“Sick Around the World,” Documentary by Journalist T.R. Reid
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For his documentary evaluating health care around the world, T.R. Reid visited 5 capitalist countries - Great Britain, Japan, Germany, Taiwan and Switzerland. He previously lived in Japan and Great Britain (x5 years), where he said his family received very good care from a doctor who lived on the block and made house calls.

The national insurance of most of these countries is covered by a sliding-scale tax or social insurance payment. None risk personal bankruptcy. The poor are subsidized. All countries spend roughly half as much on health care as the U.S. and have better outcomes. In all of the countries except Britain, medical education is free. Some profit for providers is accepted, however insurance profit for general medically necessary health care is not. Reid contrasts the five other capitalist countries with the U.S., with its “army of underwriters” practicing risk selection. In other countries claims are paid quickly, within 2 weeks. Great Britain has a public entity that makes decisions about coverage, e.g., cutoff for some procedures, such as kidney dialysis for the terminally ill. “They cover eveybody, not everything.”

Reid reports that most capitalist countries don’t trust the unfettered free market and, thus, enact serious controls. He observes that universal care in the U.S. could begin at the state or federal level. If one state created a model, others would likely follow, as in Canada, where national health care started in one province (Saskatchewan, where insurers did not want to insure rural folks), covered by taxes. One by one, other provinces demanded the same.

Health care systems in all of the countries he visited share the following characteristics:
1) Insurance companies accept everyone (no exclusions) and do not profit from basic necessary coverage – even when coverage is accomplished through a number of private insurers. E.g., Germany has over 200 private insurers, who make an end-of-year financial report. To equalize risk among insurances, those that end the year in the black, share their income with those who end the year in the red.
2) There is a mandate for all to buy into the system, and government subsidizes the poor.
3) Doctors and hospitals negotiate annually for fixed-rate payment, whether they negotiate with a quasi-government or government entity, or with private insurers as a unit, as in Germany. There is no widening gap between numbers of primary care doctors and specialists (or their pay) as there is in the U.S.
4) Bankruptcy due to medical bills is unheard of in these countries.
5) Most utilize some form of IT, electronic medical records, and individual smart cards with medical history.

Great Britain excels at providing preventive health care. There is no health care billing to Britains. An example of true socialized medicine, providers work for the government, and are paid a fixed government salary, negotiated annually. General pracitioners are paid a bonus for keeping patients healthy. Britain has succeeded in reducing wait-lines for non-emergency procedures, e.g., hip replacement have been reduced from 18 months to 2-6 mos. Since 2008, Britains can choose among government hospitals. General practitioners act as gatekeepers to specialists.

The Japanese live the longest and have lowest infant mortality. Not-for-profit insurance in Japan is managed by employers, who pay half of the $250 family monthly health fee. Eighty percent of hospitals are private. Toyota has built hospitals for its employees in Japan. The Japanese Health Ministry negotiates a standard fixed price for doctor fees, drugs, etc. Because Japanese costs are so low (e.g., cost is $10/night for a hospital room for 4), 50% of hospitals are in financial deficit, demonstrating the need to raise rates. Japanese spend 8% GDP on health, half as much as the U.S. Reid notes that U.S. health costs are much higher due to the hodge-podge of many different systems for everyone. Most countries have the same care at the same price for all.

Germany has had the Bismarck model of comprehensive health care since late 19th century. Ninety percent remain in the system; about 10% of the rich opt out and pay private coverage. Germany eliminated its former profit-based insurance. Now income-based premiums are paid to 1 of 240 private not-for-profit insurers. There is a $15 copay every 3 months, with pregnant women exempted. Insurance management gets better pay for serving more customers. Doctors (with free medical education) earn half of U.S. doctors' pay, and work long days (family doctors make $120,000/yr. – 2/3 of U.S. doctors' income). Reimbursement is negotiated annually by the German states. To equalize insurers' risk, insurers that end the year in the black, share their income with companies in the red.

Taiwan designed a new health care system in 1995 after looking at 15 other countries, discounting the U.S. health care model as a "market-not-a-system." They created a national insurance with no opt out, no gatekeepers and no wait lines. Information technology plus smart card with each person's medical history facilitate health care. Taiwan has the least administrative costs of all countries (2%), as providers bill the government directly. Taiwan's health costs are less even than Japan's (6.3% GDP). They have the leeway to increase premiums, but because they are so reluctant to do so, the government must borrow to pay providers.

The Swiss passed a referendum by slightly more than 50% to create national health care in 1994. In Switzerland, insurance is mandated and not-for-profit. Strong incentives keep administrative costs at 5% (vs. 22% in U.S.). Insurances may offer supplemental care for profit. Premiums are $750/mo for family (2nd most expensive after U.S.). The Swiss see limits to a pure free-market, and view health care as a value. The conservative Swiss President calls health care "a right," and says it would be a "scandal" for the Swiss to experience medical bankruptcy, as many do in the U.S.

Reid notes that for most of its history, until the 1980s, U.S. health insurance was not-for-profit. Since then, insurance administrative costs have ballooned. Consequently, the new Colorado Health Sciences Center has a 6-story building dedicated solely to billing, handling 1600-1700 different forms. U.S. insurances are not transparent. The for-profit insurance industry overhead costs are 18-24% of health care dollars. Other countries present one bill for surgery, whereas a single U.S. procedure can come with 30 different bills.

Reid's next documentary, due in April, will examine what happens to Americans who think they are insured, but because they carry high deductibles of $2,000-10,000, cannot access their insurance, and cannot pay for health care.

View "Sick Around the World" and related interviews, etc.:
http://www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/