

This is an edited version of a
2010 Catholic Health Assembly Keynote Address.

Universal Coverage

‘They did it. We could do it.’

BY T. R. REID

I am convinced that for a rich society, the health care destination should be universal coverage at reasonable cost. That’s where we ought to be headed, we didn’t get there and we had a hard fight to get where we got. But, I am totally confident, absolutely certain that the United States can get to universal coverage at reasonable cost. I know we can do it, because all the other countries like us, and I mean by that advanced, high-tech, industrialized, free-market democracies, all of them, provide health care of high quality for everybody, and they spend, on average, about half as much as what we do. They did it. We could do it.

How does a country manage to cover everybody, get great results — many of those countries have better health outcomes than the United States — and still spend less?

I went around the world to try to figure out how they do this. It turned out that I found another question: Why did they do it? Why would a country commit to provide health care for everybody? If you think about that question for a minute or two, it leads to one more obvious question: Why doesn’t the world’s richest country provide health care for everybody?

I still don’t know the answer to that last question. Over the course of the debate we had on health care in the last 18 months, fewer Americans supported universal coverage than when we started. You know, it became “big government nanny state” or socialism or something. That’s disheartening. So I still can’t figure out what we’re doing, but I do think I figured out how and why the other countries do it.

First of all, I’m going to tell you what I didn’t find when I went around the world looking at health care systems, because in a way, that’s just

as important for Americans to know.

Guess what? It’s not all socialized medicine out there. In fact, many rich, industrialized democracies cover everybody with private docs, private hospitals and private insurance. Japan has more for-profit hospitals than the United States.

I am going to argue that some of these other rich democracies are less socialized than the United States when it comes to health care. So, if somebody tells you universal coverage means big government, socialized medicine, I’m going to prove to you that’s not true.

There’s another interesting thing — they’re not all the same. They all cover everybody, they have all made that commitment but they all go about it in different ways, though they fall into patterns. There are certain basic models. We will start in Britain, with the Beveridge model of health care. This is named for Lord William Beveridge, who was kind of a classic British type. As happens every once in a while with these rich, titled gentry in Britain, the day he graduated from Oxford, Lord Beveridge went down to the streets of East London and spent his life helping the poor. He became

a famous social reformer, and he invented many of the things that we now consider to be normal parts of a caring community.

For example, he noticed that all of those poor children down on the streets of East London never got a decent meal; there was no decent food in the house, so he proposed that the schools serve lunch. He invented the free school lunch for poor kids and made a huge increase in those kids' lives.

Right near the end of World War II, when it was clear that the Brits and the U.S. were going to defeat the Nazis and Britain would emerge as an independent nation, the prime minister, Winston Churchill — he was a forward-looking guy — started thinking about what post-war Britain should be. He hired the great Lord Beveridge to design British social services after the war, and Beveridge wrote a famous report. The key part of it is his plan for British health care. Here's what he said: Taking care of people's health is government's job. It is a government function, just like picking up the trash and running a library and putting out fires. This is a service — when you need it, you get it — and you don't get a bill.

They pay. They pay in taxes, and the taxes are high. But when you go to the doctor in Britain or you go to the hospital in Britain, there's no bill. Ninety-eight percent of the people in Britain go their entire lives and never get a doctor bill. That is the Beveridge model of health care. In this model, government owns almost all the hospitals. There are few private hospitals. Government employs all the specialist docs and nurses in the hospitals. Government pays the bills for the family docs who run their own clinics. So if you think



T. R. Reid at the 2010 Catholic Health Assembly.

It's not all socialized medicine out there. In fact, many rich, industrialized democracies cover everybody with private docs, private hospitals and private insurance.

about that, government provides the care, and government pays for the care.

Now to me, the Beveridge model is socialized medicine — government provides the care, government pays for the care. But it's a model that works. The Brits have better overall health statistics than we do, they live longer, they treat everybody and they spend half as much per capita as we do. Therefore, this model has been adopted widely. It is used in Spain and Italy, Cuba, New Zealand, most of Scandinavia.

Now, though, we are going to jump across to the mainland of Europe, and we are going to find a mirror image of the Beveridge model. This is the Bismarck model of health care, named for Otto von Bismarck, who was chancellor of Prussia.

Through a series of wars, he united about 25 German-speaking fiefdoms and principalities into a new nation, formed in 1871.

Then Bismarck was faced with a tough political task. He had to convince these Bavarians and Frankfurters and Alsatians, etc., — all the Germans — that they now belonged to a new nation. It was run from the Prussian capital of Berlin, which nobody liked. To convince all these people that they owed allegiance to this new nation of Germany, Bismarck invented the welfare state. He invented the notion that central government should provide benefits to people who need it.

In 1873, he came up with the scheme of having the central government in Berlin provide a pension to everybody who was retired from work. We call that Social Security, and we got around to it in 1935, but he invented it. In 1883, Bismarck decided that a rich nation should provide health care for everybody. I wouldn't say that it was totally,

you know, beneficence on his part. He needed a healthy working class to build their industry. He needed healthy young men to man his armies.

He had to come up with a scheme to provide health care for everybody but not cost the government everything. Here is what he designed: in the Bismarck model of health care, everybody is required to get health insurance, and you get it through the employer. The employer pays part of the premium, and the worker pays part of the premium.

This is very familiar to us; 155 million Americans are on the Bismarck model today. In that model, the docs are private. The hospitals are private. The insurance plans are private. This is universal coverage, it is not socialized medicine. In fact, they don't have a Medicare, a system where people go on government insurance when they get old. In Germany, people stay with the private insurer, cradle to grave. They don't have a Medicaid, either. Low-income people buy private insurance and are subsidized by the government, something like we are about to do.

[The system is] definitely not socialized medicine, but it's universal coverage, and it is found in Germany, Switzerland, France to a degree, Belgium, Netherlands and Japan. It works fine because they are pretty tough on the insurance companies in ways that we have not done. In Germany, for example, if you go in the hospital, your insurance company has to pay the hospital within one day. In Switzerland, if the insurance company doesn't pay me my claim in five days, next month's premium is free. So that's the Bismarck model.

The third model is the national health insurance model, and it is a blend of the other two. The providers, the docs, the hospitals, the labs, etc., are private, and the payment scheme is government. The government runs the insurance plan. The paradigm case of this is Canada.

In the 1940s, Saskatchewan elected Tommy Douglas, an open socialist, to be its governor — they call them premier in Canada. He was a great politician; he invented this scheme where you pay into a government insurance plan, and you go to the doctor for free. Everybody in Saskatchewan got health care, and this has now spread to all of Canada.

Here's the deal: you *have* to have the govern-

ment insurance. You have to pay the premium every month. If you are employed, it is withheld from your pay. If you don't pay it, you go to jail. But it is not a tax — this is important — it is a premium. It's a premium, because Tommy Douglas thought if you made everybody pay a premium, they would feel they were buying a product, and not paying a tax.

He also came up with a very catchy name for this scheme, this plan of his for private care, public payment: Medicare. In 1944, he named it Medicare, and sure enough, when Lyndon Johnson decided in 1965 to extend health insurance to all American seniors, he took the model and the name from Canada. That is the Canadian model of health care; I call it the national health insurance model. It is used in Canada, South Korea, Taiwan, Australia, and it can work well, but it doesn't work that well in Canada, in my view.

Have you heard these horror stories about long waiting lines in Canada? I think it is true. What they've done up there is, if you're acutely ill, they will send an ambulance free, they take you to the hospital free, they give you follow-up care free — they take good care if you're sick. However, if your problem is that your back hurts, or your knee hurts, or if you've got a bum shoulder, you wait. They have done that to save money; they have limited the number of scanning machines, sur-

Right here in the United States of America, in the world's richest country, we have all four models of health care.

gery rooms, etc., and therefore, you wait. This is a province-by-province system, so some provinces are faster than that, but in a lot of Canada, it is true. They keep you waiting.

I just want to say that waiting is not a function of the model. That national health insurance model works great elsewhere. Australia has shorter waiting times than the United States for any appointment and for elective surgery. So it can work.

The fourth model is the most common in the world: There is no system at all. In those countries where people make a dollar or two dollars a day, just getting food, clothing and shelter is tough enough. Health care, that's a luxury. And so the term for that system is very straightforward: it is the out-of-pocket model of health care. If your kid gets sick and you have some money in your pocket

to pay the doctor, she gets treated. If you have no money, she stays sick or she dies. Blunt, simple, brutal, and it's a fact of life in most of the world, for the poor countries of the world.

In many of these out-of-pocket countries, you know, there are *Medecins Sans Frontieres/Doctors Without Borders*, voluntary doctors. They have a big public hospital maybe in the capital city, and people line up for days when they are sick and sleep on the street to get in and seek care. But if you live out in the villages, far from the city, you're out of luck, unless you can find some way to pay a healer. That's the out-of-pocket health care system.

Right here in the United States of America, in the world's richest country, we have all four models of health care. If you are a Native American or a veteran, for health care purposes you live in Britain. The Veterans' Administration is government-run, socialized medicine. It is the National Health Service, the Beveridge model of health care: you go in there, you wait a long time, you don't get to choose your doctor. The care is great, the nurses are caring, everything is great, and you walk out and there is no bill — because government handles it all. That's the Beveridge model of health care right here in the United States.

If you are over age 65 and on Medicare, for health care purposes, you live in Canada. That's the national health insurance model, invented in Canada and used in Australia, Taiwan and South Korea — the difference is, the other countries apply Medicare to everybody, you don't have to be 65. But in America, seniors are on that Canadian model.

If you are a working person and you are sharing the cost of health insurance with your employer, you live in Germany for health care purposes. That is the Bismarck model of health care; about 155 million Americans are on it.

For the 40 million or so Americans that as of today have no health insurance, they are living out of pocket. For health care purposes, they live in Afghanistan, or Angola, or Algeria. If they live in [a city], they can go down to a hospital and get treated for little or nothing. If they don't live near a doctor and don't have any money, they stay sick or die.

You all know the implications of the out-of-

pocket model. According to the National Academy of Sciences, about 22,000 of our fellow Americans die every year of treatable diseases because they cannot afford a doctor. In the richest country in the world, we let that happen.

One of the fundamental differences between our country and all the other rich countries, when it comes to health care, is all the other industrialized democracies have put everybody into one model. I went around the world and asked health ministers, doctors, prime ministers, politicians, patients, everybody, "Why do you have one-size-fits-all medicine? One system for everybody?" Their answer: It is vastly simpler, and therefore vastly cheaper to run a system where everybody has the same rules and the same coverage, and in most countries, the same price for the same procedure.

I don't know how many people think of France as a paradigm of management efficiency, but the French spend about a quarter as much as we do on the administrative, on paperwork, etc., in health care. They put 96 percent of their health care dollars into treating people. We spend 20 percent or 25 percent on administrative costs. According to the consulting firm McKinsey & Co., if we could be as efficient as the French in delivering health care, we would save \$400 to \$600 billion a year and cover all of the uninsured.

Preventive medicine extends lives, it fights disease and it saves money. But quite often, the saving is deferred for 20, 30, 40 years. If you talk

If you don't make the moral commitment to cover everybody, then you end up with the American health care system.

a kid out of smoking today, it could be 40 years before that lung cancer would have appeared. You need an economic incentive to convince people to spend the money on preventive care, and in our system, there really isn't that incentive.

The average American on a private health insurance plan stays with that plan, on average, 4.8 years. Then they get a new job or the spouse gets a new job, or whatever, and they move on [to another insurance company].

If you think about it, our insurance companies have to pay a dividend to their investors every

quarter. It's not in their interest to spend money to keep you healthy; by the time you get sick, you are the next guy's problem. Many of those latent diseases are going to be Medicare's problem. But a system where everybody's in, cradle to grave, has an interest in keeping you healthy.

I asked the British health minister about this once when I was over there, and he said, "From the minute the line turns blue on your mother's pregnancy test, until the minute you flat line in my hospital 90 years later, you're my patient. Of course I want to keep you healthy."

Get that? That's an economic incentive.

Here is one more reason why these countries feel that everybody should be in the same system: they think it is fairer if everybody has the same access to the same care at the same price.

This is a subjective judgment. Treating people fairly is a moral judgment. It is a moral decision. The key lesson I found traveling the world is the design of any country's health care system reflects that country's basic moral values. Designing a health care system for any country involves economic decisions, it involves medical decisions. As we have seen, it involves difficult political decisions. But primarily, it is a moral choice. If a country makes the moral commitment to provide health care for everybody, then it designs a system like the ones I saw in Britain, Germany, Japan, Canada, Taiwan, etc., where they cover everybody.

If you don't make that moral commitment, if you don't even have the conversation, as I think we have never had, then you end up with a health care system where some people get the finest care in the finest hospitals in the world with no waiting, and tens of millions barely get in the door.

If you don't make the moral commitment to cover everybody, then you end up with the American health care system. That's why I'm arguing that even though we made great strides this year,

we have fallen short. We just still don't measure up to our economic and industrial peers around the world.



Supporters of health care reform gather at a city park in Los Angeles on Sept. 3, 2009.

Go to any of the other countries like us, rich, industrialized democracies. They cover everybody, they have better results and they spend half as much. It seems clear to me: Why do you want to cover everybody? It is politically popular. Once you do it, everybody likes it. There is no country in the world that would go back to the kind of spotty, erratic coverage we have, now that they have gotten to universal coverage. In fact, when they debate health care, the bad word is "American-style medicine." They think we are ruthless. We leave people out on the street to die, in their view.

Finally, covering everybody is the right thing to do.

It's morally right for a rich society to provide health care for everybody. It's what Christ taught us to do. It's caring for the least of our brethren. And it bugs me that our great, caring, compassionate, innovative rich country still, *still* has not found a way to provide health care for everybody. But I know we could do it. If we Americans could find the political will to provide health care for everybody, the other rich countries can show us the way.

T.R. REID is a veteran foreign correspondent for the *Washington Post*, a commentator for National Public Radio and the author of 10 books, including three in Japanese. He has written and hosted documentary films for National Geographic TV, for PBS, and for the A&E Network, and he is a regular commentator on NPR's *Morning Edition*. In 2009, his book, *The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care*, explored health care systems around the world in an effort to understand why the United States remains the only first-world nation to refuse its citizens universal health care.

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, November-December 2010
Copyright © 2010 by The Catholic Health Association of the United States
