what might count as the right balance was elusive, a function of history, tradition, politics, and the flux of economic growth and economic recession (Callahan and Wasunna, 2006).

Until the 1980s, hospitals were not-for-profit entities. Under the Reagan administration, the first step was to cut off federal funding of HMOs, undoing the alliance formed in 1973 with Nixon, who embraced HMOs as the way to control costs and expand coverage for Americans. Critics of HMOs called it socialist, and doctors who participated with Kaiser were shunned. Government
funding of HMOs was low by Washington standards at $350 million in loans and grants over seven-year period from 1973 to 1980, but federal funding ceased altogether in 1981.

The U.S. Department of Health and Human Services (DHHS) commissioned a study by Touche Ross & Co on market-driven health care, "The Investors' Guide to Health Maintenance Organizations". DHHS sponsored workshops showing investors the benefit of health care investment. David Stockman wrote in 1979, "The secret is to liberate health consumers from the policy-induced stupor that has reduced them to passive, indirect payers when by nature they are accomplished, resourceful shoppers." (Bartlett and Steele, 2006, page 90). Hospital Corporation of American (HCA) was a pioneer of for-profit hospitals, as was Tenet Health. Unfortunately, this for-profit hospital model led to abuse. In 2002, Tenet was raided by the FBI for performing unnecessary cardiac procedures.

In 1996, the Health Insurance Portability and Accountability Act (HIPAA) was created with the goal of bringing administrative simplification through electronic interchange of basic transactions.

Maturation

HMOs grew rapidly in the 1980s but then started to decline in the 1990s when growth in PPOs gained momentum, while at the same time conventional health insurance enrollment declined. The National Committee for Quality Assurance (NCQA) was formed in 1979 by the HMOs' trade association and then became independent in 1991. Performance measurement systems were developed during this period, most prominently utilized by the Healthcare Effectiveness Data and Information Set (HEDIS).
In 1982, Congress moved to cap escalating hospital reimbursement rates under Medicare through implementing the diagnosis-related group (DRG) methodology. Under DRG, Medicare paid for hospital services by encounter and not length of time, which in turn compelled hospital systems to re-design their approach to length of stay. Four hundred and eighty-six DRGs were created with fixed reimbursement to replace the FFS system.

Health Security Act – Clinton Administration

The Clinton health care plan, formally titled the Health Security Act and nicknamed "Hillary Care" because of the First Lady's close involvement, was a cornerstone of Bill Clinton's first-term campaign for president in 1993. The goal of the plan was to provide comprehensive UHC for all Americans.

The core element of the proposed plan was an enforced mandate for employers to provide health insurance coverage to all of their employees. The Plan sought to have each U.S. citizen enrolled in a qualified health plan on his or her own or via programs offered by companies with over 5,000 full-time employees. Subsidies would be provided to those unable to afford coverage, including total subsidies for those earning beneath a determined level of income. Users would select plans offered by regional health alliances to be developed by each state. The Act also provided funding to be issued to the states for the administration of the plan, starting at $14 billion in 1993 and reaching $38 billion in 2003.

Instead of uniting behind the Clinton plan, Democrats offered a slate of conflicting proposals. The political jockeying within the Democratic Party, the addition of competing plans by conservatives and the insurance industry paired with their effective television commercials were influential in shaping public opinion and ultimately destroying the bill.
Victor Fuchs, a former president of the American Economic Association, helped conduct a survey in 1995 not long after the Clinton Health Security Act failed in Congress. "My principal conclusion", he wrote, "is that value differences among economists, as well as among Americans, are a major barrier to effective policy-making." His popular research underscored the idea that achieving the right balance between the market and government must reflect the culture, politics, and history of the respective country, and is very difficult to achieve (Callahan and Wasunna, 2006, Page 39).

Restructuring

After transforming many hospitals and HMOs into investor-owned companies, Wall Street turned its attention to physicians in the mid-1990s. National group medical practices and Physician Practice Management (PPM) companies formed. By 1998 10% of the nation's physicians were said to be part of a PPM. MedPartners and PhyCor were examples in the forefront. These also led to abuse. At the potential merger of Nashville-based PhyCor and Alabama-based MedPartners, a financial audit revealed problems. MedPartners' 1997 Q3 earnings were reported as $54M income on $1.61B in revenue. After being inspected by the FBI, the number dramatically turned into an $841M loss. It also proved to be an unsustainable model. PPM physicians paid up to 15 percent of their revenue to the PPM. In the end, PPMs had no real value and imploded (Bartlett and Steele, 2006).

During this period the lines blurred between HMOs, Preferred Provider Organizations (PPOs), and Independent Physician Associations (IPAs). No longer defined by one delivery model, these systems worked to incorporate elements of each other to expand market share. In some systems, the primary care physician became the "gatekeeper" for the patient, determining if, when, and to which specialist the patient would receive services. Consolidation became commonplace.
Managed Care in recent years: (After 2000)

During the economic boom of mid- to the late 1990s, employers found it necessary to compete for employees. This resulted in anti-managed care rhetoric. HMOs declined and then rebounded because of the popularity of Medicare HMOs. Market growth in Blue Cross Blue Shield was impressive, and payer companies consolidated like never before. And while health care costs stabilized in the 1990s, they soared upwards again at the turn of the new millennium.

By now, the system had evolved to such a level of complexity that there were myriad reasons for soaring costs including drug therapy, increased outpatient procedures, variation in practice behavior, high incomes for providers, overall demand for healthcare, high rate of lawsuits resulting in the practice of defensive medicine, high administrative costs, shifting of demographics and aging population, expectations for long and healthy life regardless of cost, and the cost of complying with government mandates.

Medicare Part D - 2006

The Medicare Prescription Drug Benefit, Part D, is a major health care benefit for the elderly created by the Medicare Modernization Act of 2003. Since its effective date of January 2006, Medicare Part D has provided prescription drug benefits to Medicare recipients.

Part D is subsidized by the U.S. Government and administered through private insurance companies. Currently, United Health Care is the largest provider of Part D benefits. In 2007, an estimated 24 million people were receiving benefits under Part D. At the end of 2008, estimated per beneficiary spending was $1,517, putting total expenditures that year at over $49 billion. Projected costs for Part D through 2018 is over $723 billion. About 45% of Part D funding replaces existing Medicaid, Veterans Administration (VA), and state-level programs for about 10
million people. Another 34% of the Part D covers middle-income recipients and may be lowering costs incurred with this group by other Parts of Medicare. The remainder of the budget assists catastrophic care needs for the very sick.

By design, the Medicare program is not allowed to negotiate drug prices; this is the responsibility of the private insurers who administer Part D products. The VA, however, can negotiate pricing; and conservative estimates say that if VA pricing could be overlaid on the Part D program, the government could save about $50 billion every year ("Medicare Part D." Wikipedia. Wikimedia Foundation, 22 Mar. 2017. Web. 16 May 2017).

Massachusetts Health Care Reform (Commonwealth Care) – 2006

In a move that most closely reflects solidarity for UHC in the U.S., in 2006 the Commonwealth of Massachusetts successfully implemented universal health care for its citizens, named Commonwealth Care. The law mandated that nearly every resident obtain a minimum level of insurance coverage, providing free insurance for residents who earn less than 150% of the Federal Poverty Level (FPL). It mandated that employers with more than ten full-time employees provide health insurance. If the employer failed to do so, it paid a penalty of $295 per employee per year, which was put into the Commonwealth Care Trust Fund to fund Commonwealth Care. The law established an independent public authority, the Commonwealth Health Insurance Connector Authority, also known as the Massachusetts Health Connector. The Connector acts as insurance broker to offer free, highly subsidized and full-price private insurance plans to residents. It was later used as a guide for the insurance exchanges of the Patient Protection and Affordable Care Act of the Obama administration.
In 2006, the number of uninsured residents in Massachusetts dropped from 6 percent to 2 percent. By 2011, the number of people receiving employer-sponsored health insurance fell by 500,000 ("Massachusetts health care reform." Wikipedia. Wikimedia Foundation, 15 May 2017. Web. 16 May 2017).

Patient Protection and Affordable Care Act ("Obamacare") - 2010

Healthcare reform was a major plank in President Obama's campaign; and in a message to a joint session of Congress in 2009, he cast his vision for health care reform. The Patient Protection and Affordable Care Act, commonly known as the Affordable Care Act (ACA) and nicknamed "Obamacare", was signed into law in March 2010. Three key factors led to the approval of Obamacare, all of which were lacking with the Clinton plan: (1) consistent lobbying by the president, (2) the presence of a scapegoat in the form of health insurers, and (3) the wisdom gleaned from the failure of the Clinton Health Security Act. Healthcare costs also rose dramatically from 1993 to 2009, providing a more dire economic landscape on which to paint the vision.

Under the ACA, Accountable Care Organizations (ACOs) became a foundational object of value-based reimbursement with the triple aim of (1) reducing health care costs (2) enhancing patient experience, and (3) improving population health. Even now in the latest revisions, population health has become a minor player in the system metrics (Bradley and Taylor, 2013).

American Health Care Act of 2017

As a prime example of the U.S. struggle with solidarity concerning UHC, the ideology of health care came into play again in the presidential election of 2016. Newly elected President Trump made a campaign commitment to "repeal and replace" the ACA. Just recently voted down by the
narrowest of margins in the Senate, some basic tenets of the American Health Care Act (AHCA) committed to retaining favorite parts of the ACA like coverage of dependents to age 26, prohibiting the exclusion of members for pre-existing conditions, and health insurance marketplaces. It sought to eliminate the "individual mandate", impose late enrollment penalties on people who don't stay covered, and reverse the provision for Medicaid expansion.

THE U.S. SYSTEM AND COMPARISON WITH FRANCE AND GERMANY

Citizens of the United States too quickly view all European health systems as the same and dismiss them collectively as "socialized medicine," a term that invokes strongly negative feelings for many who remember Cold War communism and its economic and societal failings. Yet each European country attacks the challenges of cost, efficiency, and access in different ways. As the U.S. health care debate continues, there is much that can be learned by examining other wealthy global neighbors. This overview will compare and contrast the systems of the United States, France, and Germany.

Health System of the United States

The following international systems reflect common characteristics found in segments of the U.S. health system:

*Germany (Bismarck)*: For those who get insurance through their jobs, hospitals and insurers are private, and financing comes through payroll deductions.

*Canada*: Everyone over 65 pays premiums, and the government manages this public plan by paying private doctors and hospitals.
**U.K. (Beveridge):** For Native American citizens and veterans the government provides healthcare financed by taxes, and the patient gets no bill. Care is delivered by government-employed providers at government-owned facilities.

**Poor nations:** For those who have no insurance, the U.S. system resembles out-of-pocket care found in most poor nations. People who can afford care get it and all others deal with the consequences ("What the US can learn from other nations' healthcare systems." Healthcare Reform Magazine. N.p., 04 June 2015. Web. 16 May 2017).

The Organization for Economic Cooperation and Development (OECD) is a consortium of 35 member countries worldwide who work collectively to identify, discuss, and analyze problems, and then develop policies to address those issues. Because of its work, the OECD has become a trusted source for data concerning health services and population health management ("History." History - OECD. N.p., n.d. Web. 01 Aug. 2017).

OECD data for 2016 reflected a recurring theme concerning the U.S. health system, ranking it the highest in health care spending per capita. In 2016 the U.S. spent approximately double that of other wealthy countries, and nearly three times the money spent by the average for all OECD countries combined ("Per Capita Healthcare Costs - International Comparison." Peter G. Peterson Foundation. N.p., 04 Feb. 2015. Web. 16 May 2017):

- U.S. $9,024
- Japan $4,152
- France $4,367
Drivers of cost for the U.S. health care include the following (Bradley and Taylor, 2013):

**Cutting edge research.** Cultural demand for the best medical technology and pharmaceuticals drives costly research and development. Continuous improvement in technology and drug therapy has the result of increasing expectations in the general patient population over time. Some analysts call the U.S. an infinity model, where medical innovation is always improving without limitation. By contrast, a finite model emphasizes quality of life over length of life, to accept illness, aging and death as a part of the human condition (Callahan and Wasunna, 2006).

**The rise in chronic diseases,** including obesity, which contributes significantly to end-of-life cost of care. Patients with chronic illness in the final two years of life account for 32% of total Medicare spending related to repeat doctor visits and hospital stays. The U.S. in comparison to other high-income nations has a higher rate of chronic illness and lower overall life expectancy.

**Fragmentation** between public and private payers and FFS models results in inefficiencies.

**Higher administrative costs.** Some estimates show that $361 billion is spent in annual administrative costs that are duplicative and wasteful. Also, insurance costs increase an average of 5% per year.
Over-testing. Fear of medical malpractice leads doctors to over-test. Inability to share test results by state, region or on the national level leads to duplicative testing.

Under-insurance. Patients who are under-insured commonly delay or avoid care due to the acceleration of greater financial responsibility transferred to them as the patient. When they do seek care, their condition has advanced to the point of requiring more involved and costly care.

The Kaiser Commission on Medicaid defined the Uninsured as those people between the ages of eighteen and sixty-five coming from low-income working families. Two-thirds have incomes below $30,000, which makes them too "wealthy" to qualify for Medicaid and much too poor to buy their insurance. Nearly 70 percent of this group come from families where at least one person works full time, while another 12 percent come from families with part-time employment.

There are also tens of millions of people who are underinsured. While they have some level of insurance, it does not reasonably cover the costs they may incur if they become sick. Viewed in the context of homeowner's insurance it is like having one's house burn down, only to discover that the insurance only covers a small portion of rebuilding costs (Bartlett and Steele, 2006).

Unfortunately, the U.S. system continues to fall far behind other industrialized nations regarding population health outcomes. In 2016, the U.S. ranked 29th in infant mortality with only six other OECD countries having worse rates, and 14 OECD countries having a rate half that of the U.S. Life expectancy at birth is another benchmark which is influenced highly by infant mortality, in which the U.S. ranked 26th with an average life expectancy of 79 years. Japan was the leader with 84 years, and virtually all western European countries had longer life expectancy than the U.S. ("America's Health Rankings"; http://www.americashealthrankings.org/learn/reports/2016-annual-report/comparison-with-other-nations; United Health Foundation, 2017).
Americans are frustrated by the idea that they spend more but get less in health care because it runs counter to their orientation with capitalism. They expect value for their investment and lay the blame for high costs on inefficient government programs, money-hungry insurance companies, wasteful hospitals, and soaring pharmaceutical expenses.

While this opinion can be supported by data, it isn't the complete picture. Most U.S. health care expenses finance hospitals, physicians, and clinics. Government spending covers 45 percent of total costs through Medicare and Medicaid. Private insurance covers 34.5 percent and private resources 13.5 percent. The remainder is VA and other third-party payers and programs.

While other countries produce better results with these outcome metrics, the U.S. excels with the following (Bradley and Taylor, 2013):

- The speed at which healthcare is delivered.
- Percentage of people who get referred to a medical specialist and who see the specialist within one month.
- Percentage of people who receive diabetes treatment within six months.
- The number of individuals who are living with a kidney transplant.
- The proportion of women age 20 to 69 years who get screened for cervical cancer.

And also:

- Knee replacements performed per year.
• Percentage of seniors needing hip replacement who receive one within six months.

• The number of catheterizations, angioplasties, and bypass surgeries; more than any European country.

• The number of MRI scanners with 26 per million people, while England has 5.6 and Canada has 8.

Though these statistics speak well for the U.S., Congress recognized the need for further improvement, passing the ACA in 2010 in order to bring basic health benefits to more Americans and to address escalating costs. Highlights of the ACA include:

• The “individual mandate”, whereby citizens must have insurance via their employer, individual plan, or public program.

• To ease access to care, the ACA prohibits coverage exclusion for pre-existing conditions.

• The ACA created Health Insurance Exchanges, where individuals with income at 100% to 400% of the federal poverty level became eligible for advance-able premium tax credits to subsidize their insurance costs.

• Medicaid expansion. As of 2015, 30 U.S. states chose to expand Medicaid, available to individuals earning at 130% or below of the federal poverty level.

The ACA represented one of the boldest and most dramatic changes in U.S. health care since the Johnson administration. Estimates are that 20 million individuals have insurance through the exchanges or Medicaid expansion (Pearl, 2017). Before the ACA, 50 million Americans were
uninsured. In developing the ACA, the Obama administration divided this vast number into three groups:

1. Those who had low incomes but didn't qualify for Medicaid. The ACA's Medicaid expansion provision was designed to help this group.

2. Those who earned more than the first group, but not enough to afford private insurance. Health Insurance Exchanges with significant subsidies based on income was designed to assist this group.

3. Those who could not afford insurance due to pre-existing conditions. The outright prohibition of this exclusion was a key component of the ACA to help this group.

Even though the ACA brought numerous improvements, there are still problems to be solved. As of 2014, these conditions remained ("The U.S. Health Care System: An International Perspective." DPEAFLCIO. N.p., n.d. Web. 16 May 2017):

- 10.4% of Americans were still uninsured.

- In the 20 states without Medicaid expansion, 3 million poor adults fall into the coverage gap. The biggest concentration is in the southern states of Texas, Florida, Georgia, and North Carolina.

- The largest coverage gains with the ACA were with low-income, people of color, and young adults.
• 49% of American adults reported getting health insurance from an employer. Still, 11.2% of full-time workers do not have health insurance. Among small firms (3 – 199 employees) in 2015, only 56% offered health insurance, compared to 98% of big companies.

• 19.3% of the population living below the federal poverty line ($23,550/year for family of four) were uninsured.

Some of the high level challenges of providing UHC in the U.S. relates to its large geographic footprint, racially diverse citizenry, high obesity rates, and concern that the medical research done in the U.S. – and which benefits the rest of the world – will be impacted negatively by cost controls characteristic of a UHC system. While the perception in the U.S. is that the systems of other countries with UHC suffer unreasonable wait times, the consensus among health care observers is that for emergent and urgent medical issues, wait times are comparable between systems. The difference comes into play concerning non-urgent and elective medical care. In these situations, wait times can vary wildly ("U.S. Health Care vs Health Care Systems in Other Countries." U.S. Health Care vs Health Care Systems in Other Countries | US Insurance Agents. N.p., n.d. Web. 16 May 2017).

There is also a deeply ingrained resistance in the U.S. to the notion of emulating another country. Americans are known more as rugged individualists and not as collectivists. Mitt Romney said in 2001, "God did not create this country to be a nation of followers." Observers also see reflected in the politics of the U.S. the concept of exceptionalism. The success of the U.S. in many areas has only reinforced this identity. There is also the fear that copying other democracies is synonymous with lurching to the left (Rmuse. "Why Americans Can't Have Universal Healthcare Like Europeans." Politicus USA. N.p., 10 Feb. 2016. Web. 16 May 2017).
The market approach is successful in most segments of the U.S. economy, but many critics are concluding that one large exception is health care. The core principle of the market approach is that companies will compete by selling more products to everyone, yet that's the last thing desired with health care. The goal of the system should be to sell less: fewer doctor visits, fewer diagnostic tests, fewer hospitalizations, fewer consultations with specialists, fewer prescriptions.

Perhaps the most dramatic example of market approach inadequacy relates to pharmaceuticals. In 1980 drug expenditures were $12 billion according to Centers for Disease Control (CDC), which was 4.9 percent of total health care outlays. By 2002, spending grew 1,250 percent to $162 billion, approaching 15 percent of total health care outlays. Only part of the increase was due to inflation. The rest was from pharmaceutical companies selling more drugs to more people for longer periods of time.

Since the 1980s America's health care bureaucracy has mushroomed into one of the nation's fastest-growing industries. Yet many critics believe it fails to serve consumers or to improve the delivery of medical services. Rather, it's driven solely by the need to manage the process of referrals, billing, and reimbursement among the nation's thousands of health plans. To do so, it uses an army of call-center clerical workers, claims-processing agents, software developers, private contractors who manage medical back offices, and on-site accounting personnel who track claims for doctors' office and hospitals.

Hundreds of thousands of people are part of the bureaucracy that has evolved from insurers' efforts to deny, discourage, or postpone medical care, and to shift more of the expense to consumers. At best, it is a costly and wasteful system that siphons off precious health care dollars. At worst, it causes injury and death.
It wasn't supposed to be this way. For-profit health care wasn't sold to the American public on this basis. When market-based medicine began to take hold in the 1980s, the idea was that it would modernize the field and reduce spending; however, contrary to American business schools, the opposite happened. A massive bureaucracy grew up to administer an ever-more-intricate matrix of health plans wanting an ever-larger share of health care dollars. Increasingly, the industry is designed to shut out those who are perceived as liabilities. The healthcare industrial complex has also become adept at lobbying Washington. In the last fifteen years, HMOs, insurers, pharmaceutical makers, hospital corps, and physicians have collectively contributed $479 million to political campaigns. More than energy ($315M), commercial banks ($133M) and big tobacco ($52M) (Bartlett and Steele, 2006).

**Health System of France**

What the U.S. and French health care systems share, and what divides them, is reflected in their respective eighteenth-century revolutions. American and French revolutionaries alike held high the Enlightenment concepts of individual rights and popular sovereignty, leading to an unavoidable tension between personal liberty and social equality in the republics they formed. This tension has been exhibited in virtually all health care reform initiatives since WWI which sought to require its citizens to participate in health insurance.

Such debates have occurred on five occasions in the United States and twice in France. Each time, a central question was whether individual liberty should be sacrificed for the sake of collective equality and the common good. In both countries, the debates contained nuanced arguments that sought to reconcile liberty and equality. Proponents argue that to compel a sacrifice in the form of a tax on the individual ultimately frees him or her from fear of medical indigence. The net outcome, states this argument, leads to greater liberty, not less. Opponents of
mandatory health insurance consistently promote voluntary measures, which make a powerful appeal to individual liberty, personal responsibility, and worker autonomy (Dutton, 2008).

These questions remain at the heart of contemporary health care debates in both countries. How should the terms "liberty" and "equality" be interpreted today? Does liberty require that health care be free from government involvement? Does equality require the same access to medical care without regard to a person's ability to pay? Does it mean that insurers must accept all people regardless of medical risk? The tension between liberty and equality has been characterized in different ways over the course of the twentieth century: as personal responsibility versus social welfare, private enterprise versus communism, voluntarism versus compulsion, and individualism versus interdependent citizenship, just to name a few.

The U.S. and French health care systems were strikingly similar one hundred years ago. Many similarities remain today:

- The U.S. and France share the designation of having two of the most expensive health care systems in the world.

- The French system shares attachment to workplace health security, respects the ideals of patient choice and private practitioners, and maintains a common distrust of "socialized medicine."

- The U.S. and France rely on health insurance where facilities and health professionals are in both the public and private sectors with funding flowing from public insurance funds and private insurers.
• Both countries have voracious appetites for better diagnostic techniques and pharmaceuticals and highly trained and compensated practitioners.

• Both have large and growing elderly populations that threaten health care pricing.

• Patients have direct access and can choose their medical care provider.

• Physicians are autonomous and have the freedom of diagnosing and prescribing, and they are reimbursed on a FFS basis.

• There is a high level of confidentiality in both systems.

• Funding is done largely by employee/employer methodology. In this system, the employer pays 13%, and the employee pays 7% of earnings.

Historically, both nations developed the concept of health insurance to protect industrial workers, therefore unwittingly creating a class of "haves" (industrial workers) and "have nots" (agricultural workers). By extension, this created the social perception that there are people who are "deserving" and those who are "undeserving" for all practical purposes. In the U.S., the distinction also caused disparity along racial and ethnic lines.

French historian Alexis de Tocqueville traveled widely in the U.S. during the 1830s, attempting to understand the institutions of the U.S. in order to further understand France in a better way, especially its challenges in balancing liberty and equality. He observed, "In America, free morals have made free political institutions; in France, it is for free political institutions to mould morals." (Dutton, 2008, Page 9)
The French Revolution was born out of much greater aristocratic privilege, and as a result, the revolutionaries exercised the power of the state to shape liberty and equality for the masses, repurposing the force previously exploited by monarchs, showing a commitment to equality differently than what the American founding fathers envisioned. Philosopher Jean-Jacques Rousseau influenced the revolutionaries in France with the idea of a "general will," a sort of infallible common good to which all should submit.

France and the U.S. were the most active social reformers in light of the Great Depression that began in 1929. Both FDR in the U.S. and Prime Minister Leon Blum in France used Keynesian public spending plans in an attempt to revive their stalled economies. Under France's system in the 1930s, a patient had the freedom to pick a doctor and received care on a FFS basis. The patient could then be reimbursed 80 percent of what was approved by a local syndicate.

These differences dating back to the respective revolutions have resulted in differences between the two systems today ("HEALTH CARE IN FRANCE AND THE UNITED STATES - Brookings." N.p., n.d. Web. 16 May 2017):

- In France, premiums are calculated as percentage of wages, not at flat rates based on risk class as in the U.S. system.

- Premiums are jointly administered by employers and employees in quasi-public funds. Private sector insurance companies work with the quasi-public entities in managing the system. Quasi-public funds cover 75% of overall costs. In the U.S., the Medicare and Medicaid programs cover 43% of total expenses.

- In the U.S., benefits are tied to income, while in France they are attached to level of illness.
• Reforms in France circa 1945 severed the connection between individual employment status and health security.

• Doctor fees are negotiated at the national level, called "conventions."

• Private insurance company total expense makes up 12% while in U.S. it is nearly three times as much at 33%.

• Out-of-pocket expense is 12%, while out-of-pocket expenses for Americans is 35%.

• Hospitals are mostly public institutions, and physicians are salaried. In the U.S., there is a combination, but mostly private.

• In France, administrative costs are 5% of total expenses. In the U.S. these costs make up 14% of total expense.

• In France, practice liability costs are low since the country has a tort-averse climate. Physician compensation and medical malpractice costs are much higher in the U.S. as tort reform laws differ by state.

Health System of Germany

Germany is a federal parliamentary republic, with a compulsory health insurance system imposed by Otto von Bismarck over 130 years ago. It has proven to be a durable system, surviving the division of the country after WWII, the fall of the Berlin wall in 1989 and reunification of Germany in 1990. The financial crisis of 2008 put a strain on the system because of the ripple effect of German investments dependent on the U.S. housing market. As with all health systems,
the chronic burden of cost containment is real and ongoing. As of 2011 the German system had accumulated a deficit of EUR15 billion (US$ 20million) (Fried and Gaydos, 2012).

In the German health system, the employee and employer together pay into "sickness funds." As of 2010, Germany had 166 sickness funds, typically organized by occupation or region. The contribution is based on the employee's gross income. 15.5% of employee earnings up to $US 62,781 is contributed to the fund. The employer contributes 7.3%, and the employee contributes 8.2%. Similar to France, the contribution made is based on income level and is not a risk-based calculation.

Two hundred forty insurance providers draw from the "sickness funds" to cover 90% of German citizens. The remaining 10% are high income earners who pay for private health insurance. Average per capita cost for medical care is less than 50% of what is spent in the U.S. The fund is managed sometimes by the government and sometimes by non-profit organizations depending on the type of care provider and setting.

The system has no deductibles and maintains low copays. The German government covers children entirely. Coverage by the system is comprehensive including physiotherapeutic, rehabilitation, eyeglasses, medical appliances and dental care. Modest copays have typically been required only for drug and dental benefits. Care is delivered by private practitioners who are private entrepreneurs and are reimbursed on a FFS basis.

Pharmaceutical provision, a matter of exceptional cost in the U.S. system, is highly regulated. Drug companies are allowed to set pricing for the first year a new drug is on the market. In the second and subsequent years, the company is subject to comparative cost/benefit scrutiny ("The
One of the hallmarks of the German health system is its decentralized structure which has successfully integrated numerous stakeholder groups in its administration and policymaking and has contributed to favorable relations with industry. Over time, however, the federal government has increased regulations on a system originally intended to reflect regional autonomy.

A central concept of the German system is contribution rate stability, linking the healthcare budget to business. The idea is to correlate the increase in premium with the growth in worker wages. In order to keep these two in sync, the system relies profoundly on budgets and pure stakeholder determination to stay within those healthcare budgets. This budget mechanism caps the amount each physician can bill the system each year. Many experts believe this system to be one of the most successful in terms of quality and cost.

Since 2009 there has been a new central health fund, and contributions to sickness funds are set uniformly. Contributions are pooled in the central fund and allocated to sickness funds on a risk-adjusted basis. The calculation is based on age, gender and morbidity scored from 80 chronic or other serious illnesses.

Hospital operating and capital costs are funded differently, through area government funds out of general taxes. The DRG reimbursement model was implemented in 2005 for virtually all hospital care to control high costs related to length of stay.

Physicians in the ambulatory private practice setting do not have hospital privileges and are reimbursed on a nationally negotiated FFS model. While private doctors can accept privately insured patients (the 10% group), they must also treat sickness fund patients (the 90% group).
Hospital physicians are salaried. Specialties that typically practice in both settings are duplicated, since a specialist who works in the ambulatory settings does not see patients in the hospital setting. Likewise, a specialist who sees a patient in the hospital does not see them once the patient is discharged.

The system has classically used supply-side cost controls. In recent years, it has worked to implement demand-side measures that are very familiar with the U.S. health system, such as these (Fried and Gaydos, 2012):

- Control of test ordering behavior.
- Utilization review including prior authorization programs.
- Gatekeeper roles for ambulatory primary care physicians.
- Preferred provider arrangements based on the physician's willingness to accept lower reimbursement rates.
- Consolidated purchasing power.

GLOBAL BEST PRACTICES

U.S. "medical care" compared to global "health care"

Health sociologists Elizabeth Bradley and Lauren Taylor have a different perspective on the OECD's measurement of healthcare expenses. The OECD defines healthcare costs as all spending on the final consumption of health goods and services plus capital investment in infrastructure. Not included in the OECD benchmark are expenses for relevant social services...
that contribute to a healthy population by supporting economic well-being, such as investments in
support of housing, nutrition, education, the environment, and employment. The World Health
Organization (WHO) describes health more broadly, defining it as a state of complete physical,
mental and social well-being (Bradley and Taylor, 2013).

For purposes of the discussion that follows, the term "medical care" will refer to the focused
OECD definition and "health care" the broader WHO definition that encompasses medical care
and relevant social services. By examining the health system design and spending of other
countries, one can see that medical care alone cannot solve the problem. Social and behavioral
factors contribute to over 70 percent of colon cancer and stroke, over 80 percent of coronary heart
disease, and over 90 percent of adult-onset (type 2) diabetes (Bradley and Taylor, 2013).

The U.S. is spending an extraordinary amount of medical care, along with substantial effort on
how it is compensated and delivered; however, it is not spending as much as other industrialized
nations on the relevant social services that produce the best in health care for its population. The
U.S. spends 10 percent of GDP on social services while France, Sweden, Austria, Switzerland,
Denmark, and Italy spend about 20 percent of GDP.

Considering the broader definition of spending for health care, the U.S. then no longer spends the
largest percentage of GDP. In 2007, the U.S. devoted 25 percent of GDP on health care while
Sweden, France, Austria, Switzerland, and Denmark dedicated 30 to 33 percent of GDP.
Therefore, while ranked first in spending for medical care, the U.S. ranked thirteenth in
investment for health care. As might be expected, the countries with high health care spending
had significantly better life expectancy and rates of infant mortality (Bradley and Taylor, 2013).
In the last century the U.S. made two significant starts toward health systems that address both medical and relevant social service components. The first was during the 1960s through the public sector; the second from the 1970s to 1990s through the private sector.

The War on Poverty during the Johnson administration centered on community centers and started to encompass a broader perspective on managing health. The Economic Opportunity Act of 1964 was the centerpiece and administered funds through the Office of Economic Opportunity. The Job Corps and Head Start programs were established on the idea that people need to be lifted out of poverty before their health status can be fully addressed. Dr. Geiger and Dr. Gibson of Tufts University received some of the first grant money and set up centers in Boston and rural Mississippi. These centers allowed people to get assistance with medical services as well as housing, job training and other support services. As the popularity of these centers grew, mainstream medicine voiced opposition, especially through the AMA. Conservative legislators also took notice and altered the scene in a 1967 legislative revision, limiting services to those living below the federal poverty line.

The election of Nixon brought new attention to the programs of the Great Society, and funding again focused on low income individuals. Left with the challenge of providing health care to the broader population while controlling costs, Nixon aligned with the HMO model pioneered by Kaiser and signed into law the HMO Act of 1973, providing grants to non-profit HMOs and loans to for-profit institutions looking to propagate the prepaid medical care model. The Act did this with a relatively small investment by Washington standards at $350 million.

Over time, the relevant social service elements of both programs were whittled away and fell back to a focus on medical care. Historically in the U.S., giving broad control to the government is readily cast as socialism and restrictive to free enterprise. History also shows that giving the
stewardship wholly to corporate America raises the risk of fueling profiteering. To balance the two is a tremendous challenge (Bradley and Taylor, 2013). Here, then, is an opportunity to evaluate international successes to see whether a healthy tension between corporate and government control over healthcare can be achieved.

A Hybrid Model based on Global Best Practices

To take broad tour at global best practices, consider the thoughts of Mark Britnell, a uniquely qualified voice in the healthcare dialogue. Mr. Britnell has been a key member of leadership for the NHS in the U.K., now serves on the Board of Management for the NHS, he is a member of the Global Agenda Council on the Future of the Health Sector for the World Economic Forum, as well as the Global Chairman and Senior Partner for Health at KPMG. He has traveled the world extensively in his role as health care policy leader. In his view, the ideal global health system would reflect the following qualities, all worthy of a brief overview (Britnell, 2015):

_UHC and health values of the U.K._ The NHS was the world's first UHC established in 1948 after WWII. Stated earlier, but worthy of repetition in this context, the first Constitution for the NHS in 2008 states, "The NHS belongs to the people and exists to improve our health and well-being, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most." ("The NHS Constitution for England." The NHS Constitution for England - GOV.UK. N.p., n.d. Web. 01 Aug. 2017)
**Israel's primary care system.** The foundation of this system is strong primary care made possible through four major HMOs. The HMOs act as purchaser and provider of preventative, primary and community services, and some run hospitals. Accessibility to care is high, virtually around the clock, with two-thirds of its citizens recently reporting being able to see a primary care provider the same day. Israel has the best life expectancy in the world at 82.1 years and spends the lowest share of GDP on medical care at 7.2%.

**Brazil's community services.** The Unified Health System and Family Health Programme were created by constitution in 1988. This nationally scaled model of community services works with geographically defined population groups of about 4,000 in size. Each care team consists of a doctor, nurse, nurse auxiliary and six community health workers. This team serves 100 to 150 households and visits them monthly regardless of need and conducts immunization, chronic disease management, health promotion and screening updates.

**Australia's mental health system and general well-being.** The OECD report Making Mental Health Count cites spending at hospitals for mental health dropped from 46% to 12% and community psychiatry rose from 24% to 39% under this system. Australia is ranked first on the 2014 OECD Better Life index which measures major determinants that support good mental health. Employment, civic participation, education, sense of community and work-life balance are featured in this report.

**Health promotion of the Nordic countries (Denmark, Finland, Iceland, Norway and Sweden).** These countries are global leaders with the lowest behavioral health risk factors such as smoking, alcohol consumption, obesity rates and exercise.
*Africa's patient and community empowerment.* For economic reasons, this continent has been forced to be innovative, forging relationships with patients as partners and communities as care givers. Africa has tremendous patient activation highlighted by community activism, patient education, and social marketing.

*United States' research and development.* The medical research and development (R&D) of the U.S. benefits the entire global community. $130 billion was invested in R&D in 2011, more than the investment of all EU member nations combined. The U.S. investment level is the highest in terms of GDP, but also produces the most Nobel prizes and "high impact" drugs. The integrated health delivery system of Kaiser has reached worldwide recognition.

*India's innovation, flair and speed.* Apollo Hospitals is the largest provider of telemedicine in India. It has made an exceptional impact on leveraging the medical expertise of the highly populated cities to the large rural population of the country.

*Singapore's information, communications and technology.* This country introduced its National Electronic Health Record (NEHR) in 2011. All hospitals, community facilities, general practitioners and long-term care homes are linked to the NEHR, enabling full analysis of clinical, financial and operational data.

*Choice of France.* The country's system is based on three principles: (1) personal payments by patients (2) choice of doctor and (3) clinical freedom. One-third of hospitals are for-profit, one-fifth are not-for-profit, and the remainder are publicly owned.

*Funding of Switzerland.* This is the least financially distressed of the featured countries, grounded in a very strong global economy. The country spends a generous 11.5 per cent of GDP or $10,000 per person on medical care. Life expectancy is high at 82.7 years.
**Aged care of Japan.** Life expectancy here is 83.3 years with one-quarter of the Japanese people now over the age of 65. The population is set to shrink from 122 million in 2015 to 90 million by 2055. With a sluggish economy and low growth, this places a huge burden on the medical care system. In 2000, Japan implemented a forced long-term care contribution plan. Everyone over 40 years of age is required to contribute.

**Improving upon the U.S. Health System**

While it is beneficial to have a perspective on the history of U.S. managed care and to have broad exposure to global best practices, medical managers must also seek a pragmatic battle plan.

Robert Pearl, CEO of Kaiser Health, recommends four "pillars" in his recent book, Mistreated.

*Integration matters.* Studies show that medical care delivery through integrated systems with multi-specialty medical groups and associated hospitals reflects higher quality care at a lower cost. Large integrated systems are able to benefit from economies of scale but can readily appear impersonal. They must strive to create an environment that allows not just operational excellence, but also customer intimacy, something at which community physicians and hospitals excel. Greater integration and a renewed focus on primary care would make it possible to improve population health outcomes and potentially reduce expensive hospital stays.

*Health care must be prepaid.* While other countries have implemented different cost control mechanisms, the most successful to date in the U.S. has been the prepaid model of HMOs. At the organization level, it provides incentives for keeping patients well so there is lower utilization of expensive medical services. While the U.S. system is excellent at dealing with medical crises, it is always preferable to avert the crisis and avoid the need for medical intervention.
Health care must be technology enabled. Today, fragmentation generates substantial cost. A system that has a comprehensive electronic health record and technology-enabled communication with patients and capability for virtual consultations will save significant expense. Telemedicine must be brought to the forefront using mobile and video technology.

Health care must be physician led. Having the best training and development programs in place for physician leaders will be crucial. In the U.S. for every 100,000 patients, there are sixty-six specialists and forty-six primary care physicians. In global health systems with the best outcomes, that ratio is reversed (Pearl, 2017).

These four pillars have been implemented to varying degrees and with different levels of success in the United States. The U.S. is a market-driven economy, yet history has shown that the balance between equity and choice is delicate and hard to achieve. A healthy market-driven system should embody patient choice, negotiated contracts and open bidding. Price, quality and market share should all be rallying points for market dynamics. Markets can be introduced into different sectors of the health care delivery chain: in funding, in production, in providing competitive incentives to influence behavior of physicians, nurses, support personnel or providers of home care. It isn't just one large choice between state-run or market-run, but rather a chain of smaller decisions and approximations, if not outright compromises. "The best way of dealing with the market-government balance is by simply positing that universal access to necessary health care is a central organizing principle of a good society. From this normative starting point, a market becomes an instrument of social policy, rather than a religious belief system." - Richard B. Saltman (Callahan and Wasunna, 2006, Page 45).
CONCLUSION

This paper has examined the evolution of the U.S. managed care system over the past century. It has considered the way in which that system compares with the wealthy industrialized nations of France and Germany. It has taken a brief overview of best practices from around the globe and looked at ideas specific to improving the U.S. system. This has been presented with the goal of assisting medical managers to be better informed, to think more deeply and independently, and to better adapt to the continuing shift in the U.S. system both in the public and privates domains.

"I'd say the only thing more difficult than peace between Israel and the Palestinians is health care." - Donald Trump (Lahut, Jake, James Higdon, Aaron David Miller, David Priess, and Jeff Flake. "Trump: Health care is 'only thing more difficult' than Middle East peace." POLITICO. N.p., 13 July 2017. Web. 01 Aug. 2017.) This quote encapsulates the challenge for today’s medical managers, and underscores the vital role they serve in their organizations, their communities and their country in solving this challenge. They help shape organizational vision and are responsible for operational excellence, and they are crucial in leading their people to deliver high quality health care for patients at a sustainable cost.

This retrospective on U.S. health care within the context of global best practices demonstrates that through solidarity, stakeholder cooperation and determination, the delivery of health care characterized by fast service, high quality, and low cost is ultimately possible.
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