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Timothy Stoltzfus Jost
Washington and Lee University School of Law, jostt@wlu.edu

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Why Can’t We Do What They Do? National Health Reform Abroad

Timothy Stoltzfus Jost

Even Americans who have only a vague knowledge of health policy know that the U.S. is different. We do not have "socialized medicine," like our European or Canadian neighbors. We believe that health care is not rationed here, and that, unlike citizens of other nations, we do not have to wait in long queues when we need medical care. We believe that U.S. health care is the best in the world.

At the same time, the U.S. spends more on health care – both per capita and as percentage of gross domestic product (GDP) – than other nations do. One in six non-elderly Americans has no health insurance, and voluminous studies show that lack of health insurance has a dramatic effect on both access to care and on health status. Furthermore, on many of the most important indicators of population health, such as infant mortality and life expectancy, the U.S. scores worse than do other nations.

How do we reconcile our beliefs with these facts? Why do other nations have universal health coverage while we do not? What, in fact, do other nations do when it comes to health care? And how do they do it? Why can’t – or don’t or won’t – we do what they do?

This article addresses these questions. It begins with an overview of the public health insurance systems found in countries with economic and political systems similar to our own, exploring the structural and operational underpinnings of these systems and comparing their cost and performance to that found in the U.S. It then considers the legal, political and social factors that account for the profound differences between our system and the systems of other nations.

What Do Other Nations Do, and How Do They Do It?

All other developed nations of the world, including developed countries in Western Europe, Asia, North and South America, and on the Pacific Rim, provide health care for all or most of their residents. Although private health insurance products are available for purchase on a voluntary basis in virtually every country, no other developed country relies on private insurance as does the United States to provide primary coverage for its population. All developed nations have recognized that voluntary private insurance cannot cover everyone, (as it does not in the U.S.) and have developed some form of public health insurance.

Two Basic Models of Health Insurance

Two primary models can be found in the world: social insurance and national health insurance. Each term refers to a specific approach to the task of financing and organizing a nation’s system for providing personal health care. The first, and older, model is social insurance, often called the Bismarck model after the German leader who established the first social health insurance system. The second, more recent, is the national health insurance model, often called the Beveridge model after Lord Beveridge who proposed this approach for the U.K. during World War II.

Chancellor Bismarck established the German social insurance system in 1883 in an attempt to turn back the tide of socialism that he feared would engulf Germany. Under the German system as it has developed, most citizens have an obligation to secure health insurance coverage, which in turn is paid for, usually by a deduction from earnings, on the basis of the insured’s income rather than the insured’s risk status or family size in order to ensure affordability. In Germany the conceptual foundation of health insurance lies in a belief that members of a society have obligations to each other, a concept referred to

Timothy Stoltzfus Jost, J.D., is the Robert L. Willett Family Professor of Law at Washington and Lee University. He has published many books and articles about health care law and comparative health law and policy.
as "solidarity," rather than in the belief that individuals are responsible only for themselves. This insurance obligation is effectuated through a system that collects the revenues needed to sustain health care. Employers and employees each contribute a percentage of wages to social insurance funds; in turn, these funds provide health insurance for employees and their families. Most persons in Germany whose income falls below a certain level (46,350 Euros in 2004) must participate in this social health insurance program. Persons with incomes above this level are not required to participate, and many buy private insurance instead. However, about 60 percent of all of these upper income persons in fact participate in the public system, because family coverage costs extra in the private system but not in the public, private insurance rates are risk-adjusted while social insurance rates are not, and persons who opt out of the social system may find that claims are denied for certain services.

Social insurance funds in Germany are not administered by the government, but rather by non-profit organizations, which are accountable to their members (and their members' employers). There are many of these funds, some tied to a particular employer, others occupation based, and still others locally-based. Thus employees of Mercedes or BMW would be insured through a company fund; farmers, miners or seamen are covered by special funds, and many people are insured through a general locally-based fund or through special funds that used to only cover white collar workers. All social insurance funds operate within a framework of laws, and all cover essentially the same services and charge similar (though not identical) premiums. In order to ensure the stability of the health funds - and thus the effectuation of a truly nationwide system - health plans that have younger and less costly members must transfer money through a risk-equalization scheme to the plans that have older and more expensive patients, but the plans also compete with each other for members and thus have some incentive to keep their premiums down.

Health insurers have traditionally paid hospitals on the basis of negotiated budgets, though Germany is moving toward payment on a diagnosis-related group (DRG) basis. Physicians and dentists in Germany who furnish health care to plan members are organized into corporate bodies that resemble unions. Thus, universal coverage was enforced independent of the economic or employment status of any individual.

The method for allocating this budget among physicians is complex and somewhat resembles in its formula the U.S. Medicare Resource Based Relative Value Scale, (RBRVS) which is a weighted fee-for-service payment scheme. Under the German system, each doctor sends his or her claims to the physician's organization for the region in which the doctor is located. Claims are coded for a certain number of points for each service, with more complex services weighted for more points than simpler services. The total physician budget for a geographic region is divided once each quarter by the total number of points billed that quarter, in order to reach a figure known as a point value. This conversion factor is then multiplied by the number of points billed by each doctor to figure out how much that doctor has earned. While this is a simplified rendition of the payment formula, the bottom line is that under the German system, physicians work under a global budget that rewards those who work harder while paying less to those who provide fewer services. The system realizes for the insurer the benefits of capitation for controlling costs, but at the same time offers the provider fee-for-service incentives to provide the insured patient all needed services.

For each component of the health care sector (physicians, hospitals, pharmaceuticals, etc) and in each region, budgets in Germany are established globally within a framework of "premium stability." This framework limits the rate of increase in social insurance premiums to the rate of increase in inflation generally and tends to ensure that practice style and practice choices evolve within a fundamental environment of overall health care spending control. When necessary, doctors are required to accept lower payments for what they do, in lieu of the insurers trying to directly control the manner in which doctors choose to practice. But this strategy has resulted in increasingly acrimonious relations between providers and insurers, and Germany is trying to find other ways of holding down costs, including managed care approaches that more directly affect practice style itself.

The social insurance model created in Germany has been adopted in much of the world. Other central European countries, including Austria, Switzerland, France, Belgium, and the Netherlands have social insurance systems, as do many South American and Asian countries for at least part of their workforce. Many of the emerging democracies of Eastern Europe have also embraced the social insurance model. Part A of the U.S. Medicare program in most respects resembles a social insurance system. Though these systems vary in many important respects, in each one health insurance is financed primarily by payroll taxes or wage-based premiums, and services are purchased from independent health care providers who often are in private practice.

If the social insurance model was adopted by conservative governments to suppress the growth of socialism in the late 19th and early 20th century, the national health insurance model emerged from the triumph of socialism in Europe after World War II. The United Kingdom had adopted a limited social insurance system in 1911, but many people were excluded from it, and the U.K. emerged from WWII determined to provide health care as a right to its entire population. Access to health care would no longer depend on belonging to a social insurance plan (which was usually, in some sense, employment-related), but rather would be free at point-of-service to all residents that were covered by the social insurance plan, independent of the economic or employment status of any individual.

The English NHS is financed through general revenue taxation. These funds are administered by local units called primary care trusts. These units purchase services from NHS hospital trusts, which are currently public corporations, as well as from general practitioners, who are private businessmen. These services are then provided to the general public, in most instances without cost, although co-payments are imposed for some things like drugs, and a few services - like most dental care - are provided mainly in the private sector.

The U.K., like many European countries, has a strong gatekeeper system. Every Briton has a general practitioner (GP), and a patient's first contact with the health care system is almost always with the GP. GPs still make house calls in the U.K., and the level of satisfaction with primary care in the U.K. is very high. Specialist services, including surgery, are only provided through hospitals and upon referral from a GP.

Many nations have adopted the national health insurance model of public health insurance in the past half century, although, again, in each nation the model looks somewhat different. Canada, Australia, the Scandinavian countries, Spain, Portugal, Italy, and some Latin American and Asian countries have national health insurance systems. Other countries, particularly less developed countries, provide services through public hospitals and clinics without necessarily
developing a full and comprehensive national system of health care finance that would be essential to make such a network of services accessible to all persons. Our own Medicaid program, as well as our veterans', military, and Indian health services, resemble the "national health insurance" model, in that all use general revenue funds to pay for health services, but they are different in that their coverage is limited to certain narrowly delineated populations, which may even, as with Medicaid, vary from state to state.

In virtually all countries, voluntary private health insurance of the sort sold in the U.S. to both groups and individuals continues to exist, although it serves different functions in different countries. In some, such as Germany and the Netherlands, it covers wealthy people who are not covered by social insurance. In others, such as Canada, it covers services such as pharmaceuticals, which are not universally covered by public insurance. In yet others, such as France, it covers cost-sharing obligations, much like our own Medigap policies. In still others, such as the U.K. or Australia, it allows privately insured persons to jump the queue and get services faster or more conveniently than publicly insured patients.

Coverage and Benefits

Countries that have national health insurance programs cover all of their citizens and long-term residents, although in most countries individuals can choose to carry private insurance and obtain services privately. Some countries with social insurance funds, such as France or Austria, cover their entire populations as well. Others, however, such as Germany and the Netherlands, only require people whose income falls below a certain level to be part of the social insurance program. Although people with higher incomes can choose to be uninsured, few make this choice. In Australia, government subsidies are available that cover 30 percent of the cost of private insurance for hospital care, while tax penalties are imposed on higher income persons who choose not to purchase private insurance. This results in about 45 percent of the population being privately insured for hospital care.

In several of the southern European nations, many people choose to purchase care privately, even though everyone is covered by national health insurance, because they believe that they will get better care or more attention from their providers.

A number of countries apply means tests for determining coverage for certain services or for determining the applicability or level of cost-sharing. The Irish health care system is partially means tested: only low income holders of medical cards (about a third of the population) have free access to general practitioner services, and higher income people without medical cards must pay a co-payment for hospital and pharmacy services under some circumstances. In the U.K., where long-term nursing home care is primarily regarded as a social service, nursing homes are publicly funded only for those who do not have the means to pay privately. Pharmaceutical coverage in the U.K. is also means tested to the extent that the system waives required co-payments for low-income persons, although the government also waives co-payments for children, the elderly, and persons with certain chronic conditions. No developed nation other than the U.S., however, makes access to public health insurance depend totally on economic "medical dependency" (Medicaid), or on age and disability status (Medicare). And no other developed country has nearly as high a proportion of its population uninsured.

Social insurance and national health insurance programs vary somewhat in the benefits they offer. The Canadian health insurance program, for example, only requires the provinces to cover hospital, physician, and surgical dental services, though most provinces also cover pharmaceutical costs for at least some of their residents. Coverage in Australia is limited to hospital, physician, and pharmaceutical care. Most countries do not cover nursing home care or cover it as a social service rather than a health care service. In some countries some benefits that are nominally covered are in fact not generally available because of high cost-sharing obligations, limited coverage, or lack of provider participation.

Delivering Health Care In Other Nations

Though public finance of health care services is quite common in other countries, public provision of health care services is less universal. In most national health insurance countries, many health care services are furnished by private entities and health professionals in private practice. In few countries, for example, does the government directly employ primary care physicians or dentists. Pharmaceuticals and medical devices are generally produced by private manufacturers and sold through private pharmacies or medical equipment suppliers. In most national health insurance countries public hospitals are dominant, but in some private nonprofit or private hospitals also exist. Private hospitals are even more common in social insurance countries.

What Do We Get for Our Money Here, and Why Are Our Costs So Much Higher?

No other country spends as much on health care as does the U.S. As shown on the accompanying table, social insurance countries generally spend more on health care than do countries with national health insurance. The table, derived from a recent study of international health care pricing, illustrates the differences among nations in health care spending as a percentage of GDP and in absolute dollar expenditures. To be sure, some of these differences may be attributable to the fact that nations classify health spending differently; for example, many government-borne costs of long-term care, which are classified as health expenditures in this nation, may be treated as social welfare spending in other nations. But even when these differences of classification are taken into account, the U.S. spends more.

What does the U.S. get in return for its higher expenditures? Certainly not better health status. Life expectancy for males at birth is

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Source: G.F. Anderson, et al, Health Affairs

75.7 in the U.K., 77.6 in Sweden, 75.6 in Germany, 75.8 in the Netherlands, but only 74.4 in the U.S. Infant mortality rates stand at 5.5 deaths per one thousand live births in the U.K., and 3.7 and 4.3 respectively in Sweden and Germany; the comparable figure for the U.S. is 6.8.

Health status, of course, depends on diet, housing conditions and societal inequality, and not just on health care. But it would also appear that far higher spending on health care in the U.S. fails to assure residents better or more accessible health care. Indeed, by some measures we get less actual health care than do residents of other countries, although by other measures, we receive the same or slightly more. During the year 2000, for example, the U.K. had 151 hospital admissions per 1000 population, Germany had 205, and the U.S. had only 118. The U.K. had .9 acute care hospital days per capita, Ger
Some countries that spend less on health care than we spend also explicitly ration access to services. In the U.K., for example, people often have to wait to see a specialist, and then must wait again for surgery that the specialist may deem necessary. Waits are particularly common for certain conditions such as varicose veins, hernias, cataracts, or painful joints—problems that have more to do with quality of life than with the preservation of life. Repeated efforts to clear waiting lists have proven unsuccessful.

In the U.S., health care access is also rationed, however, although not overtly and not for certain populations. Affluent and well insured persons have ready access to the most advanced and sophisticated forms of health care, regardless of whether it is required or elective. But those Americans who cannot afford to pay for health care and do not have health insurance are effectively denied access to non-emergency care. Persons who have lower incomes and are publicly insured, who are underinsured in relation to their financial circumstances (as a result of high deductibles and cost sharing as well as limited coverage), or who are completely uninsured, may wait a long time for care or go without it completely.

Waiting lists are essentially a measure of the gap between need for care as professionally determined and its actual availability; that is, a person on a waiting list only because a doctor has determined that he or she needs care is not yet available. One study that attempted to quantify the gap between need for care and its availability found that the effects of the implicit limitations on health care access among uninsured persons in the U.S. were more severe than those imposed by the explicit lists in the U.K. Even more important, perhaps, nations with national health systems whose spending levels approach those seen in the U.S., such as Germany or Switzerland, do not have serious problems with waiting lists. In other words, nations appear to be able to achieve near-universal health coverage while spending less and without lengthy waits for necessary care.

Waiting lists are not just a function of health care expenditures, moreover, but also of health system organization and the behavior of the health care sector: Waiting times in England vary dramatically from procedure to procedure and tend to be worst for conditions that are of little interest to doctors. Perversely, hospitals there have some incentive to maintain lengthy lists, because from time to time they are offered financial incentives by government programs aimed at reducing waiting times. Similarly, many doctors have little incentive to reduce waiting times because patients who get tired of waiting can pay privately to have the same procedures done expeditiously by the same doctors.

Moreover, factors other than rationing are equally or more important in explaining international differences in health care costs. One of the most important factors is that we simply pay higher prices for health care services in the U.S. than do other countries. The average U.S. expenditure per hospital day in 1999 was $1859, three times the median for the developed countries that are members of the Organization for Economic Cooperation and Development (OECD). The average physician salary in the U.S. is nearly twice that of Germany, and nearly four times that of the U.K. We also, of course, spend far more on the administration of our health care system. Our highly fragmented health insurance system requires health care institutions and professionals to hire numerous personnel for billing who are unnecessary in unitary systems. Private insurance also costs far more than public insurance. Public systems do not spend the money spent by private insurance companies on marketing, underwriting, and profit. The U.S. pays a very high price for maintaining a market-based health care system, and much of the money we spend does not produce health care goods or services.

Another major difference can be seen in U.S. spending on health care technology. For example, in 2000, the U.S. maintained 8.1 MRI units per million inhabitants, compared to 3.9 in the U.K. and 6.2 in Germany. We had 13.6 CT scanners per million compared to 6.5 per million in the U.K. and 8.2 per million in Canada; on the other hand, Germany had 17.1 per million. Technology that would only be available in regional medical centers in some countries is available not only in community hospitals but in clinics and even physicians' offices in the U.S. While this means that these technologies are immediately available to Americans, it also means that they are used more often in the U.S. In 1999 U.S. physicians performed 388.1 coronary angioplasties per 100,000 population compared to 51 in the U.K. and 165.7 in Germany. Kidney dialysis rates were 86.5 per 100,000 compared to 27 in the U.K. and 64 in Germany.

For all of our technology, however, there is little evidence that the quality of care is better in the U.S. than in other countries. A recent study comparing the performance of the U.S. health care system with those of four other countries using nineteen process and outcome indicators (such as cancer or transplant survival rates or vaccination rates), found that the U.S. scored best on three indicators, worst on two, and somewhere in the middle on the others. There is also little evidence that patients in the U.S. are more satisfied with the quality of health care than are consumers of health care in other nations. A recent five-country survey of "sicker adults" for example, found that 44 percent of U.S. respondents were dissatisfied with their care, compared to 31 percent of U.K. respondents, and 36 percent of Canadians; while 23 percent of U.S. respondents believed that a mistake had been made in their medical care in the past 2 years, compared to 20 percent of Canadian and 13 percent of U.K. respondents. Fifty-eight percent of U.S. respondents rated their doctors as excellent or very good on diagnosing their medical problem, compared to 52 percent of Canadian respondents and 57 percent of U.K. respondents; while 40 percent of U.S. respondents reported difficulty in seeing a specialist when needed, compared to 53 percent of Canadian respondents and 38 percent of U.K. respondents. In a 2001 survey of citizens' views of access to quality of care, 57 percent of U.S., 53 percent of U.K. and 54 percent of Canadian respondents rated overall medical care as excellent or very good, while of respondents who had either themselves been hospitalized or had a family member hospitalized in the past 2 years, 50 percent of U.S., 54 percent of Canadian, and 48 percent of U.K. respondents rated care as excellent or very good.

Perhaps the single most important factor underlying lower overall and per capita health care spending in countries with national health services is that most funds for health care flow through a single, central budget. The health budgets of nations with tax-financed national health services are visible to all public and must compete with other funding priorities, such as education or defense. Furthermore, it is hard to grow a publicly accountable health budget, because...
nowhere in the world is raising taxes popular. Health services must learn to make do, therefore, on available funds.

In social insurance countries, funding does not flow through a central general budget, and is less well controlled; nonetheless it is still subject to government oversight and is generally held in check. As noted above, budgets for specific health sectors allow reasonably tight control of expenditures.

In the U.S., by contrast, funds flow from a multitude of sources, such as general revenues appropriated by federal and state governments, payroll taxes, premiums paid directly to thousands of individual insurance plans by employers and employees (rather than into a visible central fund) and extensive out-of-pocket payments by individuals and families. As a result, there is little chance for either discipline or control. Indeed, even in the case of the U.S. Medicare program, which is financed in a unified fashion and centrally administered, recent legislation adding prescription drug coverage plans to Medicare creates the very type of private and decentralized purchasing scheme that characterizes health expenditures for the non-Medicare population, and that makes budgeting and cost containment so difficult to achieve.

Other countries are also able to control their expenditures because they have a more limited understanding of legal rights within their health care systems than we do. While it is true that U.S. employers have the option not to provide health plans to their workers, if they do, the laws that govern workplace benefits – in particular the Employee Retirement Income Security Act (ERISA) gives covered persons the legal power to enforce benefit rights in court. Medicare and Medicaid, the nation’s primary publicly financed health insurance programs, both create legal entitlements. If beneficiaries or recipients are denied services, they can go to court and demand that the service be supplied.

The British, on the other hand, do not have individual entitlements to health care. Rather, the NHS has an obligation to provide health care services to the British public within the constraints of available resources. In recent cases the courts have asked local health authorities (which preceded the current primary care trusts as local purchasers) to justify their decisions denying services, but the responsibility of the NHS is merely to act reasonably, not to provide any particular service to any particular patient.

Germans do have rights to particular services. These rights can be enforced through a separate system of social courts whose jurisdiction extends to disputes between health insurers and their members. But the courts have become increasingly deferential to the coverage decisions of health insurers and their corporate representatives, seemingly realizing that resources are limited. Further, even if a social insurer has the obligation to provide a service, payment formulas and negotiated budgets act to limit total payments for provider claims. Thus the breadth of population coverage seen in other nations is to some extent offset by the fragility of the legal protections which are conferred on beneficiaries for coverage of services and on providers for payment for services. Access to care is universal, but not unlimited.

Indeed, providing near universal access at a much lower cost is not easy. In virtually every nation, providers claim that they are underpaid, and strikes for higher payments are not unknown. Hard bargaining with providers is the norm. In some countries (though not in all), health care facilities are dingy and not always clean. The expansive hospital atriums and sparkling waiting rooms that we have come to expect are not standard in much of the world. But most other countries are able to muddle on, producing adequate (and often excellent) health care, making it available to all, and still holding the line on cost. In the end, most other countries manage - unlike the U.S. - to provide universal and comprehensive coverage for health care that is more or less equivalent to the care offered here.

No other country spends as much on health care as does the United States of America.

Why Don’t We Do It The Way Other Countries Do?

If other countries can have universal or near universal coverage of their populations and spend less on health care than we do, without obvious sacrifices in quality, why can’t we do the same? Why does it seem to be our fate to have the most expensive health care system in the world and still have over 43 million uninsured persons?

Volumes have been written on the topic of American exceptionalism in health policy, and only the briefest survey of this literature is possible here. Explanations tend to focus on five factors, each of which seems to play a role, though commentators disagree on their relative importance: U.S. political institutions; the U.S. social culture and character; a weak left and the limited strength of unions in the U.S.; the political power of provider and insurer interest groups; and the strength of path dependency.

U.S. Political Institutions

First, the unusual character of American political institutions makes radical innovation very difficult. A U.S. President is the leader of his party, but not necessarily of the government in the same sense as a British prime minister is head of the government. It is possible in the U.S. for Presidents to confront Congresses of different parties, with the result that efforts at reform get hopelessly mired in partisan politics. Even when one party controls the presidency and both Houses, as was the case during 1993 and 1994 when President Clinton’s national health reform plan collapsed in spectacular failure, the minority may be large enough, and their ability to use the arcane rules of debate strong enough, to defeat even a popular measure. The futility of the majority can, of course, achieve the same result.

Most European nations have parliamentary governments, in which the executive and legislative branches are controlled by the same political party or governing coalition. Party discipline is stronger than in the U.S., and when it really matters, party leadership can force back-benchers to tow the line. Of course, few countries have two party governments, as we do in the U.S., and coalition governments bring their own problems and complications, but in most European countries it is possible for ruling parties to enact and implement health reform legislation. Thus, for example, Germany adopted major health care reforms in 1988, 1992, 1997, and 1999, while Britain made significant changes in its health care system during the Thatcher administration and again when Labor returned to power.

By contrast, the governing institutions of the U.S. were in fact designed to block radical change. The current situation in which both houses of Congress and the Presidency are controlled by the same political party is a marked deviation from the norm of divided government that has prevailed in the United States over the past half century. Members of Congress are not, in general, dependent on the President for their jobs, and are relatively free to pursue their own course on health policy. Senators often have their own power bases and shape their policy to reflect the ideology and the special interests of their own states. Most House members currently run unopposed or with token opposition, and are not dependent on the national party leadership for reelection. Party discipline is at best, therefore, uneven.

Moreover, the rules of the Senate in particular militate against control by narrow majorities. Sixty votes are necessary to break a filibuster, or to deviate from budget rules. Some level of consensus and cross-party support is necessary, therefore, to adopt health reform legislation. Perhaps most importantly, the presence of veto points throughout the American political process gives interest groups opposed to legislation extraordinary opportunities to block it or water it down. The rough road traversed and close victory achieved by the recent Medicare Modernization Act, which had strong backing from the President and the leadership of Republican majorities in both
Houses, attests to the difficulties of making changes in the U.S. health care systems. It is difficult to imagine the political stars that would have to converge to bring about universal health coverage.

The federal system of the U.S. also militates against the adoption of universal coverage. Though a number of countries that have universal health care systems are also federal states, social welfare programs tend to be weaker in such countries. Throughout the nineteenth century and into the 1930s, it was generally believed in the United States that responsibility for social welfare resided in the states, and that the U.S. federal government lacked the constitutional authority to enact universal health insurance. When the federal government enacted public assistance programs in the 1930s, it acted through the states. The Medicaid program was built on this model in the 1960s, and there still seems to be strong support for the notion that providing health coverage through Medicaid-like state programs. The preemption provisions of the Employment Retirement Income Security Act (ERISA) — and fears of business out-migration — on the other hand, make it effectively impossible for states that would like to adopt universal health coverage on their own to move ahead by building on the established foundation of employment-based group coverage through the use of an employer mandate. In addition, state constitutional restraints on taxation and borrowing make it difficult for states to create public programs, and renders them dependent upon the federal government, and its health policy and programs, for leadership in extending coverage. Liberal states, on the one hand, have been blocked with moving forward with health care reform, while regional conservatism (and indeed, frankly, racism) has played a major role in the past in blocking universal federal initiatives to address the problem.

The U.S. Social Culture and Character

Second, there is the cultural aversion of Americans to the use of government to solve problems, and in particular, to the creation of social welfare programs. We like to believe that private know-how and entrepreneurialism can solve all problems, even ones such as health care coverage lapses and excessively high spending levels, which so obviously and consistently defeat the power of even the most creative entrepreneur.

Indeed, it is far from obvious that the American people want their government to adopt universal coverage, or at least that they want it enough to push their lawmakers into doing something about it. European health care systems reflect a deeply rooted belief in the importance of social solidarity, a value that is widely shared across the citizenry. Even though the welfare state lacks the support in Europe that it enjoyed a generation ago, and most European countries have experimented with harnessing market forces in health care delivery and financing, there is still strong support for universal health care and little support for turning health care coverage over to the caprice of markets.

Americans are far more ambivalent about universal coverage. Though a strong majority of Americans believe that legislation should be passed to help the uninsured, consensus evaporates when specific approaches to accomplishing this goal are discussed. There is considerably more support for solutions like expanding state Medicaid programs or increasing employer coverage than for creating a new national health insurance, and a majority of those polled usually oppose substantial tax increases to expand coverage. Although the Clinton plan seemed to enjoy strong popular support at the outset, this support evaporated once the public was convinced that it would result in government control over health care, higher taxes, and health care rationing.

It is also arguably true that Americans — particularly those who are reasonably affluent, well insured, and able to get the ear of politicians — do not mind spending more on health care than do other nations. The French spend more on food than we do, the British more on housing. It appears that Americans simply have a taste for spending more on health care. We are the richest nation on earth, and wealthy nations tend to spend a higher proportion of their national product on health care than poorer nations. We clearly are enamored by health care technology, and expect to have it available when and where we want it.

Nevertheless, the economic market for health care and political market for health care policy are so distorted in the United States, that it is difficult to believe that we have the mixture of cost and access that most Americans would choose, given a choice. Indeed, the peculiar nature of the political marketplace in the United States seems to explain much about the peculiar nature of our health policy.

A Weak Left and Limited Government

A third factor is the lack of a strong left wing in American politics, (and the presence of a strong right wing) and also the weakened nature of the American labor movement. The lack of a powerful left wing labor movement in the U.S. has been a particularly important factor in explaining the American rejection of the welfare state. Organized labor has never been as strong here as in Europe and has seen a more precipitous decline in its membership in recent decades. But perhaps even more important, labor has not been the political force in the U.S. that it has been in Europe. We have no labor party or labor-based socialist parties. Though labor unions are traditionally associated with the Democratic Party, they have not historically dominated that party. Most importantly, organized labor has focused traditionally more on private benefits for its members to be gained through collective bargaining than on public welfare benefits to be obtained through political action. Indeed, Samuel Gompers and his AFL played a major role in defeating national health insurance when it was first mooted in the second decade of the twentieth century because he preferred to retain union control over benefit programs.

The weakness of the left in the United States is matched, moreover, with a powerful right wing. Right wing pressure groups like the Christian Coalition played a major role in defeating the Clinton plan. Public relations-savvy conservative think tanks like the Heritage Foundation have managed very successfully to keep the media focused on their market-oriented proposals for health care system organization, and distracted from exploring reform ideas that might actually work here because they have worked elsewhere.

The Power of Special Interest Groups in Opposing Reform

Perhaps an even more important political factor in explaining our peculiar American situation has been the role of special interests that oppose universal health coverage in American politics. As Robert Evans has often pointed out, in health care as elsewhere in the economy, one person's cost is another person's income or profit. We spend currently $1.6 trillion on health care, and millions of individuals have a massive investment in the continuation of the current system. On the other hand, American political campaigns are particularly expensive by international comparison. Special interest groups contribute freely to American politicians, and expect that their interests will be attended.

The recently adopted Medicare bill, loaded with special interest provisions, especially its prohibition against government “interference” with price negotiations between drug benefit plans and pharmaceutical companies, is a classic example of the pork barrel character of American health care politics. Doctors throughout the world have tended to oppose government involvement in the health care system, at least initially. Not surprisingly, the American Medical Association played a peculiarly important role in opposing the adoption of universal health insurance, particularly in the middle of the twentieth century when it was at the peak of its political power. But provider interests have not been
alone in this. Business and employer groups have also proved very effective in opposing health care reform. Though the present employment-based system is burdensome to them, it at least gives them control over benefit costs and structures, and gives them a means of attracting workers. They also fear the higher taxes that would accompany a government-run system. Business coalitions played a leading role, for example, in defeating the Clinton plan.\textsuperscript{118}

Perhaps the most important impediment to universal coverage at the present time, however, is the commercial insurance and managed care lobby.\textsuperscript{119} Though private health insurance existed in both Germany in the 1860s and Britain in the 1940s, it was in both instances generally offered by nonprofit fraternal and mutual organizations that did not pose a significant political obstacle to the enactment of a universal system.\textsuperscript{120} Countries that use a social insurance approach to coverage, moreover, in general initially co-opted existing private health insurers by permitting them to operate the system.\textsuperscript{121} By contrast, health insurance and managed care are important and influential forces in the U.S., as they demonstrated through the "Harry and Louise" commercials. This series of commercials in the early 1990s when the Clinton Health Plan was under debate, which showed a clearly affluent couple expressing their concerns over the dinner table about what the plan would do to them, helped kill it.\textsuperscript{122} Similarly, insurers' power in Congress guaranteed that the Medicare prescription drug legislation would include, by the Administration's account, $46 billion dollars in subsidies over the next ten years to entice managed care companies to participate in the Medicare program.\textsuperscript{123}

Path Dependency: The Stickiness of What Is

Though each of these accounts of American exceptionalism has explanatory power,\textsuperscript{124} in the end, one of the most plausible explanations is the theory of path dependency. This theory has been popularized in the health policy area by Carolyn T rawh in her book, Accidental Logics, which recognizes that, in a sense, every country is exceptional.\textsuperscript{125} The notion of path dependency emphasizes the power of inertia within political institutions. Once nations get into the habit of doing things in a particular way, they tend to keep on doing them that way.

This is not a theory of historical determinism, however. From time to time "critical moments or junctures" appear when a policy a consequence of factors in the broader political arena makes major institutional changes in health care systems possible.\textsuperscript{126} Thus the German social insurance system was created by a powerful German chancellor faced by a strong socialist challenge in the tumultuous time following German unification in the late 19th century.\textsuperscript{127} The British National Health Service was established as the Labor Party, which, receiving a decisive political mandate following the end of World War II, turned its hand to rebuilding a devastated health care system.\textsuperscript{128} The Spanish and Portuguese national health services came into being as those countries emerged from long-standing fascist dictatorships.\textsuperscript{129} The Dutch social insurance system was imposed by the German occupation during World War II.\textsuperscript{130} The greatest change in the American health care system, the creation of Medicare and Medicaid in 1965, resulted from the landslide victory of Lyndon Johnson, which brought into power for the first time in history a working majority of liberal and moderate northern and Midwestern Democrats.\textsuperscript{131} There are few examples of situations where national health services simply evolved, though the Scandinavian national health services may represent this possibility.

At this point in time, it appears particularly unlikely that in the U.S. a window of opportunity will open any time soon for health care reform. The conservative Republicans who currently dominate all three branches of the federal government are aggressively hostile to social welfare programs.\textsuperscript{132} The tax cuts enacted since 2000, combined with high military spending and subsidies for favored businesses, have resulted, apparently intentionally, in massive budget deficits that make any major new social initiative almost unthinkable.\textsuperscript{133}

But countries do change. One impressive fact when one reviews the history of universal health coverage throughout the world is how recently many countries have adopted it. Switzerland only established a system of universal coverage in 1996 and Israel in 1995, while the Australian system dates only from 1984. The Spanish and Portuguese national health systems were created in 1986 and 1989 respectively.

One can, just barely, imagine a scenario in which a universal health care system might become politically viable in the U.S. If, for example, our employer-based health insurance system continues to implode, driven on by the risk-segmentation that will result if employers abandon relatively well subsidized defined-benefit health plans (plans that provide employee with a defined set of benefits and relatively well articulated coverage standards ), in exchange for poorly subsidized defined-contribution health plans (which offer employees only a limited sum of money to procure coverage), the number of uninsured – and seriously underinsured – Americans will continue to grow. At some point, a critical mass of the uninsured will consist of politically active, middle class Americans, who will demand a response from the government. At some point, moreover, doctors, and perhaps even drug companies will feel the pinch as more and more Americans are priced out of the market for their goods and services. Hospitals, moreover, will face an increasing uncompensated care burden. At the same time, the political pendulum may swing back toward the left, and a majority of Americans may become more comfortable with a larger role for government in the American health care system. Perhaps the opposition of business to national health insurance will soften as employees become ever more dissatisfied with ever more limited health coverage. Perhaps insurers may ultimately conclude that they are better off trying to find a role in a national health insurance system, perhaps as claims processors and fiscal intermediaries, than to chance a fight to the death. Perhaps the day will come when we do health care finance pretty much like other countries do it. We will never do it just like they do it, however, in part because "they" do not do it in any one particular way. The British health care system is different from the German system – which in turn are different from the Canadian or Irish systems. But that is the beauty of it. In the wealth of experience that the world has had with providing universal health insurance, there is a world of ideas for us to draw on – in terms of broad models for carrying out universal coverage, in terms of technical approaches to addressing technical problems, and in even in terms of political strategies for bringing universal coverage into existence. The ideas, the models, even the technology is there. We only have to decide that we want it.

References

1. Institute of Medicine, Care Without Coverage: Too Little, Too Late (Washington, D.C.: National Academy Press, 2003).
4. Id., at 335.
5. Id., at 204.
7. Tariffcheck 24, "Soll ich in der gesetzlichen Krankenversicherung bleiben oder mich privat versichern?" <http://www.tariffcheck24.de/Tariffcheck24-
45. Mossialos and Le Grand,
44. See R.B. Saltman,
43. See Mossialos and Le Grand,
42. Mossialos and Le Grand,
41. Australian Private Health Insurance Administration Council,
40. See Health Canada,
39. Id.,
38. Only 1 percent or fewer are uninsured. See Mossialos and Le Grand,
37. Id.,
36. See Jost,
35. Australian Private Health Insurance Administration Council, Industry
34. See E. Mossialos and
33. Id.,
32. See World Health Organization,
31. See European Observatory,
29. Systems: Improving Performance (Geneva: World Health Organization,
28. World Health Organization,
27. Jost,
26. See Mossialos and Le Grand,
25. European Observatory, supra note 8, at 102–06.
21. Jost,
20. Id.,
19. Only in some Canadian provinces is the purchase of private insurance for
18. publicly provided services illegal. Jost, supra note 3, at 491.
17. Id.
16. See Jost,
15. Id., at 25.
13. Id., at 245.
12. European Observatory, supra note 8, at 41–44.
10. Mossialos and Le Grand,
8. European Observatory on Health Care Systems, Health Care Systems in
6. Mossialos and Le Grand,
5. Under legislation adopted in the mid-1990s, most of the insurance funds
4. were opened up so that anyone could join any plan. This allows the plans
to compete on the basis of premiums, and has in general meant that many
Germans have moved to the former-white collar or business-related funds,
which had better risk-profiles and thus lower premiums. See Jost, supra
note 3, at 240.
3. European Observatory, supra note 8, at 41–44.
1. \footnote{Note 1.}

89. Jost, supra note 3, at 79–76.

90. Id., at 76.


93. Jost, supra note 3, at 177.


96. Id., at 608–611.

97. Blendon, Benson, and DesRoches, supra note 91.

98. Id. It should be noted, however, that the public tends to be more supportive of collective responsibility for health care and less interested in market approaches than current policy elites. See M. Schlesinger, "On Values and Democratic Policy Making: The Deceptively Fragile Consensus around Market-Oriented Medical Care," *Journal of Health Politics, Policy and Law* 27 (2002): 889–925.


101. Blake and Adolino, supra note 78, at 683.


104. Gordon, supra note 78, at 298.

105. Navarro, supra note 103, at 190; Blake and Adolino, supra note 78, at 686.


111. Gordon, supra note 78, at 297.


113. N. Laham, supra note 99, at 206.

114. See Steinmo and Watts, supra note 84, at 364.

115. See e.g. Tuohy, supra note 84, at 40 (U.K.); Tuohy, supra note 84, at 53 (Canada).


118. Laham, supra note 99, at 208–10; Hacker and Skocpol, supra note 92, at 186, 189.

119. Gordon, supra note 78, at 211, 257; Skocpol, supra note 99, at 134–39.

120. Jost, supra note 3, at 72, 205–06.

121. This also happened in the United States when the Medicare program was created in 1965, and private insurers were brought in as carriers and intermediaries to operate the program. Health insurance coverage of the elderly was thin enough at that time, however, to make this strategy possible.

122. Skocpol, supra note 99, at 138–39; Tuohy, supra note 84, at 153.


124. Indeed, an attempt to use Boolean Analysis to test the power of these hypotheses found that all of them seemed to contribute to the explanation, though it found the veto points hypothesis most powerful. It also found, however, that the United States is the only country where all of the obstacles to change discussed above coexist, and also the country in which all but one of these factors was most unfavorable to reform. Blake and Adolino, supra note 78, at 699–701.

125. Tuohy, supra note 84, at 5, 123–124.

126. Id., at 6–7, 123.


128. Tuohy, supra note 84, at 38–41.


132. Skocpol, supra note 92, at 199.

133. Hacker and Skocpol, supra note 92, at 193; Skocpol, supra note 99, at 173–178. The recent adoption of a prescription drug benefit for Medicare would seem to contradict this, but so much of the benefit of that legislation goes to special interest groups, most notably drug companies and managed care organizations, that it is perhaps better viewed as special interest legislation than as a social program expansion.