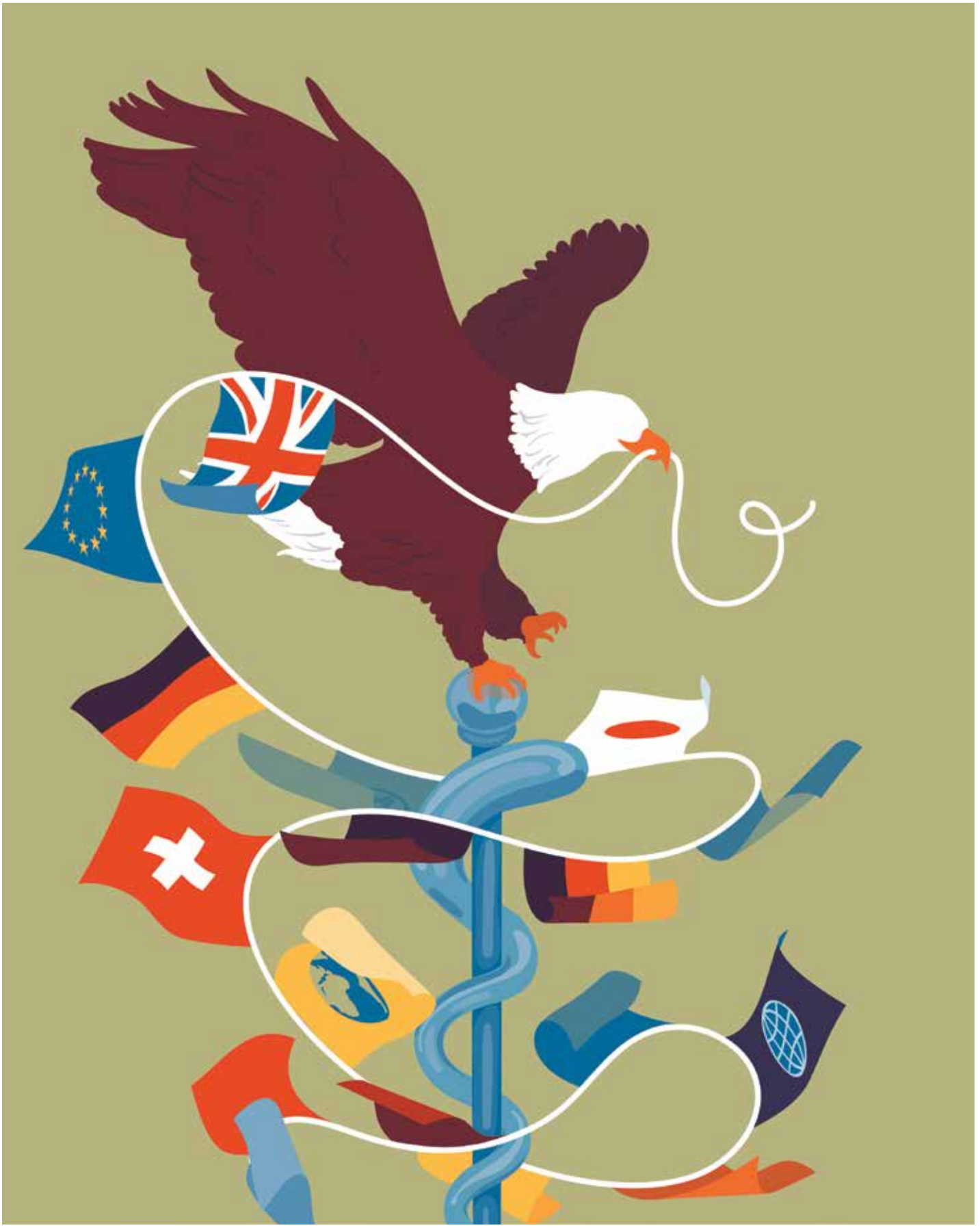

Lessons From Abroad for Catholic Health Care

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The development of health care systems across the world has been a dynamic process shaped by a myriad of political, economic, social and religious factors. These international health care models provide a stark contrast to the United States' approach to providing equitable health care and to how U.S. Catholic health systems have tried to navigate the complexities of the American health care marketplace. The contrast between these international models and American health care needs to be considered in the evaluation of the future direction of U.S. Catholic health care.

EARLY DEVELOPMENT OF HEALTH CARE MODELS

The mid-19th into the early 20th centuries marked a pivotal period in the evolution of health care systems, with significant reforms and innovations taking place in Europe. Over the decades, nations have developed various models of health care delivery, each reflecting their unique sociopolitical contexts and priorities.

The mid-19th century also marked a turning point in the development of health care systems worldwide. Prior to this period, health care was provided by individual practitioners, religious institutions and charities. Patients paid practitioners directly, or care was provided on a charitable basis. Public health interventions were minimal, and medical care was often expensive and inefficient. However, the Industrial Revolution and the expansion of urban populations in Europe and North America created new challenges that demanded systemic approaches to health care.

Germany played a crucial role in the development of modern social health insurance systems. In 1883, under the leadership of Chancellor Otto von Bismarck, the world's first national health insurance program was established in Germany. The program was aimed at providing protection for industrial workers against the financial burden of illness. Bismarck's social insurance model was based on the principle of social solidarity, where workers, employers and the state shared the cost of health care. This system also reflected Germany's growing industrial power and its desire to create a stable and loyal working class.

The German system was initially designed to cover working-class individuals, leaving the wealthy and the poor outside its scope. Over time, the system expanded, and by the 20th century, it had evolved into a comprehensive, multipayer system that covered nearly the entire population. The German model became a template for many other countries, including Japan, and is still largely intact and financially solvent today.[1]

The contrast between these international models and American health care needs to be considered in the evaluation of the future direction of U.S. Catholic health care.

Switzerland, like Germany, developed a health insurance system in the late 19th century, but its

approach was slightly different. In 1911, Switzerland introduced compulsory health insurance, which required citizens to purchase insurance from private insurers, although premiums were subsidized by the government for the low-income population. The system was designed to offer universal coverage, but the actual implementation of the system varied by region, reflecting Switzerland's federal structure.[2]

Unlike the German model, which relied heavily on employer contributions, the Swiss system was based on individual workers paying private insurers, who then managed the delivery of care. In the Swiss system, private insurers fund the system through individual contributions, but, importantly, they do not make a profit. They cover their costs annually. Any profit is directed to lowering premiums in a subsequent year. The government reviews costs annually and determines reimbursement standards.

The Swiss health care system remained relatively decentralized throughout the 20th century, with each canton maintaining a high degree of autonomy over health care delivery. Today, the Swiss system is widely regarded as one of the most efficient and equitable in the world, providing universal coverage through a combination of public regulation and private insurers. The key points to this system are that the government actively assesses costs, and that the funding model does not allow the insurance companies, who manage claims, to benefit from a profitable markup for services. Profit is directed toward cost containment.

In contrast to the German and Swiss systems, the United Kingdom developed a health care model based on social welfare principles. The Beveridge Report of 1942, authored by economist Sir William Beveridge, laid the groundwork for the establishment of the National Health Service (NHS) in 1948. The NHS was designed to provide comprehensive, universal health care to all citizens, regardless of income. It was, and still is, funded primarily through taxation, with health care services provided by the government.

The establishment of the NHS marked a major shift in British health care, moving away from the charitable and private provision of care toward a system of universal public provision. The NHS was based on the principle of equity, aiming to provide health care according to need rather than ability to pay. The Beveridge model has influenced health care systems in many countries, particularly in Europe and the Commonwealth, and remains a key reference point for debates about universal health care. It is important to note that although the NHS provides universal coverage, the Beveridge model also allows individuals to pay out-of-pocket for private health care insurance or providers outside the system.

Japan's health care system is another notable example of an evolving model that blends elements of different approaches. Japan introduced universal health insurance in 1961, following a period of rapid economic growth and industrialization. The Japanese system combines elements of the Bismarckian and Beveridge models, with both employer-based and government-administered health insurance programs. The country's health insurance system is financed through premiums paid by employers and employees, as well as contributions from the government.

Japan's approach to health care is characterized by a focus on preventive care and a strong emphasis on public health. The government provides extensive health screening programs, and citizens are encouraged to undergo regular health checks. The country's low-cost, high-quality health care system is often cited as one of the best in the world,[3] with Japan consistently achieving some of the highest life expectancy rates globally.[4]

STRUCTURAL DIVIDE OF AMERICA'S HEALTH SYSTEM

The United States presents a stark contrast to many of these mentioned countries. Its health care system has traditionally been dominated by private sector providers, with minimal public involvement until the mid-20th century. Unlike Germany or the U.K., the U.S. did not introduce a social health care system until the 1960s, with the establishment of Medicare and Medicaid. These programs were designed to provide health care coverage for the elderly, disabled and low-income individuals. Medicare and Medicaid, along with the Veterans Affairs health care system, mimic the U.K. system, with heavy government regulation on services and reimbursement.

For the rest of the U.S., most of the population continues to fund their health care through employer-sponsored insurance, where private employers offer health insurance plans to employees. There is still a significant portion of the popu-

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lation who do not receive sufficient or any coverage from an employer. Instead, their health care needs to be self-funded, if they can afford it.

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The U.S. health care system is, in fact, an inefficient mash-up of the described international systems, with the addition of a health care marketplace. There are health care aspects that mimic the best international systems (Medicare, Medicaid and the VA), but for most of the population, we are left with private, profit-driven health insurance, or systems like those in low-income countries where the individual or family must self-pay for their care.

The Affordable Care Act (ACA) expanded coverage options while retaining employer-sponsored insurance. Knowing that many people cannot afford to self-fund their health care, the ACA tried to create a Bismarck model, where the cost of health care was shared between the government and workers. The immediate problem was that the insurance model in the U.S. was still based on profit from providers, unlike the German system. Further, as recent events have illustrated, Congress has not kept its promise to support those who cannot afford to cover the full costs of their health care insurance.

CATHOLIC HEALTH CARE'S EVOLUTION IN AMERICA

The history of Catholic health care in the U.S. is deeply intertwined with the country's broader health care development. Catholic hospitals and health care organizations have played a significant role in providing care, particularly in underserved areas, and have often been at the forefront of caring for vulnerable populations, such as immigrants and those who are poor. While they provided labor due to their calling, and accepted donations and pay for services to help fund care, the sisters realized that this model was insufficient. They had to find ways of having steady revenue streams, and later they navigated the private insurance model, as well as Medicare and Medicaid, to continue providing financially viable care.

Catholic health care in the U.S. dates to the 18th and 19th centuries, with Catholic religious orders, mostly of Catholic sisters, establishing hospitals and health care facilities in cities across the country. These institutions were initially focused on providing care to the poor, immigrants and those with no other means of support. The sisters played a crucial role in the establishment of these early hospitals, often in areas where medical care was scarce or unavailable.

Catholic hospitals were often seen as an alternative to Protestant and secular institutions, especially in places where new communities were created through western expansion. The ethos of Catholic health care emphasized compassion, care for the whole person, and a commitment to the sanctity of life. In many cases, Catholic hospitals were among the first to offer services to marginalized populations, such as African Americans, who were often excluded from mainstream health care institutions.[6] At the same time, as historian Barbra Mann Wall has documented, the sisters were entrepreneurs, seeking out specific populations that could help to provide a steady revenue stream, like railroad workers, miners and seamen. Charitable donations "never accounted for more than 9% of total receipts," for the sisters' hospitals in the late 19th and early 20th centuries.[7]

In the 20th century, health care changed significantly because of scientific advances.[8]

Catholic health care in the U.S. expanded significantly, as religious orders continued to establish hospitals and health care networks across the country. By the mid-20th century, Catholic hospitals had become a major component of the U.S. health care system, particularly in urban areas. Catholic health care organizations played a key role in the development of health care infrastructure, often filling gaps in services where government programs and private insurers were not active.

The 21st century has brought both challenges and opportunities for Catholic health care in the U.S. On the one hand, Catholic hospitals face increasing pressure to adapt to the changing health care landscape, particularly as the U.S. moves toward even more market-driven models of care. The rise of for-profit hospitals, mergers and acquisitions, and cost-cutting initiatives have raised concerns about the future of Catholic health care's mission of serving the poor and vulnerable.

The challenge that Catholic health care faces is the same that faces American health care. How can we create an equitable health care delivery system that is efficient and still meets the needs of the entire population?

CATHOLIC HEALTH CARE AT A CROSSROADS

The challenge that Catholic health care faces is the same that faces American health care. How can we create an equitable health care delivery system that is efficient and still meets the needs of the entire population? International health care systems have accomplished that by having the government play an important role in regulating health care costs through different mechanisms. As mentioned previously, the federal government has already done that in the Medicaid, Medicare and VA systems. While those systems are not problem-free, the model does work.

Catholic health care institutions in the U.S. can learn valuable lessons from international health care systems, especially those that have succeeded in providing universal and equitable care. In particular, the German, Swiss and U.K. models offer insights into the role of social solidarity, public funding and regulation in ensuring access to care. These countries have demonstrated that it is possible to provide high-quality, affordable health care for all citizens while balancing the needs of the public and private sectors.

For Catholic health care in the U.S., the key challenge lies in adapting these international lessons to the nation's unique cultural and political context. Catholic health care organizations can advocate for policies that promote universal access to care, while also ensuring that their services remain grounded in the values of compassion, service to the poor and respect for human dignity.

As health care systems continue to evolve, Catholic health care institutions must reflect on the lessons learned from international models. By embracing the strengths of systems that prioritize equity, public responsibility and a holistic approach to health care, the Catholic health ministry can continue to fulfill its mission of serving the most vulnerable members of society. Ultimately, international health care systems provide valuable insights into how Catholic health care in the U.S. can adapt and innovate in the face of growing challenges, ensuring that it remains true to its moral and ethical foundations.

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NOTES

1. "Health Care in Germany: Learn More – The German Healthcare System," Institute for Quality and Efficiency in Health Care, December 18, 2024, https://www.ncbi.nlm.nih.gov/books/NBK298834/.
2. The following source provides an overview to many different international health systems: "International Profiles of Health Care Systems, 2011," The Commonwealth Fund, November 2011, https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2011_nov_1562_squires_intl_profiles_2011_11_10.pdf.

3. Xing Zhang and Tatsuo Oyama, "Investigating the Health Care Delivery System in Japan and Reviewing the Local Public Hospital Reform," *Risk Management and Healthcare Policy* 2016, no. 9 (2016): 21-32, https://doi.org/10.2147/RMHP.S93285.
4. Truman Du, "Here's How Countries Compare on Healthcare Expenditure and Life Expectancy," World Economic Forum, November 23, 2022, https://www.weforum.org/stories/2022/11/countries-compare-on-healthcare-expenditure-life-expectancy/.
5. Emma Wager and Cynthia Cox, "International Comparison of Health Systems," KFF, October 8, 2025, https://www.kff.org/global-health-policy/health-policy-101-international-comparison-of-health-systems/.
6. Kevin J. Jones, "The Nuns Who Witnessed the Life and Death of Martin Luther King Jr.," EWTN News, January 19, 2026, https://www.ewtnnews.com/world/us/the-nuns-who-witnessed-the-life-and-death-of-martin-luther-king-jr.
7. Barbra Mann Wall, *Unlikely Entrepreneurs: Catholic Sisters and the Hospital Marketplace, 1865-1925* (Ohio State University Press, 2005), 106-107.
8. There are many examples that could signal this shift. In 1910, for example, the Flexner Report, officially titled "Medical Education in the United States and Canada," was released by the Carnegie Foundation: https://ia803109.us.archive.org/32/items/carnegieflexnerreport/Carnegie_Flexner_Report.pdf. Written by Abraham Flexner, it argued for standards for medical education of physicians. After the report, many substandard medical schools closed. In 1917, the American College of Surgeons proposed minimum standards for hospital accreditation. Around the same time period, in 1915, Catholic health ministry leaders founded the Catholic Hospital Association, now the Catholic Health Association, as a way of ensuring consistency of standards for their hospitals. See the following:
Wall, *Unlikely Entrepreneurs*, 166-68.

QUESTIONS FOR DISCUSSION

This article by CHA's Brian Kane, senior director, ethics, highlights that the United States "spends more on health care than any other country, yet it struggles with significant disparities in access to care, quality of services and health outcomes. Its private-sector-sponsored insurance model has led to high costs, inefficiencies and unequal access to care, particularly for marginalized groups."

1. As CHA focuses on its Health Care Reimagined strategic objective, who do you turn to as an innovative thinker on the future of U.S. health care? What do you appreciate about his or her ideas?

2. What did you learn about the history of health care in the U.S. and other countries that you didn't know? How does that affect your thinking about systemic reform or possible improvements in your own health system or care environment?

3. What change would you most like to see to U.S. health care, particularly to curb staggering medical costs or to assist people deferring care because they can't afford it?

4. What innovative ideas do you have that will enable Catholic health care ministries to continue our mission to care for the most vulnerable in our communities during an ever-challenging financial, political and social environment?

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