NATIONAL HEALTH INSURANCE

Health is described as a state of complete physical, social, and mental wellbeing. In order to ensure that the population of a given nation remains at or achieves a good health status, health expenditures must be financed. Health care expenditures are the total amount of spending for personal health care, administration, research, construction, and other expenses that are directly related to patient care. Although insurance coverage is not the sole determinant of health, timely access to quality care does play a key role in maintaining and improving health. Many developed nations have a system of national health insurance to finance health care for their citizens. Though these plans vary, all provide national health insurance and take into account the political, historical, and social factors of the given society. Variations in national health insurance plans may relate to the organization of the health care system in a given country, or to the provisions of the plan. Many plans guarantee minimal national health insurance to all constituents; others provide insurance to all who meet low income standards, and yet others provide national health insurance with provisions that allow citizens to purchase supplemental private insurance. Countries that have national health insurance plans include Australia, Japan, China, Sweden, Russia, the United Kingdom, Germany, the Netherlands, Austria, Sri Lanka, Chile, and Canada, to name a few.

These national health insurance plans have limitations and differing levels of effectiveness. The Canadian national health insurance plan is one of the most impressive and historically established plans among developed nations. Initially developed in 1968, this plan is funded by federal and provincial tax revenues, as well as insurance premiums paid by all paying citizens. Consequently, Canada ranks high on indicators that suggest the health of a society. Infant mortality, for example, is low in Canada, and the life expectancy of Canada’s citizens is high. Despite this success, some have criticized Canada’s system for a decrease in the professional authority of physicians and the rationing of health care. Critics of Canada’s national health care system argue that in theory the system provides everyone with health care, but not necessarily superior health care.

In contrast, Sri Lanka, a peripheral or developing nation, instituted a national health insurance plan in 1992. The Sri Lankan government provides health care to its civilians mostly free of cost. The Sri Lankan government split the management of health care between provinces and administrative divisions. Provincial levels of government are responsible for the management of all health care institutions; divisions, which include medical officers, are responsible for administering health care. Though the national health insurance plan of Sri Lanka is not as well established as Canada’s, health indicators for this country are good. Like Canada, Sri Lanka boasts a relatively low infant mortality rate (59.6 per 100,000 births), and life expectancy has been increasing. Although it is too early to assess the limitations of Sri Lanka’s national health insurance plan, the plan includes provisions for development and change. The Sri Lankan Ministry of Health is responsible for the formulation of health policy; the ministry monitors the performance of the country’s health organizations, and moderates and changes policy when necessary.

The United States stands as one of the world’s developed nations that does not have a comprehensive national health insurance plan. Despite the lack of such a plan, the United States spends a larger percentage of its gross domestic product (the nation’s total economic output) on health care expenditures than any other country, including countries that provide national health insurance coverage. Many American citizens have no insurance. The American health care system can be characterized as heavily influenced by such political action committees (PACs) as the American Medical Association (AMA), the American Hospital Association (AHA), the American Pharmacists Association (formerly the American Pharmaceutical Association, APA), and other special interest groups. The American health care system is also based upon a profit incentive, and health care expenditures are funded through numerous sources. These factors have contributed to vast inequalities in who receives health insurance and health care. These factors also explain why there is no national health insurance system in the United States, and the emergence of categories of Americans who are characterized as underinsured and uninsured.

The U.S. medical-industrial complex—the rapidly growing industry that supplies health care services for profit—is the result of the AMA’s and APA’s professional and political efforts during the nineteenth century to establish accredited medical training and unfavorable views of holistic medical practices. These historical efforts led to a great increase in the power of these and other special interest groups associated with American health care. While changes to existing insurance standards and policies are the responsibility of the U.S. government, the corporations that make up the medical-industrial complex employ PACs to influence congressional decisions regarding health care. Failures in efforts during the 1990s to implement a national health insurance system illustrate the strength of the influence of the medical industry. In November 1993 the administration of President Bill Clinton announced a national health insurance plan called managed competition. This plan would have provided national health coverage and was designed to account for problems related to both access to and the cost of health care. But the aforementioned special interest
groups opposed this plan, voicing reservations about new forms of bureaucracy and cost controls. The AMA and AHA opposed the proposed limits placed on physician fees and hospital charges, while the APA opposed cost controls on the production of drugs. Ultimately, the Clinton plan was not implemented.

Corporate managed care represents an evolutionary process in the American health industry that started in the 1970s when prepaid health maintenance organizations (HMOs) were introduced. Ideally, the purpose of managed care is to provide appropriate health care, including preventive services, thereby reducing costs while maintaining, even improving, quality. In practice, such plans typically compete for subscribers by offering the lowest possible cost for health care. Health care is generally organized into plans that consist of an insurer who administers the plan and who has numerous contracts with physician groups, clinics, laboratories, and so on. Since the inception of corporate managed care, preferred provider organizations (PPOs) and point-of-service (POS) plans have been developed in addition to HMOs. However, many contemporary managed care corporations operate on a for-profit basis, which can lead to controversy. The primary issue is that the provision of health care is pitted against the pressure on corporations to make profits; the mission of offering access to care runs contrary to the incentive of financial gain.

Health insurance in the United States is provided through a mixture of private (individual, employers, family) and public (federal, state, and local government) insurance programs. In 1965 Title XVIII of the Social Security Act created both the Medicare and the Medicaid insurance programs. These programs were the first and remain among the few federal insurance programs established in the United States. Medicare is designed to provide health insurance to persons over the age of sixty-five, permanently disabled workers and their dependents, and persons with end-stage renal disease. Medicaid is a jointly funded federal and state program that is designed to provide health insurance to the poor, with stringent eligibility requirements. State Child Health Insurance Programs (SCHIPs) are a more recent initiative to provide public health insurance in the United States. These programs allow states flexibility in planning and implementing health insurance for low-income children under the age of eighteen.

Most U.S. health care expenditures are covered through private insurance programs. Private insurance is funded largely by employers with employee subsidies. In addition, many Americans own family or individual policies. Nonetheless, in 2004 approximately forty-five million Americans were uninsured and did not have any private or public health care coverage. Many of the uninsured are poor working-class Americans who may work only part-time. There are others who are considered underinsured. They have jobs that provide minimal health care coverage, or insurance policies with major loopholes that are often costly to the consumer.

The profit motive and the influence of the medical-industrial complex are not solely responsible for the lack of national health insurance in the United States. The culture of the United States is based heavily on the principles of individualism, capitalism, and laissez-faire. For many Americans, the notion of government-run national health insurance seems un-American. Alternative versions of national health insurance that are being promoted in the United States include single-payer and pay-or-play insurance plans. Proponents argue that these alternatives are less socialistic and would promote capitalism. Although Americans do not agree on the solution, most public health officials, health care providers, and U.S. citizens agree that a more inclusive type of health insurance should be developed.

SEE ALSO Health Economics; Insurance; Insurance Industry; Medicaid; Medicare; Mental Health

BIBLIOGRAPHY