Learning Objectives

Upon completion of this unit, students should be able to:

1. Discuss the history health insurance in the United States.
2. Understand the crisis in health care costs.
3. Understand the crisis in health care coverage.
4. Discuss why the U.S. lacks National Health Care.
5. Discuss issues pertaining to reforming U.S. Health Care.
6. Evaluate a health care system.
7. Discuss and evaluate health care in other countries like Germany, Canada, Britain, etc.

Written Lecture

Unit V is comprised of Chapters 8 and 9 on healthcare systems. The United States does not have a health care system so much as it has an agglomeration of public and private providers functioning autonomously in myriad and often competing ways.

Fee-for-service insurance began during the Great Depression, with the founding of Blue Cross and Blue Shield (collectively known as "the Blues"). The primary purpose of this insurance was to protect the income of doctors and hospitals. The Blues offer fee-for-service insurance, usually with annual and lifetime maximums and only to persons assumed to be healthy. Historically, the Blues established their fees based on community rating, but competition from commercial insurers has forced many Blue Cross/Blue Shield plans to shift in recent years to actuarial risk rating.

Simultaneous with the rise in fee-for-service insurers, the first health maintenance organizations (HMOs) developed. The primary purpose of these plans was to provide affordable health care to the public. These plans accepted all within a given community and kept costs down by paying doctors on salary and emphasizing preventive care.

In 1965, the federal government instituted Medicaid and Medicare. Medicare covers virtually all Americans over age 65 plus some permanently disabled persons, while Medicaid covers a small portion of persons who are both poor and either aged, blind, disabled, pregnant, or the parent (almost always the mother) of a dependent child.

The most striking change in the U.S. health care system over the last quarter century has been the rise of managed care. Managed care refers to any system that controls costs through closely monitoring and controlling the decisions of health care providers. Managed care is now used by most U.S. insurers, of all types. However, opposition to managed care, and questions about its impact on quality of care, has led to a significant watering down of the "management" part of managed care.
Costs for health insurance have risen dramatically in recent years, as have the costs individuals must pay in addition to insurance. Patient demand, malpractice costs, our aging population, or the existence of advanced technology fail to explain the rising costs of health care. Rather, research suggests that rising costs are linked to two underlying factors: a fragmented system that multiples administrative costs, and the fact that health care providers (doctors, hospitals, pharmaceutical companies, and so on) have greater power to set prices than do health care consumers, whether individuals, the government, or insurers.

Chapter 9 focuses on alternative health care systems. Any health care system or proposed system can be evaluated according to whether it provides universal coverage, portable and comprehensive benefits, geographically accessible care, affordable coverage, financial efficiency, and reasonable levels of consumer choice.

Over time, as the convergence hypothesis explains, health care systems around the world have become more similar, in part because largely capitalist countries have moved toward restricting market forces in health care, whereas largely socialist countries have moved toward increasing market forces. Nevertheless, substantial differences remain.

Health care in Germany is overwhelmingly obtained through nonprofit social insurance plans known as sickness funds. Social insurance refers to insurance provided on a nonprofit basis by social groups, such as cities, occupations, or industries. All Germans receive a comprehensive package of health care benefits, and costs of care are considerably lower than in the United States. To restrain costs, Germany has, among other things, shifted from paying doctors fee-for-service to paying by capitation and used both education and economic incentives to encourage the use of more cost-effective drugs.

Unlike the United States, Canada offers universal coverage, but through a National Health Insurance program run by a single-payer —the government. Canadian hospitals receive both an annual operating budget and a capital expenditure budget from the government. Hospital doctors are paid on salary, while other doctors submit their bills directly to the health insurance system using a fee schedule negotiated annually between the provincial governments and medical associations.

Canadians have greater access to care than U.S. citizens. Moreover, costs of care in Canada are far lower and outcomes are at least as good if not better. However, reductions in federal subsidies for health care have let to longer waiting lines (although very rarely for emergency care).

Whereas Canada provides its citizens with National Health Insurance, Great Britain provides a National Health Service (NHS). In Great Britain, individuals need not purchase health care or health insurance because the government directly pays virtually all health care costs for all citizens. Compared to the United States, access to care is greater and costs of care are far less, although waiting times for non-emergency care can be long.

General practitioners in Britain work as private contractors, paid via a version of capitation payments from the government. Specialists almost always work as salaried employees of the NHS at hospitals or other health care facilities. To restrain costs, the NHS has relied on national and regional planning, kept doctors’ salaries low, and shifted services to the private sector.
The health care system in China demonstrates how a poor country can provide good health care at low price. Following the successful Communist revolution, the new ruling party declared that health care in China would emphasize four things: mass campaigns, the health of the masses rather than that of the elites, prevention rather than cure, and integrating western medicine with traditional Chinese medicine. To achieve its goals, given its large and poverty-stricken population and its lack of financial resources and medically trained personnel, China relied on two innovative strategies: mass campaigns and physician extenders.

In recent years, as China's economy has changed from a largely socialized and centrally controlled system toward a more decentralized, economically heterogeneous, model, its health care system also has changed. Whereas citizens previously received care at little cost through government-supported facilities and providers, families now typically must pay for care on a fee-for-service basis. As a result, access to care has declined, especially in rural areas.

Nevertheless, and despite its relative poverty, China boasts health outcomes only slightly below those of the industrialized nations. Research on China and on other nations has identified three factors that allow poor nations to offer good health outcomes at low costs: (1) improving access to medical care, (2) emphasizing the use of family planning and encouraging education for men and, most importantly, (3) educating women.

The Mexican health care system is particularly important to U.S. residents because the two countries share a long border. Individuals from both sides cross the border to seek health care. Others cross the border for travel and pleasure, sometimes bringing illnesses with them.

Health care in Mexico is provided within a three-tier system: private health care for the wealthy, government-provided insurance for salaried workers, and a separate government-provided insurance plan for most of the rest. Access is best for those who can purchase care and worst for those in rural and poorer areas.

Learning Activities (Non-Graded)

For a review of the Key Terms of the unit, click here to access the interactive Unit V Flashcards in PowerPoint form. (Click here to access a PDF version.)

For additional review and understanding of the material covered in Unit I, complete the Chapter 8 and Chapter 9 Review Questions, Critical Thinking Questions, and Internet Exercises located at the end of each chapter of the textbook.

Click here to access a PDF of the Unit V Learning Activity: Critical Issues in Health Care via Film.

These are non-graded activities, so you do not have to submit them.