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Analysis of American Health Care System with respect to current affairs: Is Universal Health Care a Potential Reality?

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Declaration

I declare I have written this Bachelor Thesis
„Analysis of American Health Care System with respect to current affairs. Is Universal Health Care Potential Reality?“ on my own.
I cite the literature and materials used in the references index enclosed.

Jindřichův Hradec, April 2010

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student´s signature

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Abstract

The main task of the Thesis is to analyze an American health care system, its management and behavior including its pros and cons. To describe and study the system will help to understand its eventual future progress and to answer a basic question 'Is Universal Health Care a Potential Reality in U.S.A.?'. With a respect to current affairs, as was the comprehensive health care reform signing, it will be possible to think and forecast relevant course of events that might improve consciousness about American health care delivery. The representative of well behaving health care system is considered that one in United Kingdom - National Health Service - socialized medicine system, which is based on an idea that health care should be available to all, regardless of wealth or income.

Anotace

Hlavním úkolem této práce je rozbor amerického systému zdravotnictví, jeho správy a fungování včetně stanovení výhod a nevýhod systému. Popis a prostudování systému zlepší pochopení jeho možného budoucího vývoje a napomůže také k zodpovězení klíčové otázky, zda ´Je všeobecné zdravotnictví možnou realitou v U.S.A.?´. S ohledem na současné události, a to podepsání komplexní reformy zdravotnictví, bude možné uvažovat a současně předpovídat případné dění, které by mohlo vylepšit povědomí o výkonu amerického zdravotnictví. Za zástupce dobře fungujícího zdravotnického systému se považuje systém socialistického zdravotnictví ve Velké Británii – National Health Service založený na myšlence, že zdravotní péče by měla být dostupná všem, bez ohledu na bohatství nebo příjem.

Key words

Health care, insurance, coverage, socialized medicine, universal health care, Medicare, Medicaid, Bismarck, Beveridge, NHS, HMO

Klíčová slova

zdravotní péče, pojištění, pokrytí, socialistické lékařství, všeobecná zdravotní péče, Medicare, Medicaid, Bismarck, Beveridge, NHS, HMO

CONTENT

INTRODUCTION

Good health is the most important thing for everyone. Although medical science has developed a lot, new medicines have been discovered and invented, there are still illnesses which cannot be treated. The main task of medical science today is the treatment of these fatal diseases, measurability of the quality of healthcare, ethic or increasing economic demands of healthcare systems.

Any healthcare system is considered as providing primary, secondary and tertiary care. Primary means homecare – availability of care near your home. Secondary means ambulatory healthcare and finally tertiary means special care for example in the form of upper-regional centers.

Although medical care in Czech Republic is basically free of charge, the government encourages all citizens to be responsible for their health and has introduced a system in which the patient partly shares the costs of some treatment and medicine. According to law, all citizens are covered by health insurance. Though there are several health insurance companies, both private and state, most people belong to the General Health Insurance Company (GHIC).

In Britain, the National Health Service (NHS) provides free health care to all people in the country. The system was born out of a long-held ideal that good healthcare should be available to all, regardless of wealth – and that principle remains at its core. Everybody is free to chose a general practitioner (GP) in his own home area and be registered on his list. In towns it is usual for three or four GPs to join together in partnership and thus share the cost of expensive medical technology. If you need a special treatment, the doctor will send you to see a specialist at a local hospital. In England, the companies also pay insurance for their employees and the government for other people as it is in the Czech Republic.

In the United States, there are ‘many’ different types of healthcare. Most employed people are insured through their employer. There exist special retire health plans, private insurance etc. but the problem there is, that private health insurance is expensive, especially for treatment that needs specialists. Many people, however, are not poor, but do not have money to pay for private health insurance because it is very expensive. If they fall ill, they must pay for it themselves. This is a big problem in the USA, because hospitals must take care of people, if they fall ill, even if they do not have money, and this is difficult for many hospitals.

To manage the task of describing and analyzing an American health care system I decided to take as an example the system of socialized medicine, which works quite well. The National Health Service in Great Britain is considered as a representative of health service of Europeans countries. Also few opinions and feelings of Americans are included in this Thesis. It is also written with looking at U.S.'s current affairs – mainly the Health Care Reform Act, President Obama signed at the end of March 2010 and which is going to work in 2014. Is it even possible to implement a universal coverage in U.S.? That is the essential question of this Thesis.

THEORETICAL PART

1. American pluralistic broad health care system

Today there are more health plans to choose from than ever before in USA. Not everyone has a choice. In USA large amount of money are spent in the private healthcare system to provide advanced sophisticated care while the immunizations programmes and preventive medicine is ignored.

1.1. Private Insurance

"The two major private types of health plans are:

- Fee-For-Service (FFS) is a payment system by which doctors, hospitals and other providers are paid a specific amount for each service performed as identified by a claim for payment
- Managed Care is a system of health care that combines delivery and payment; and influences utilization of services, by employing management techniques designed to promote the delivery of cost-effective health care. Managed Health Care Plans is an arrangement that integrates financing and management with the delivery of health care services to an enrolled population. It employs or contracts with an organized system of providers which delivers services and frequently shares financial risk." [1] It is possible to visit a certain doctor within a certain net of doctors with the plus that you pay less. You do not pay the deductibles but a flat sum of money for each visit of a doctor which is called a copayment ("cost-sharing arrangement in which a member pays a specified charge for a specified service e.g., $10 for an office visit. The member is usually responsible for payment at the time the service is rendered." [2]) There is necessary for everyone to have a Primary Care Physician (PCP).

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[1] US Department of Health and Human Services: Assistant Secretary for Planning and Evaluation: Glossary of Managed Care Terms; [cit. 28.3.2010], available at *http://aspe.os.dhhs.gov/progsys/forum/mcobib.htm*

[2] US Department of Health and Human Services: Assistant Secretary for Planning and Evaluation: Glossary of Managed Care Terms; [cit. 28.3.2010], available at *http://aspe.os.dhhs.gov/progsys/forum/mcobib.htm*

"There are four types of managed care plans:

- Health Maintenance Organizations (HMO) usually only pay for care within the network. You choose a primary care doctor who coordinates most of your care. Some HMOs directly own health care premises and employ professionals or they can recruit the care somewhere else. In practice, an HMO is an insurance plan under which an insurance company controls all aspects of the health care of the insured. Each member is assigned a primary care physician (PCP) who is responsible for the overall care of members assigned. Specialty services and non-emergency hospitals require a specific referral from the PCP.
- Preferred Provider Organizations (PPO) usually pay more if you get care within the network, but they still pay a portion if you go outside. PPO is **a** health care delivery system that contracts with providers of medical care to provide services at discounted fees to members. Members may seek care form non-participating providers but generally are financially penalized for doing so by the loss of the discount and subjection to copayments and deductibles.
- Point of Service (POS) plans let you choose between an HMO or a PPO each time you need care. POSs is a health services delivery organization that offers the option to its members to choose to receive a service from participating or a nonparticipating provider. Generally the level of coverage is reduced for services associated with the use of non-participating providers.
- Individual Practice Association (IPA). "IPA is a type of HMO that contracts with individual practitioners or an association of individual practices to provide health care services in return for a negotiated fee. The individual practice association, in turn, compensates its physicians on a per capita, fee schedule, or other agreed basis." [3]

The pros of this private system are lower costs of provided care, enforced healthcare plans or higher rate of innovations in the relationship with the clients. As cons might be considered the quality of healthcare (chronical diseases) or we can say, that there is no free choice of doctor.

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[3] US Department of Health and Human Services: Assistant Secretary for Planning and Evaluation: Glossary of Managed Care Terms; [cit. 28.3.2010], available at *http://aspe.os.dhhs.gov/progsys/forum/mcobib.htm*

1.2. Health Insurance Financed from Common Resources

Access to health care and health insurance is always a key issue in the political campaigns. Two federal programs that provide health insurance to millions of Americans are Medicare and Medicaid. "Congress established both Medicare and Medicaid in 1965 as part of President Lyndon Johnson's social services programs.

Because its clients are retirees, Medicare was originally managed by the Social Security Administration (SSA). Medicaid was managed by Social and Rehabilitation Service. Both were part of the Health, Education and Welfare (HEW) Department. In 1980, President Reagan split HEW into the Department of Education and the Department of Health and Human Services (HHS). In 1933, the first private hospital insurance was approved; it led to the establishment of Blue Cross. In 2001, President Bush renamed HCFA the Centers for Medicare & Medicaid Services (CMS)." [4]

1.2.1. Medicare

This federal social insurance program is administered by the government and providing health insurance coverage for people who are aged 65 and over, or for some people under 65 who have disabilities. Medicare operates as a single-payer which means that it collects all medical fees and then pays for all services through a single government source. This kind of publicly-managed health insurance is typically extended to all citizens and legal residents in wealthy nations.

Australia, Canada and most European countries have a single-payer health insurance programs that provide universal health care. The United States has Medicare but this system is only for senior citizens and some of the disabled – that is the problem in USA. Single-payer healthcare may be operated in a number of ways. The case in United Kingdom works well - doctors may be employed and hospitals run by, the government. Alternatively – the government may purchase health care from outside the net of organizations which is the approach in Canada.

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[4] US Politics: The U.S. health care system: What is Medicare?, [cit. 28.3.2010], available at *http://uspolitics.about.com/od/healthcare/a/medicare.htm*

In 1965, when Medicare was legalized, just 56 % of Americans over 65 had hospital insurance. Today almost all elderly Americans have hospital insurance through Medicare. And in 1965, about 29 % of elderly Americans lived in poverty; by 1998, that had fallen to less than 11%.

"Medicare has two parts:

- hospital insurance helps cover inpatient care in hospitals, critical access hospitals, or skilled nursing facilities. It also covers some home health care and hospice care. Most people don't have to pay a premium for hospital insurance because they paid Medicare taxes while working,
- coverage for doctor services, outpatient hospital care, and some medical services not covered by hospital insurance – this focuses on outpatient care but also covers some rehabilitation (physical and occupational therapy)." [5]

1.2.2. Medicaid

If you can't afford to pay for medical care, Medicaid can make it possible for you. Medicaid is a state administered program and each state sets its own guidelines regarding eligibility and services.

„Medicaid is available only to certain low-income individuals and families who fit into an eligibility group. Medicaid does not pay money to individuals - instead, it sends payments directly to the health care providers. Depending on a certain state's rules, people may also be asked to pay a part of the cost (co-payment) for some medical services.

In general, you can apply for Medicaid if your income is low and you match one of the descriptions of the Eligibility Groups:

- Pregnant Women (married or single; both mother and child are covered),
- Children and Teenagers,

  Apply if you are the parent or guardian of a child who is 18 years old or younger and your family's income is limited, or if your child is sick enough to need

[5] US Politics: The U.S. healthcare system: What is Medicare?, [cit. 28.3.2010], available at *http://uspolitics.about.com/od/healthcare/a/medicare.htm*

nursing home care, but could stay home with good quality care at home. If you are a teenager living on your own, the state may allow you to apply for Medicaid on your own behalf or any adult may apply for you. Many states also cover children up to age 21,

- Person who is Aged, Blind, and/or Disabled

  Apply if you are aged (65 years old or older), blind, or disabled and have limited income and resources. Apply if you are terminally ill and want to get hospice services. Apply if you are aged, blind, or disabled; live in a nursing home; and have limited income and resources. Apply if you are aged, blind, or disabled and need nursing home care, but can stay at home with special community care services,

- Other Situations

  Apply if you are leaving welfare and need health coverage. Apply if you are a family with children under age 18 and have limited income and resources. Apply if you have very high medical bills, which you cannot pay (and you are pregnant, under age 18 or over age 65, blind, or disabled)." [6]

The protests against this coverage might be about the ineffectiveness and wasting with the financial resources. The salaries of the professionals are not reflecting the quality and fastness of services provided – the queues might appear. Again – the client does not have a free choice of a doctor he wants to be treated at.

1.2.3. Who and how is the health care financed?

Who provides the health care?

1. Sick-bed facilities or hospitals owned or managed by
   - Religious Council
   - The government of the state or region
   - Independent non profit-making organizations
   - Large private companies

[6] US Department of Health and Human Services: Centers for Medicaid and Medicare Services: Medicaid Eligibility, [cit. 28.3.2010], available at *http://www.cms.hhs.gov/MedicaidEligibility/02_AreYouEligible_.asp#TopOfPage*

2. Outpatient clinics and Ambulances managed for example by Partnerships of Health Care Professionals
3. Individuals or Groups of health field employees in order to face the pressures in this area

Who pays for the service?

1. The patient
    - In a form of a charge for a operation (“free-for-services”)
2. The patient and another participation
    - 0 (seldom)
    - Deductible which is a specified amount of money a member must pay before insurance benefits begin, usually expressed in terms of an "annual" amount
    - Copayment represents a cost-sharing arrangement in which a member pays a specified charge for a specified service (e.g., $10 for an office visit); the member is usually responsible for payment at the time the service is provided
    - Coinsurance is a form of supplementary insurance together with deductibles (which represents the basic amount) plus a certain percentage amount over a client's health care plan limit

Who is the subject who pays the extra health care?

1. Those who provide it and pay for it also
    - Managed Care Organization (MCO) who owns the Health Care Facility plus runs the Health Insurance Company together
    - Employers who have enough capital for the payments and offerings the care to their employees (so called company doctors)
2. Those who do not provide the health care but pay for it
    - Medicare and Medicaid programs
    - Those who pay the insurance through the benefit programs for employees (for example the dentists)

1.3. For-profit health care

"Although most industrialized nations have universal health care coverage, the United States is unfortunately not among them. No doubt the existence of some 1,500 profit-seeking insurance companies contributes to this terrible fact. High-quality comprehensive health care should be made available to everyone regardless of race, class, ethnicity, gender, or age. Most Americans still depend on their employers for health insurance, while employers, in an effort to reduce costs or keep them at previous levels, have pushed employees into managed care.

Now, under current system, most of insurance companies are making billions profiting from people's health. And these profits are happening at a time when about 14 percent of American children don't have health insurance. Increasingly, more and more Americans are growing disillusioned with current system of for-profit health care. How far can this go?

People favor more government regulation over current health-care system. Yet, because of an expensive propaganda campaign, special-interest groups have for decades denied any serious reform. If the United States had a single-payer system of health-care financing, for example - wherein the government funded and paid for people's health care with taxes - everyone would be comprehensively covered with less administrative overhead." [7]

„The for-profit health care system says that people have to pay at a private clinic if they need a hip replacement, knee surgery, or other treatment. But what about the people who can't afford to pay those thousands of dollars? What about seniors, single parents, or those dealing with chronic disease? Letting the rich pay to get faster health care in the private sector contravenes the equality of access to medical services. All should have equal access to quality health care. Privatizing health care will only benefit those who can afford to pay, and will allow some doctors, business people and corporations to make money off sick and injured. The argument that a new system would be based on public-private systems in Sweden, France, Switzerland or other European countries might be better – so a "mixed" delivery of public and private might be better." [8]

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[7] Find Articles: When Wealthy Isn't Healthy, [cit. 5.4.2010], available at *http://findarticles.com/p/articles/mi_m1374/is_3_59/ai_54574807/*

[8] Profit is not the cure: The myths of for-profit health care, [cit. 5.4.2010], available at

"The biggest problem with health insurance in U.S. is that the companies are allowed to cover whatever they want and reject whatever they want. Further, they can pay doctors whatever they want and charge consumers whatever they want. The system only works for the insurance companies who are making record profits while we get less coverage for more costs. This is all driven by the profit motive – not by any concern for consumers.

Now, it's so hard to say, if the new bill that Obama is signed is going to solve America's fundamental problems, which is why many people are opposing it. Comprehensive health insurance is a matter of economic security. While many Americans don't have health insurance at all, many more Americans have health insurance that doesn't pay for care when they get sick or injured. When that happens, illness can lead to economic ruin. Half the personal bankruptcies in America occur because health insurance companies refuse to pay medical bills. Unfortunately, while the president's plan became law, Americans would still be only a major illness or injury away from personal bankruptcy, except the federal government will have required them to buy a private health insurance policy." [9]

That means they will no longer have the opportunity to say "I'll take my chances and not buy insurance". They will be required to buy insurance no matter what happens. First, Americans have to change their minds about the liberty they grew up in – freedom is important, they do live in democratic system, but if health care system needs to operate well, it needs to be governed by the State. We can say that the market needs to be reformed – to take the profit motive out of it might improve the situation, as it improved in Germany, United Kingdom, Switzerland or Japan – all of these are not-for-profit systems.

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http://www.profitisnotthecure.ca/cure/myths.html

[9] Elephant Journal: Non-for-profit health insurance is the only ethical answer, [cit. 5.4.2010], available at *http://www.elephantjournal.com/2010/03/not-for-profit-health-insurance-is-the-only-ethical-answer/)*

1.4. Universal Health Care

"Universal health care is health care coverage for all eligible residents of a political region and often covers medical, dental and mental health care. Typically, costs are borne in the majority by publicly-funded programs. Universal health care is implemented in all industrialized countries, as well in many developing, non-industrialized countries. However, the United States does not currently have a universal health care system, but 2010 legislation implemented universal health care insurance system to be working in 2014.

The United States is the only industrialized nation that does not guarantee access to health care as a right of citizenship. 28 industrialized nations have single payer universal health care systems, while 1 (Germany) has a multi-payer universal health care system like President Clinton proposed for the United States."[10]

The number of people with health insurance is still rising, but the same thing is happening to those uninsured ones. Universal Health Care should be dedicated to the idea that health care, while essentially very personal, can be delivered through the coordinated efforts. Very strong efforts can be seen in improvement in wellness education, disease management, and attention to the health concerns.

Universal health care is often associated with the term ‚socialized medicine', but in U.S. often used pejoratively. Americans do use this term to after a certain kinds of publicly funded health care that successfully works in European countries such as Great Britain, Sweden, Switzerland, Germany or even in Japan.

The first system of socialized medicine based upon compulsory insurance with State subsidies was created by Otto von Bismarck at the end of 18th century. Then many years later, socialized medicine was implemented in the Soviet Union at the beginning of the 19th century. After that, around 1940, the New Zealand operated in 'mixed economy' system and established a direct provision of health care by the state, free of costs. After World War II. Great Britain introduced the National Health Service, and also China and Cuba adopted socialized medicine, even in U.S. was initiated a program to help poor mothers and their children. So why they do not continue in this socialized

[10] Connecticut Coalition for Universal Health Care: The Case for Universal Health Care in the United Sates: The Case for Single Payer, Universal Health Care for The United States, [cit.2.4.2010], available at *http://cthealth.server101.com/the_case_for_universal_health_care_in_the_united_states.htm*

type of providing health care? Why they became too exaggeratedly proud to their freedom and liberty? Maybe it is not helping them, but it derogates them from being the country no. 1, as they wish to be.

2. European health care models

2.1. Bismarck Model

"France, Germany, Japan, the Netherlands, Belgium, Austria or Switzerland represents the social insurance, or Bismarck health system model - named for the Prussian Chancellor Otto von Bismarck, who invented the welfare state as part of the unification of Germany in the 19th century.

Although government, at various levels, is involved in financing health care, the social insurance model represents a partnership between the public and private sectors of the economy for the purpose of ensuring health care coverage for citizens. National health insurance is usually part of a general program of social security, also including old-age pensions, maternity benefits, unemployment compensation, disability insurance or children's allowances.

Bismarck-type health insurance plans have to cover everybody, and they don't make a profit. Doctors and hospitals tend to be private in Bismarck countries.

Social insurance health care systems vary regarding the organizational structure an financing of the system. In general, social insurance systems integrate public/private initiatives to ensure that all or most citizens have the access to a basic package of health care services. Financing of social insurance systems also varies.

Social insurance systems also formalize global budgeting in an effort to control health care spending. Global budgeting refers to the setting of financial spending limits on the delivery of health care services. Generally, an agreed-upon spending limit is established between physician and hospital services. A similar agreements are established with hospitals" [11]

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[11] Matcha, D. A.: Health Care Systems of the Developed World: How the United States' System Remains an Outlier, [cit 5.2.2010], available at *http://books.google.cz/books?id=d9n3FgcFSscC&pg=PA13&lpg=PA13&dq=Bismarck+Model+matcha+duane&source=bl&ots=9_3s6awYFD&sig=9z8HUjNL7kQs-wOFC-avS_vSYxI&hl=cs&ei=hyh8S_LBEaTmnAPe-eTXBA&sa=X&oi=book_result&ct=result&resnum=1&ved=0CAcQ6AEwAA#v=onepage&q=&f=false*

2.2. The Beveridge Model of Healthcare

This healthcare model was named after Lord William Beveridge and Nye Bevan, the social reformers who designed Britain's National Health Service. Both men were influenced by Marxist ideas, and we can say that Beveridge was the architect of the system and Bevan was the builder.

Beveridge was a British economist and social reformer, closely associated with the development of the welfare state. He became director of the London School of Economics and then he was the right man for designing the rebuilding of Britain after World War Two. He published his 'Beveridge report' in 1942 and recommended that the government should find ways of fighting with the five 'Giant Evils' of 'Want, Disease, Ignorance, Squalor and Idleness'.

"The welfare state was supposed to be introduced in 1945 including the establishment of a National Health Service in 1948 with free medical treatment for all. A national system of benefits was also introduced to provide 'social security' so that the population would be protected from the 'cradle to the grave'. People in work still had to make contributions each week, as did employers, but the benefits provided were now much greater." [12]

"In this system, health care was provided and financed by the government through tax payments, just like the police force or the public library. Many, but not all, hospitals and clinics are owned by the government; some doctors are government employees, but there are also private doctors who collect their fees from the government. In Britain, you never get a doctor bill. This system tends to have low costs per capita, because the government, as the sole payer, controls what doctors can do and what they can charge." [13]

British citizens are very proud of their National Health Service (NHS) - a government-run institution that provides hospitals and doctors to all citizens. The main reason is because they in return do not pay any bills.

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[12] BBC. Historic Figures: William Beveridge, [cit.4.2.2010] available at *http://www.bbc.co.uk/history/historic_figures/beveridge_william.shtml*

[13] PNHP. Physicians for the National Health Program: Health Care Systems - Four Basic Models [cit. 4.2.2010], available at *http://www.pnhp.org/single_payer_resources/health_care_systems_four_basic_models.php*

2.3. The Soviet Style - Semashko Model

This type of model is very similar to the Beveridge one. All the health care facilities and premises are owned by the state. All health services are centrally financed through the state budget. Different levels of administration (central, regional, local) are responsible for planning, allocation of resources and managing capital expenditures. The state totally controls the distribution of all health resources. Although the fundamental principle of justice is "to each according to his (her) needs", there is no idea of the health care needs and no public debate on their definition.

We can find some advantages in this kind of system:

- Justice and equality – everybody has the same right to health care
- The state is responsible for health care policy (treatment and prevention) and is morally obliged to provide decent health to every citizen
- simplicity

But as advantages, also disadvantages are very significant for this model. For example no justice and no equality in practice – a special health care system for the privileged people. The citizen's legal right to health care does not impose any parallel legal obligations on the state. The huge problem are systematically growing costs of running the system. No rationality in the system, no guidelines for rationing, no professional responsibility for saving the public money. ("It is all ours. We can afford".) Also growing gap between demand and supply of health care services, bureaucracy or paternalism are the worst problems is Russia.

During the last 15 years much happened.

1. The first reform (1999) came up with decentralization
   - loss of control
   - growing costs and limits for contracting
   - growing inequality and injustice
   - no explicit system of health care allocation
2. The second reform (2003) was centralized (National Health Fund)
   - bureaucracy
   - difficult access to primary health care service (specialist care)

- growing queues in clinics and hospitals
- dissatisfaction of patients, physicians and nurses
- no explicit system of health care allocation
- growing inequality and injustice

3. September 25, 2005. Election to the new parliament; the would-be winner promises a radical reform of the health care system

2.4. The National Health Service in England

The United Kingdom of Great Britain and Northern Ireland (UK) consists of four countries: England, Scotland, Wales and Northern Ireland. "The National Health Service (NHS) came into operation in 1948 following the provisions of the NHS Act of 1946. This Act was of crucial importance in establishing the post-Second World War pattern of health service finance and provision in the United Kingdom. It introduced the principle of collective responsibility by the State for a comprehensive health service, which was to be available to the entire population free at the point of use. Freedom from user charges was a key feature of this approach which placed heavy emphasis on equality of access." [14]

During the establishment of the NHS was important to deal with the advance in primary health care - the patient's first contact with the system - and the hospital service. "General practice (GP) covered workers under National Insurance Act of 1911. The GP should be available, attend patients at home, carry out treatment and obtain specialist help when needed. He would attend in childbirth and advise on how to prevent diseases, he should play a part in antenatal supervision, child welfare or physical culture. This was in contrast to the day-to-day example of the GP's life. In many cities overcrowding led to domestic violence, lice infestation and skin diseases such as impetigo." [15]

The NHS system was born out of a long idea that good healthcare should be available to all, regardless of wealth, and that principle remains at its core. The NHS offers free healthcare to all residents in United Kingdom which consists of four countries: England, Scotland, Wales and Northern Ireland. The structure and

[14] European Observatory on Health Systems and Policies: Health Care Systems in Transition: United Kingdom (1999), [cit. 4.2.2010], available at *http://www.euro.who.int/document/e68283.pdf*
[15] Rivett, G.:From Cradle to Grave: Fifty years of the NHS*;* [cit. 3.2.2010] available at http*://www.nhshistory.net/*

management differs slightly in each country.

“The new service run by the Minister was "tripartite".

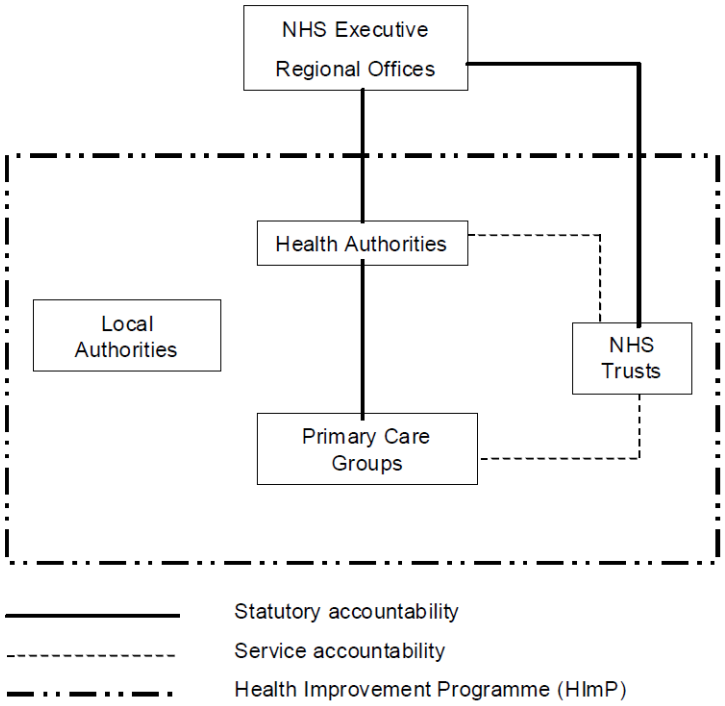
- Hospital services. The municipal and the voluntary hospitals were brought together in a single system in which all staff was salaried. Organization was based upon 14 Regional Hospital Boards that oversaw local hospital management committees. The teaching hospitals were directly responsible to the Ministry of Health ‘for they served the nation, not the locality.’
- Family doctors, dentists, opticians and pharmacists were self-employed under a contract for services from an Executive Council. The family doctor acted as gate-keeper to the rest of the NHS, referring patients where appropriate to hospitals or specialist treatment and prescribing medicines and drugs. In 1955 some money was made available to GPs to develop group practices. Dental services consisted of check-ups and all necessary fillings and dentures. Eye tests were provided by opticians on production of a GP referral note. Pharmacists provided over the counter remedies and dispensed the GP’s prescriptions.
- Local authority health services were managed by a Medical Officer of Health, who had lost command of municipal hospitals but still ran immunization and maternity clinics, provided community nurses to support to the family doctors and oversaw the control of infectious diseases. A major innovation, health centers in the community, had been planned but few were built. These were to be premises with accommodation and equipment to enable family doctors, dentists, nurses and others to work together to provide a range of services on the spot. There were also to be specialist ear clinics at which patients could get an expert opinion and, if needed, a hearing aid.“ [16]

“Within this structure, there are four main organizations:

1. regional health authorities (RHAs)
2. district health authorities (DHAs)
3. general practice fundholders (GPFHs)
4. NHS trusts” [17]

[16] Rivett, G.:From Cradle to Grave: fifty years of the NHS*;* [cit. 3.2.2010] available at *http://www.nhshistory.net/*
[17] European Observatory on Health Systems and Policies: Health Care Systems in Transition: United Kingdom, [cit. 18.2.2010], available at *http://www.euro.who.int/document/e68283.pdf*

Scheme 1: Structure of the NHS



Source: European Observatory on Health Systems and Policies: Health Care Systems in Transition: United Kingdom

"The NHS had become a service provided to all without payment. Private sector organizations came to build and operate hospitals under the public/private partnerships, and to run clinical services such as Independent Treatment Centers and NHS Walk-in Centers. Private practice was now an important part of a new and more sophisticated market." [18]

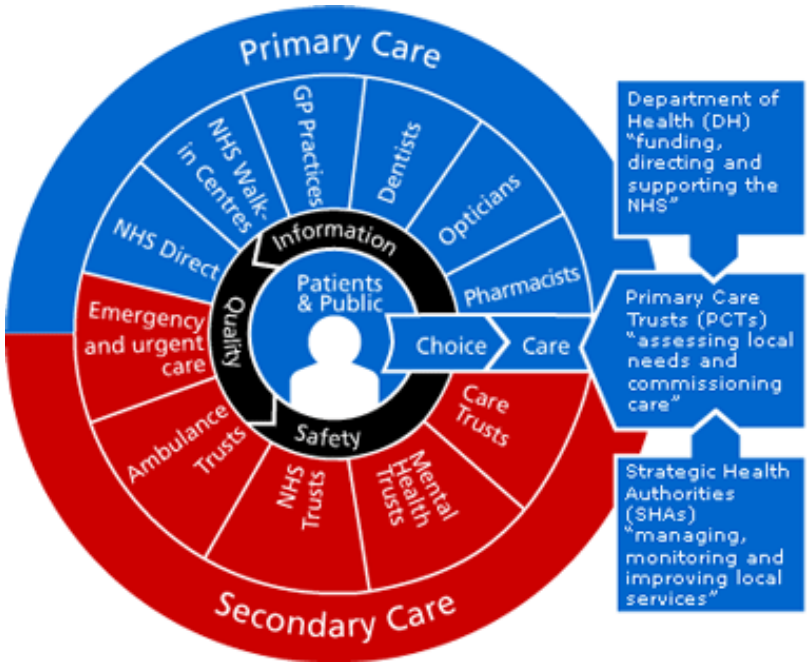
2.4.1. Primary and Secondary Care

The NHS is divided into two sections:

- primary care is the contact for most people and is delivered independent contractors - GPs, dentists, pharmacists and optometrists
- secondary care is known as acute healthcare and can be realized as an elective care or emergency care. Elective care means planned specialist medical care or surgery, usually provided by a primary or community health professionals such as a GPs.

[18] Rivett, G.:From Cradle to Grave: fifty years of the NHS, [cit. 3.2.2010] available at *http://www.nhshistory.net/*

Scheme 2: The Structure of the NHS



Source: NHS Choices: Your health, your choice: About the NHS: Authorities nd Trusts

"Primary care is the care provided by people you normally see when you first have a health problem. It might be a visit to a doctor or a dentist, an optician for an eye test or a trip to a pharmacist. NHS walk-in centers and the NHS Direct telephone service are also part of primary care. All of these services are managed for you by your local primary care trust (PCT). There are currently 152 primary care trusts in England.

Strategic health authorities (SHAs) were created by the government in 2002 to manage the local NHS on behalf of the secretary of state. There were originally 28 SHAs and on July 1 2006, this number was reduced to 10. SHAs manage the NHS locally and provide an important link between the Department of Health and the NHS. SHAs are responsible for:

- Developing plans for improving health care in a local area
- Making sure local health services are of a high quality
- Increasing the capacity of local health services so they can provide more services
- Making sure national priorities (programmes for improving cancer services) are integrated into local health service plans.

The Department of Health controls the NHS. The secretary of state for health is the head of the Department of Health and reports to the prime minister. The Department of Health controls England's 10 Strategic Health Authorities (SHAs), which oversee all NHS activities in England. In turn, each SHA supervises all the NHS trusts in its area. The devolved administrations of Scotland, Wales and Northern Ireland run their local NHS services separately. " [19]

[19] NHS Choices: Your health, your choice: About the NHS: Authorities nd Trusts, [cit 28.3.2010], available at *http://www.nhs.uk/NHSEngland/thenhs/about/Pages/authoritiesandtrusts.aspx*

PRACTICAL PART

3. Health Care Reform in U.S.

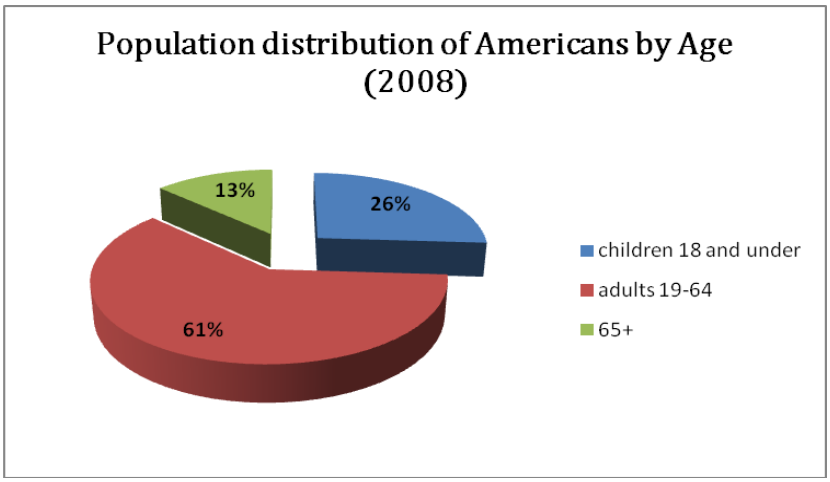
The United States of America is a federal constitutional republic comprising fifty states. The U.S. is said to have a mixed economy because privately owned businesses and government both play important roles. In this mixed economy, individuals can help guide the economy not only through the choices they make as consumers but through the votes they cast for officials who shape economic policy. The population and the labor force have shifted dramatically away from farms to cities, from fields to factories, and, above all, to service industries.

The United States is the only industrialized country in the world without a universal health insurance system. In 2008, the U.S. census reported that over 46 million Americans have no health insurance. As you can see, in the *Table no.1* and *Pie Chart no.1*, the American population is divided into three sections with the most numerous adults, which creates more than 60% of the whole population.

Table 1: Population Distribution by Age (2008)

Population Distribution by Age (2008)		
AGE	**PERCENT**	**NUMBER**
children 18 and under	26%	78.677.200
adults 19-64	61%	184.079.200
65+	13%	37.787.700
TOTAL	**100%**	**300.544.200**

Chart 1: Population Distribution of Americans by Age (2008)



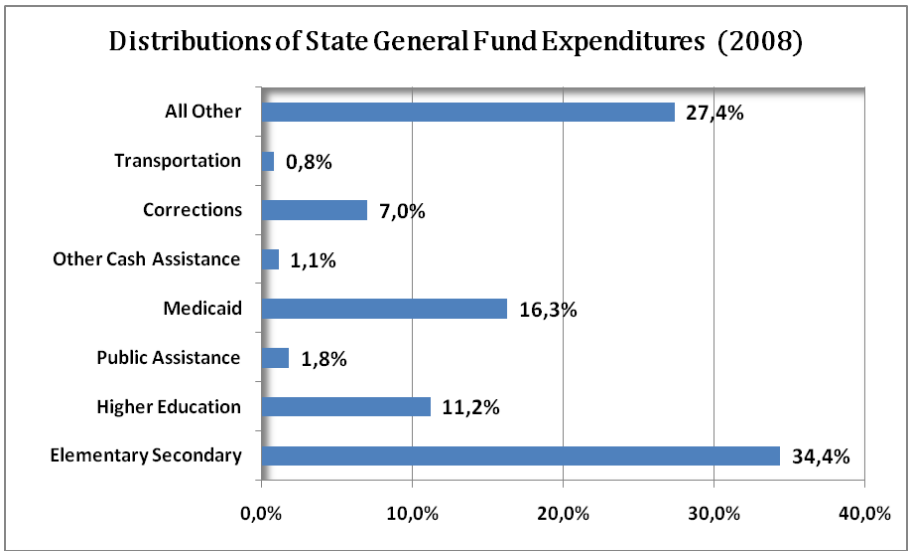
Source: StateHealthFacts.org: 50 States Comparisons, available at *http://www.statehealthfacts.kff.org/comparetable.jsp?ind=2&cat=1&sub=1&yr=134&typ=1*

"Most Americans are not satisfied with the nation's health care system. At the root of this dissatisfaction is its price tag.

- An overwhelming 80 percent of the public is dissatisfied with the total cost of care in the nation.
- Slightly more than half are dissatisfied with the quality of care in the nation.
- At the same time, most people are satisfied with their own health insurance coverage and with various aspects of their medical care.
- Problems paying for care are on the rise.
- One in four Americans says their family has had a problem paying for care.
- Among the uninsured, 68 percent had delayed care in the same period."[20]

The tables below illustrate percents of general and health care expenditures in U.S.A. As you can see, the hospital care reflects the biggest amount of all other items. Elementary, secondary and higher education expenditures also represent very high amounts of money spent. America spends much more for health care in comparison with other socialistic health hare system countries.

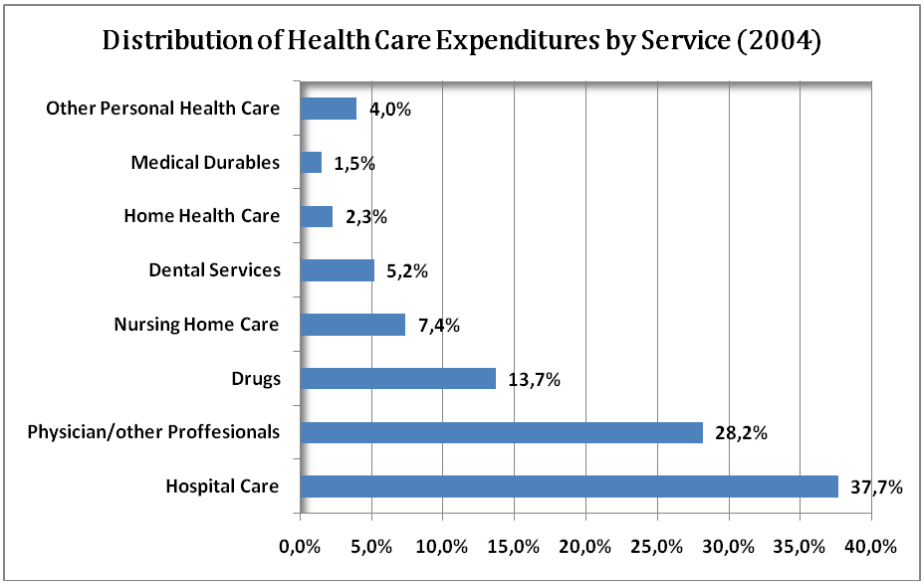
Table 2: Distribution of State General Fund Expenditures (2008)



Source: StateHealthFacts.org: 50 States Comparisons, available at *http://www.statehealthfacts.kff.org/comparetable.jsp?ind=2&cat=1&sub=1&yr=134&typ=1*

[20] The Henry J. Kaiser Family Foundation: ABC News: USA Today: Health Care in America 2006 Survey, [cit. 30.3.2010], available at *http://www.kff.org/kaiserpolls/upload/7572.pdf*

Table 3: Distribution of Health Care Expenditures by Service(2004)



Source: StateHealthFacts.org: 50 States Comparisons, available at *http://www.statehealthfacts.kff.org/comparebar.jsp?ind=593&cat=5*

3.1. Current affairs

Barack Hussein Obama, the President of the United States of America, signed comprehensive health reform, the Patient Protection and Affordable Care Act, into law on March 23, 2010.The following summary of the new law focuses on provisions to expand coverage, control health care costs, and improve health care delivery system. It's main aim is to remake the nation's health care system and guarantee access to medical insurance for tens of millions of Americans.

The bill arranges the biggest expansion of federal health care guarantees, and its enactment was a giant victory for President B. H. Obama and Democrats - no Republicans supported the bill in either the House or Senate. The bill deals with the core principle that everybody should have some basic security when it comes to their health care. "The president emphasized that this year, some 4 million small-business owners will be able to get tax credits to help cover the cost of providing health insurance to their employees, while insurance companies will no longer be able to deny coverage for children because of pre-existing medical conditions. The overall $940 billion plan is projected to extend insurance coverage to roughly 32 million additional

Americans. But on the other hand – many of the plan's most important benefits won't happen until 2014." [21]

"The American people will see immediate (either now or in six months to one year) benefits:

- an immediate guarantee that children can get health insurance even if they have a pre-existing illness
- young adults may stay on their parents' policies (all plans) until they turn 26 years
- prohibit to drop people from coverage when they get sick in all individual plans, or to place lifetime or annual limits on the amount of health care people receive
- lower seniors prescription drug prices by beginning to close the hole, giving them $250-$500 to help pay for drugs if they fall into that coverage gap
- require new plans to cover preventive services and immunizations without cost-sharing
- ensure consumers have access to an effective internal and external appeals process to appeal new insurance plan decisions"
- require premium rebates to enrollees from insurers with high administrative expenditures and require public disclosure of the percent of premiums applied to overhead costs" [22]

The reform wants to give more power to the people so that they are more involved with the decisions that Insurance Companies make. Now people have the right to vote whether they are fine with increasing costs or not – before the reform it was just simply settled. The reform is trying to make Insurance Companies more transparent so that people can see how the costs of things changing affect them. In this case the percentage of premium costs going up (which no one likes since it makes medicine, surgeries, even doctor visits, etc.) is more pricey.

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[21] CNN:CNN Politics: Obama signs health care bill; Senate takes up House changes, [cit.31.3.2010], available at *http://www.cnn.com/2010/POLITICS/03/23/health.care.main/index.html*

[22] Good News Network: Top Ten Immediate Benefits From Newly Passed Health Care Reform, [cit. 266.3.2010], available at *http://www.goodnewsnetwork.org/most-popular/general/immediate-health-care-reform-benefits.html)*

"Expanding coverage to the uninsured as well as addressing health care cost and quality issues have emerged as the dominant drivers for systematic reform. Leading health reform proposals rely on a combination of public and private approaches to expand coverage, control costs and improve quality with shared responsibilities across employees, employers, government, consumers and insurers." [23]

United States began to expand and think about to reform their health care system years ago, but no President was successful. The main task is to reduce the growing number of uninsured residents in their state. By the year of 2008, Massachusetts, Maine and Vermont legalized universal coverage plans for all of their residents and some other states started to plan a comprehensive reform. However, state capacity, deficits, worsening economy and budget shortfalls have limited States' ability to further advance coverage innovations. The economic downturn has burdened family finances and stimulated some Americans to cut back on medications and forgo preventive care and visits to the doctor.

Overall, the American health care system is very strong. Most new drugs in the world are developed by the U.S. drug companies and much of the advancement in medical devices such as heart implants are developed there as well. Their system produces many highly skilled surgeons and people come from all over the world to have U.S. doctors and hospitals perform complex medical procedures. Their basic health care system is less effective, however. About 15% of our population does not have health insurance (see *Pie Chart no.2*), either because they cannot afford it or because they do not think it is necessary. This tends to limit access to basic health services for the poorer segment of their population and as a result, by some measures, their population is less healthy than other developed countries. The recent reforms are intended to address this issue. The new law will require all Americans to buy health insurance and provide subsidies to those who cannot afford it. This has been very controversial for American population, because they have a culture of individual freedom and responsibility. Many of them feel this is an intrusion on their personal freedom.

The recent reforms signed by The President of U.S.A. are intended to address an issue relating prohibit to drop people from coverage when they get sick. The

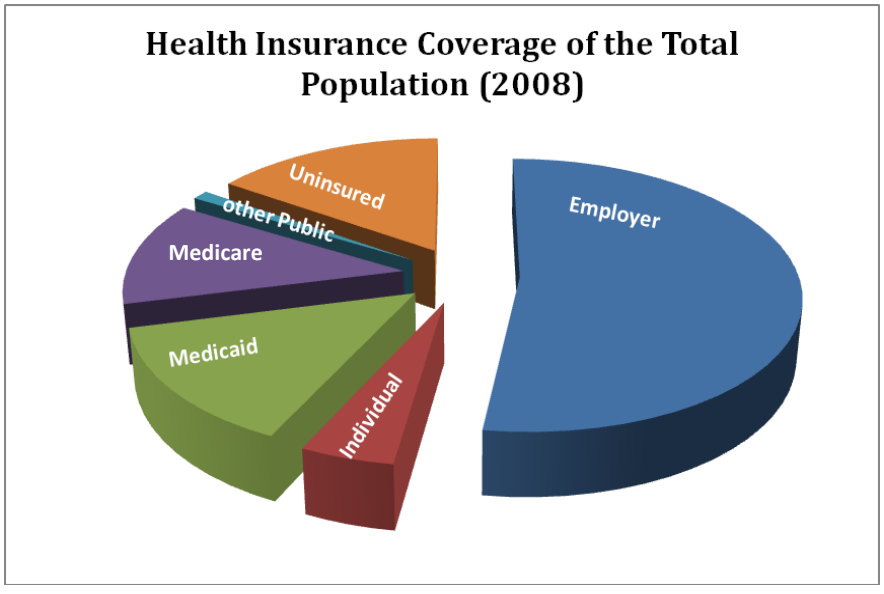
[23] The Henry J. Kaiser Family Foundation: Kaiser Facts: State Variation and Health Reform, [cit. 31.3.2010], available at *http://facts.kff.org/chartbook.aspx?cb=56*

government chose not to eliminate the tax incentives, but rather to impose a complex system of insurance regulation that will result in more government involvement in the medical system. This might be controversial for most Americans who believe that the doctors and patients should decide chat treatment is appropriate – not the government. Under their current health care system, if they lose their jobs, they lose their health care, because most people receive health instance from their employers, as you can see on the *Pie Chart no.2.* While they are moving to highly regulated system, it is still primarily a private system. Every system has its strengths and weaknesses, and the American one also – but for the most part of American citizens that is consistent with their culture of individual freedom.

Table 4: Health Insurance Coverage of the Total Population (2008)

Health Insurance Coverage of the Total Population (2008)		
METHOD	**PERCENT**	**DOLLAR**
Employer	52,3%	57,194,100
Individual	4,7%	13,995,800
Medicaid	14,1%	42,326,300
Medicare	12,4%	37,183,500
Other Public	1,1%	3,505,000
Uninsured	15,4%	46,339,500
TOTAL	**100,0%**	**300,544,200**

Chart 2: Health Insurance Coverage of the Total Population (2008)



Source: StateHealthFacts.org: 50 States Comparisons, available at *http://www.statehealthfacts.kff.org/comparetable.jsp?typ=1&ind=125&cat=3&sub=39*

"The legislation passed by the House of Representatives will do the following:

- Most individuals will be required to have health insurance beginning in 2014.
- Individuals who do not have access to affordable employer coverage will be able to purchase coverage through a health Insurance Exchange with premium and cost-sharing credits available to some people to make coverage more affordable; small businesses will be able to purchase coverage through a separate Exchange.
- Employers will be required to pay penalties for employees who receive tax credits for health instance through the Exchange, with exceptions for small employers.
- New regulations will be imposed on all health plans that will prevent health insurers from denying coverage to people for any reason, including health status, and from charging higher premiums based on health status and gender.
- Medicaid will be expanded to 133% of the federal poverty level ($14,404 for an individual and $29,327 for a family of four in 2009) for all individuals under age 65.

All individuals will be required to have health insurance, with some exceptions, beginning in 2014. Those who do not have coverage will be required to pay a yearly financial penalty of the greater of $695 per person (up to a maximum of $2,085 per family), or 2.5% of household income, which will be phased-in from 2014-2016. The Congressional Budget Office estimates that the legislation will reduce the number of uninsured by 32 million in 2019 at a net cost of $938 over ten years, while reducing the deficit by $124 billion during this time period." [24]

[24] The Henry J. Kaiser Family Foundation: Kaiser Facts: Health Reform, [cit. 31.3.2010], available at *http://www.kff.org/healthreform/upload/8023-R.pdf*

3.2. The Socialized Medicine

"Americans might see some problems with the implementation of the Universal Healthcare:

- Reduces patient motives to find the best possible prices for the best possible services available - patients in the U.S. who receive "free" health care have no incentive to keep their health care dollars. Care is "free" so they visit the doctor's office a few times a month or request "free" prescriptions.
- Reduces physician motives to provide competitive care and reduces drug companies' incentives to provide new drugs and treatments. With no incentive to provide quality care, physicians and nurses leave the government-monopolized area for better opportunities in a freer country. Drug companies are defended by price controls and regulations and soon finish research and development of new medication.
- 'Steals' from 'your' wallet to pay for 'my' health care. - Do U.S. citizens have a right to health care, just as they have a right to food, shelter and property? However, they have no "right" to force others to provide these things - all "free" medical care is subsidized through taxes "stolen" from other people.
- The quality of "free" health care will be worse and the average citizen will get sicker. - As the poor and middle-class wait in agony for simple procedures, those with resources can travel to other countries for treatment.
- Destroys the privacy. - Suddenly your problems are mine and mine are yours.
- Destroys your liberty. - When you blindly support a system that bestows power The power of government can be used against you as you are forced to use medicines or accept treatments from well-connected health care companies."[25]

[25] Liberty Page: The Problem with Socialized Health Care, available at *http://www.liberty-page.com/issues/healthcare/introduction.html*

The term ‚Socialized Medicine‘ is used to describe a system of publicly administered national health care. This system can range and be divided into two sections of possibilities:

- programs in which the government runs hospitals and health organizations
- programs in which there is national universal health care

We can say that these programs are often associated with communist run countries, because almost every Western Country - except the United States - has in some form socialized medicine working. England has had a socialized program since 1948 in which provides free physician and hospital services for all citizens. Recently, the program has been modified to include some small fees for doctor services, but the concept of the NHS stays still pure.

In the United States, public opinion was not huge to accept socialized medicine, often because the program will be costly and the quality of patient‘s care will go down. Despite these feelings, some Americans vote for so-called “single-payer national health insurance” which is a system in which a single public or quasi-public agency organizes health financing, but delivery of care remains largely private.

Currently, the U.S. health care system is terribly expensive and inadequate. “Despite spending more than twice as much as the rest of the industrialized nations, the United States performs poorly in comparison on major health indicators such as life expectancy, infant mortality and immunization rates. Moreover, the other advanced nations provide comprehensive coverage to their entire populations, while the U.S. leaves over 46 million completely uninsured and millions more inadequately covered. The reason they spend more and get less than the rest of the world is because they have a patchwork (or mosaic) system of for-profit payers. Private insurers necessarily waste health dollars on things that have nothing to do with care: overheads, underwriting, billing, sales and marketing.

Single-payer financing might be the way to recapture wasted money and to recover American health care system. Under a single-payer system, all Americans would be covered for all medically necessary services, including: doctor, hospital, preventive, long-term care, mental health, reproductive health care, dental, vision, prescription drug and medical supply costs. Patients would have free choice of doctor and hospital, and doctors would gain their autonomy over patient care. Physicians would be paid fee-for-service according to a negotiated formulary or receive salary from

a hospital or nonprofit HMO. Hospitals would receive a global budget for operating expenses. Health facilities and expensive equipment purchases would be managed by regional health planning boards.

A single-payer system would be financed by eliminating private insurers and recapturing their administrative waste. Modest new taxes would replace premiums and out-of-pocket payments currently paid by individuals and business. Costs would be controlled through negotiated fees, global budgeting and bulk purchasing."[26]

3.3. Opinions of American citizens

Teri Mullen
Middleton, MA
50 years old
Employer: Administrative Assistant in South Shore Community Church
Health Care Plan: Blue Cross-Blue Shields
[cit. 28.3.2010]

"I think that probably we in the US have the best medical care available to us. People come from all over the world to be treated in our hospitals. On the other hand, our health care system is very conservative, and doesn't embrace the holistic practices at all. We have been very fortunate over the years to have good health insurance that our employers help pay for. If you are in that category of U.S. people you can access the best health care. If you are very poor, at least here in MA, you can get excellent free care. It is those in the middle, whose employers either don't offer, or don't help pay for insurance that have difficulty. Generally speaking they are underemployed and would have to pay a very high price for insurance... Several years ago here in MA we passed a health reform bill that made affordable health insurance available to these 'middle people' and it seems to be working well. Another part of the puzzle is the enormous cost of health care here. We in the US are basically a consumer society, and tend to demand the biggest and best always. It shows up in our health care costs by the patient demanding certain treatments, tests, medications etc. that may not always be medically necessary or there could be less expensive options... Also the pharmaceutical companies spend huge amount of dollars on research, development and advertising, which all comes down to higher medication costs. Here in the US we are what I call a 'law suit happy' culture. Everyone can sue anyone. In fact one lady sued one of the large coffee chains (like Dunkin Donuts) because her coffee was hot. She spilled it on her leg and received a burn. She actually won the suit and was awarded a large financial settlement. When applied to the health care cost situation, physicians and health care centers are in the position of having to purchase very expensive malpractice insurance in case of a law suit."

[26] PNHP: Physicians for a National Health Program: Single Payer National Health Insurance, [cit. 2.4.2010], available at *http://www.pnhp.org/facts/single-payer-resources*

Jerry Micherda
Salem, MA
38 years old
Employer: Tecomet, Inc.
[cit. 29.3.2010]

"It's also hard to describe American Healthcare System for two reasons. First of all, last week our President Obama has signed a new Healthcare Bill into law. It will not be implemented till a year 2014, but it will completely change the American Healthcare System. The entire Healthcare System is being reorganized, and so far no one really knows, including our politicians, what it will really cost and how it will work. It's also very possible that it might be overturned by our future President, since there is about 50% of people opposing it. The other reason that makes describing the American Healthcare System hard, is because like everything else in America, our Federal Government (Washington DC) gives lots of power to the State Government. That means, that each of our 50 states has a right to make its own changes, adjustments, etc. You could almost compare it to the various nations of the European Union. Maybe not as drastic difference, but each State has lots of its own power in governing not only the Healthcare System, but everything that has to do with its people's lives and politics.

...We have a privatized healthcare system. I think not too long ago I was reading that we are the only 'civilized' country in the world that has a medical system 'for profit'. As far as the quality of the healthcare, I believe we do have one of the best in the world. BUT, I said 'the quality of the healthcare' not 'the quality of the healthcare system'! Because the system is horrible. And by 'system' I mean how to get the health care when you need it, how easily it is available, and how affordable it is. Once you break through the system and you can afford it, it is excellent. Unfortunately, the road to that excellence is very hard, and to many impossible to cross.

A typical person needs to have a health insurance to see a doctor or go to a hospital. You can either go to one of the many many insurance companies and pay for it, or you can get it from your employer (assuming you have a job). I do not know if I ever met one or two people that are paying for the health insurance themselves. Only because it is so incredibly expensive. This is where many small business owners struggle in the US. Most people get their insurance from their employers. It's also very expensive, but your employer covers some of the costs.

A typical working person has his health insurance mostly paid by his employer. Although we have many different health insurances, you do not have many choices. Usually, the employer negotiates a good deal with one or two insurance companies and gives you couple of different options to pick from. Your employer will pay about 70-80% of the insurance cost and you will pay the rest. And don't think that this is where it ends. When you go to a doctor or go buy prescription medicine, you still have co-pays. Those are small 'fees required *to pay.*

I will give you my personal example - at work, I have two different insurances to pick from. Each has its advantages and disadvantages. I can pick the insurance only for myself, for myself and my wife, or for my whole family (myself, my wife, and any kids). Since my wife's insurance at her job is more expensive than mine, I picked 'myself and my wife' option. My employer pays about $1400/month and I pay additional $400/month (that amount is taken out of my paycheck automatically). When I need to go see a doctor, this insurance pays for everything minus $30. This is the so-called co-pay. So no matter what I go for, and what the doctor does, I still have to pay him $30 for each visit. When I buy medication (prescription), I have to pay either $20 or $40 co-pay

depending on medication, the rest is paid for by my insurance. When I need to go to a hospital, I have to pay $500 and the rest is paid by my insurance.

Now, you probably heard that the insurance company can cancel my insurance at any time. And when you get very sick, and they have to pay a lot of money for you, they do it. Not often, but it does happen. They can also deny your coverage when they decide it is not needed. They also tell the doctor which medications they will pay for and which they will not. I used to take those nose drops for allergies. Summer time, I always needed these drops so my doctor would write me a prescription. When I buy them at the pharmacy, I would pay $40 co-pay, the insurance would pay the rest (about $30). After 3 years, the insurance company no longer pays for this medication! Why? Because now there is some other new medication, similar to this one and it costs less. So my doctor had to change my medication. This new one did not work for me. So now I have an option to pay 100% for the old one or nothing!

I could go on with stories like these for a long time. But like I said before, the healthcare is very good, but it is very expensive! If you don't have a job, you don't have a healthcare insurance, this is when things get very interesting. If you want to hear about that I'll give you another example of mine.

Few years ago I quit my job and were looking for a new one (don't ever quit before you find a new job). So I did not have any health insurance. One day my back starts hurting so much I can't even get out of my bed! Then it hurts and hurts for so long that I start calling doctors. It took few days to find a doctor that would want to see me. Every time you call, they ask you 'what kind of health insurance do you have?' If you don't have anything, they 'might' not have any opening till 3-4 months! This way they get rid of you. I finally found a doctor. They told me to make sure I have my credit card with me when I come ☹ The doctor gave me some pain medication and sent me home. It went on for couple of months. Finally I needed to have a MRI done. This is where the problem starts. To do a MRI of my back, it costs $4000. If I had health insurance it would cost me $30. It took many phone calls to find a hospital that would do a MRI for me without the health insurance. Even when you tell them you will pay for it, they don't trust you, they don't want to deal with it, and they refuse it. I finally got healthy - went home to Poland!

Technologically, we have the most advanced hospitals, laboratories, medication, doctors, specialists, etc in the world. When you get sick and go to the hospital you get incredibly good care. When my father had a heart attack 3 years ago, the ambulance was at home in less than 4 minutes (US average is 4 minutes!). In the emergency room in the hospital there were 12 doctors and nurses working on him at the same time! In less than one hour he had stunts installed and his surgery was done! Incredible, excellent care. Do you know how much it cost for the ambulance only? It was over $4000. But how do you put a price on your life?

Of course now with hard economic times, many employers do not want to pay for your health insurance. Or they hire you as a part-time employee (less than 40 hrs/week). As a part time employee you usually don't get health insurance.

Just a little bit about Obama's plan. It does not address any incredibly rising costs of our healthcare. It forces businesses to pay for your insurance (but if they cannot afford it then what?), it forces people to have health insurance (but if you cannot afford it then what?). Obama's plan forces everyone to have the health insurance, but businesses and people cannot afford it. And don't forget that there are no two health insurance businesses alike. One might offer $30/visit co-pay, another might be cheaper but you will pay $50/visit co-pay. Some other one might be even cheaper but will not cover medication. It's very very tricky.

I did not even tell you about the retirement plans we have. When you retire, you get the government 'health insurance'. It covers so little that everything you do requires huge co-pays, medication is very expensive, and it makes me sad… when I look at my parents… every doctor's visit is so expensive for them. They often say, in the 'good old U.S. of A.', that the health system is excellent when you rich and healthy. Once you get really sick, the doctors can do amazing things, but you'll have to sell your house!

When we change to more of the European system (government run system), the competition slows down, technology slows down, medical businesses loose interest and purpose in being the best. One of the problems that I noticed is that people do not know any better. The USA is a very isolated country. Average people do not know what it means to live in Europe, or Asia, or anywhere else. They think that what we have here is the best in the world. They hear from media stories on how people are dying in other countries waiting for a doctor's visit! We do live on a huge island. For many many years this country was the best in the world. So this mentality will never die.

Dianne Panarelli Miller
Abington, MA
48 years old
Employer: none; she is an artist, painter
[cit. 28.3.2010]

"I think that the government can't handle Medicare and now want to mishandle the whole system. Most of the U.S. people is not happy about what the President has done. I didn't vote for this president and am not happy with anything he has done so far. The health care will benefit the people who are not working, does not want to work or are here illegally. Some of the problems with our health care could have been handled with a strong overview of our insurance companies. The hospitals and med field is now already over worked and understaffed... My husband is out of work now for a year. There are no jobs to be had and things are difficult. I have to pay for our own insurance, which may get easier because of the changes, but we would rather have work. Hopefully, the people will smarten up and vote out anyone who has been in office too long!"

Jerry Williamson
Hingham, MA
49 years old
Employer: Genetix, Inc.
[cit. *30.3.2010]*

"As you may know, the U.S. Congress has just passed legislation that will guarantee health care coverage for everyone. Part of the changes that are outlined in this new law require mandatory coverage levels to be provided by US businesses. This is not terribly different from current requirements although it creates an exemption 'threshold' for small companies (less than 50 employees). Many people believe that this will stop growth in small companies under the basic idea that if you have more than 50 employees you will have a huge expense of healthcare coverage (therefore it is best to keep the employment numbers to below 50).

In many ways, the new healthcare law will bring the US system much closer to a government-run system such as exists in the UK. There, the National Health Service covers all citizens, regardless of income. The result is a reduction in the quality of care due to the mandatory methods of delivery. For example, in England, if you choose to go to an Emergency room for care, you will wait many hours. Another effect of this 'mandatory and standardized' approach is that everyone is treated the same – there is far less room for individual treatment plans and very little experimental protocols. In the U.S., there is a vast amount of research funding for new approaches to treating disease; however, if these new approaches cannot be tested due to a 'standardized protocol', the levels of research will go down (which will have negative effects on many current advancements in medicine).

Simply put, in order to provide healthcare for all, there needs to be better organization (which means more government involvement); limits to treatment expense (which means some expensive 'experimental' approaches will cease); and a mechanism to pay for the healthcare for the currently uninsured (which means higher taxes for those who are employed). The US is viewed by many to have one of the most advanced (and expensive) healthcare systems in the world. Hopefully, the changes recently enacted by the U.S. Congress will not diminish the quality of healthcare that is delivered as has happened in other government-run system such as the NHS in England.

Lauren Bass
Hingham, MA
48 years old
Employer: none, she is an artist/"stay-at-home mom"
[cit.29.3.2010]

"I'm a liberal democrat. Generally, I support Obama's overhaul of the healthcare system although I would have liked to see a public option. I feel we have really great research hospitals, top notch higher education, research labs and innovation. There is really great healthcare available in our country for those who can afford it. Because of this, many Americans feel we have the 'best healthcare in the world'. However, to too many of our citizens this excellent care is out of reach. So all the 'best care in the world' doesn't really matter if it's not accessible.

I think when you look at statistics of our overall health compared to other industrialized nations we're not at, or even near, the top because so many Americans can't afford good healthcare. Also, we pay much more in this country for our care and get less. It seems that our healthcare model is not very efficient. I think our healthcare premiums and what we pay for procedures is twice or more than that of Canada & Europe. Obama is trying to change that.

Our country is extremely polarized at the moment. Personally, I would like to see our country move in the direction of Europe & Canada. My impression is overall the healthcare is better in Europe & Canada than in the US because they take care of more of their citizens. I think no one should be denied quality healthcare. I would like to see it available to everyone regardless of income. I listen to National Public Radio a lot. The callers who live in Canada or Europe generally have said that these systems work well and are happy with them. Or at least that's my impression.

My in-laws lived in Paris for 12 years. They felt they got better care in France than here. Maybe that has changed since they've been here for about 10 years. But back then they expressed that point of view.

The right in our country has demonized the word socialist and anything that looks slightly socialist is therefore evil. I don't agree with that at all. Also, those who aren't insured will often not do preventive healthcare at a Dr.'s office because they can't afford it but then end up in the emergency room down the line. This costs much more and the costs are passed to the taxpayers. So we end up paying for it anyway when it's much worse and more expensive.

The new healthcare bill requires (in a few years) that everyone get health insurance or they will face a fine to address this. I do feel lucky that my husband has a good job where we have good coverage. I also feel fortunate to live in the Boston area when it comes to healthcare. We in the Boston area generally feel that we have the best hospitals & Dr.s in the country.

The US is a leader in new technologies and high end care. Many feel that it's the capitalist, profit motive of our country that's made this happen. I would like to retool and combine the best of Europe/Canada with our model. Things will have to happen slowly though because politically it's just such a poisonous environment right now."

3.4. Help with health costs in Britain

The treatment on the NHS is free at the point of delivery, there may still be some costs - for example, out-of pocket payments or a journey to hospital. BUT - unlike in U.S. - much or all of the costs can be reclaimed, which eases any added stress.

"The maximum charge for a complex course of dental treatment is £198. Most courses of dental treatment cost £16.50 or £45.60. Everyone still receive free NHS dental treatment if they meet the exemption criteria. You can get free NHS dental treatment if you are under 18 or 18 and in full-time education, if you are pregnant, or have had a baby in the 12 months before treatment starts and other exemptions. You are also entitled to free NHS dental treatment if you or your partner receive either income support, jobseeker's allowance or Pension Credit."

The conditions might differ according to a kind of a treatment you need. For example "if you need sight tests, you can get it for free if you are under 16 or 16-18 and in full-time education, or you are 60 or over , diagnosed glaucoma patient etc. Etc.

About the prescription charges – on April 1, 2009 the prescription costs increased to £7.20 for a prescription, £104 for a 12-month prepayment certificate (PPC), and £28.25 for a three-month PPC. The following items are supplied free of charge:

- Medication administered at a hospital or an NHS walk-in centre.
- Prescribed contraceptives.
- Medication personally administered by a GP.
- Medication supplied at a hospital or primary care trust (PCT) clinic for the treatment of a sexually transmitted infection or tuberculosis.

You can get free NHS prescriptions if, at the time the prescription is dispensed, you:

- are 60 or over,
- are under 16,
- are 16-18 and in full-time education,
- are pregnant or have had a baby in the previous 12 months and have a valid maternity exemption certificate,
- etc.

In Britain, they can also reclaim Healthcare Travel Costs - the cost of travelling to hospital or other NHS premises for NHS-funded treatment or diagnostic test arranged by a doctor or dentist.“ [27]

3.5. Findings

We could rave about the system here in Czech Republic - the long waits to get tests, the doctors who won’t take new patients into their practice etc. By my opinion, in a few words - the system here is under-financed, over-worked and not self-sustainable. Most people are hard-working professionals, swamped in the system and frankly, it is not worth their time and trouble because they are not compensated properly.

A good choice to try in U.S. might be a public option with private companies to compete. I also think that this would enable some to purchase extra treatment not covered by the public option, a common problem in Canada and the UK to keep the costs down. I do think there have been positive changes, for example, the elimination of pre-existing conditions which could only succeed if all people were in the insurance pool or children to 26 able to be covered under their parents’ plan. I believe that they already have some successful models such as Veterans’ Benefits to help them on that path. What I think is good about the American system is the professionalism of the doctors and nurses.

[27] NHS Choices: Your health, your choice: Help with health costs
http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Dentalcosts.aspx

Conclusions

United States of America is an industrialized country, its health care is very successful but the health care system is not really working well. The amounts of uninsured people, health care costs or health care expenditures are huge. The most enormous amounts of dollars are spent for hospital care or drugs. We can look at other indicators and talk about America's health care problems for hours.

The President of United States is trying to create a hope for those, who were not able to buy insurance because it was out of price for them. Yes, if the country implements a reform, it means a obligation for its citizens to fulfill it and behave according to it. And that is the thing which is going to be very hard to accept for Americans.

They all actually came to the country to grow up in liberty, freedom and democracy – and now, someone is dictating them what to do with their health, with the most important thing in everyone's life. And what happens? They feel outraged, disappointed or angry. Of course this is happening. They are not used to listen to anybody and 'run if he whistles'. They hate the fact that it will no longer be possible to say "I will take my chance and not buy an insurance," because everyone is now forced and required to buy insurance.

The USA is very isolated country, they all live in a big island and average people do not know any better. They think what they have is the best in the world because that was true – but many years ago. They hear from media how people are dying in other countries, how long waiting times at the doctor they have to fight with etc.

Their fears are mainly about a few problems. When they change to government-run system, the competition slows down, technology slows down, medical businesses loose interest in being the best etc. For many many years this country was the best in the world. The rights in their country demonized the word socialist and anything that looks slightly socialist is therefore evil.

We can talk about the market that needs to be reformed in light of for-profit health care system. We can talk about many other things that need the reform of its management. But for sure – something needs the reform. It might be the market, the government of American mentality.

To implement any health care reform in U.S. and lead it until institution would need some brave people with some big money to change the way business is done. They need a large, non-for-profit insurance company – with administrative salaries based on the numbers of insured. It needs to be created by people with huge money to fund a start-up, people who have the capital to help launch a program such as this. It's probably just a deluded dream on my part, but this might be the solution. Life without insurance and health care would be a horrible thing to face.

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List of Schemes, Tables and Charts