



THE U.S. HEALTH CARE SYSTEM IN INTERNATIONAL PERSPECTIVE

Few Public Services Despite the Highest Health Care Taxes

- The United States health system is a hybrid, with 60% of health care publicly-financed, but most care delivered privately.¹ While the U.S. system is often thought of as being privately financed through employers, this is not the case. Private employers cover fewer than half of all Americans—43%—and pay less than one-fifth of total health care spending.² In contrast, about 60% of the U.S. health system is publicly (taxpayer) financed. Taxes fund coverage for more than 20 million government employees, and for more than 70 million persons including the elderly (Medicare), the permanently disabled, the very poor (Medicaid), people with end-stage renal disease, and veterans. In all, 34% of Americans have government-paid insurance. The rest buy their own coverage (7%) or are uninsured (16%). **Despite having the smallest percentage of the population with government assured coverage of any developed nation (34% versus 100% in most developed countries), Americans pay the highest health care taxes in the world.**³
- Among Organisation for Economic Cooperation and Development (OECD) countries, there are three main types of health care programs.⁴
 - < A **National Health Service**, where medical services are delivered via government-salaried physicians, in hospitals and clinics that are publicly owned and operated. The U.K. and Spain are examples of such a system.
 - < A **National Health Insurance System**, or *single-payer* system, is a health care system in which a single entity, such as a government-run organization, acts as the administrator to collect all health care fees, and pay out all health care costs. Medical services are publicly financed but not publicly provided. Examples include Canada, Denmark, Norway, and Sweden.
 - < A universal **Multi-payer Health Insurance System**, or *all-payer* system, as in Germany and France. These systems provide universal health insurance via sickness funds, which are used to pay physicians and hospitals at uniform rates. These rates are negotiated annually.

High Prices, High Private Administrative Costs

- **The U.S. spends considerably more on health care than any other OECD country**, averaging \$4,887 per person in 2001, and climbing to \$5,440 in 2002.⁵ Canada spends just 57% that of the U.S., Sweden spends just 46%, and the U.K. spends only 41% as much as the U.S. on health care.⁶
- **In 2004, private insurance accounted for 37% of all U.S. healthcare spending.**⁷
- **The U.S. also spends the highest proportion of Gross Domestic Product (GDP) on health care:** 14.6% in 2002, compared to an OECD median of 8.3%.⁸
- **Americans pay higher prices for healthcare-related services** than citizens of other countries. For instance, the average cost of a one-day hospital stay in the U.S. was \$2,434 in 2002, compared with \$870 in Canada and even less in other OECD countries.⁹ Prices for pharmaceuticals and physician visits are higher as well. Even adjusting for per capita GDP,

the supply of healthcare resources, and the added cost of malpractice litigation, a study in *Health Affairs* finds that Americans pay more for the same- or lower-quality care.¹⁰

Administrative Costs in the U.S.

- In 2005, *Health Affairs* released a study of health insurance costs in California. It found that \$230 billion of health spending was devoted to insurance administration and only 66% of health spending went to medical care. Twenty-one percent of private health spending went to billing-related tasks, and an additional 13% of spending went to non-billing administrative functions.¹¹
- Private insurers spent eight percent of their premiums on billing, marketing and other financial activities, physician offices spent 14 percent of revenues and hospitals spent seven to 11 percent of revenues on these activities.¹²
- Recent studies show that if California were to implement single-payer health care, total spending on health care could be reduced by about \$8 billion.¹³

High Costs Drive Americans into Debt

- In 2003, nearly 29 million adults (14%) reported medical debt. Seventy-seven million had medical bill problems or medical debt and 12.4 million reported having both.¹⁴
- Uninsured debtors and dependents represent 32.6 percent of people who filed for medical bankruptcies and 33.1 percent of those who filed for other bankruptcies. 39.9% of medical bankruptcies came from people who experienced a gap in their coverage over the past two years.¹⁵
- People ages 19 to 64 who lacked coverage (35%) had significantly higher rates of medical bill problems and debt than did those with regular health insurance coverage (60%). In order to cope with medical debt, 28% had to significantly change their way of life.¹⁶

Health Insurance: Rising Premiums, Falling Coverage

- **In 2005, 46.1 million Americans under the age of 65 were uninsured, up from 45.3 million (15.6%) in 2004.** This is the fifth straight annual increase in the number of people without health insurance.¹⁷
- **Health insurance premiums in the U.S. are rising fast. Between the spring of 2004 and the spring of 2005, health insurance premiums rose 9.2%,** a slight decrease after four consecutive years of double-digit growth.¹⁸ Growth rates in insurance premiums remain far greater than both inflation and wage increases (3.5% and 2.7%, respectively).¹⁹
- In 2006, employer premiums for medical care plans averaged \$617.18 a month per participant for family coverage and \$266.50 a month for single coverage. Employer contributions were higher for those employees who were not required to contribute than for those who were.²⁰

Who Are the Uninsured in America?

- Eighty percent of the uninsured are adults.²¹
- Fifty-two to 59% come from low-income families.²²

- At least two-thirds of uninsured nonelderly adults are employed, but are not offered coverage or cannot afford the coverage that they are offered.²³
- Thirty-three to 38% are not college-educated; more than 25% did not graduate from high school.²⁴
- Surveys show that the nonelderly uninsured are racially and ethnically split: about half are white and half are minorities.²⁵

Small Firms, Part-Time Workers, and Younger Workers Have Less Coverage

- Between 2001 and 2005, rates of self-employment, part-time work, temporary or contract work, and employees in smaller businesses went up. While 2.2 million more workers joined the workforce, 1.8 million have incomes below the Federal Poverty Level.²⁶
- **Smaller firms are significantly less likely to provide health benefits.** In 2005, while 92% of firms with 100 or more workers offered health insurance, only 65% of firms with up to 24 workers provided benefits. Fifty percent of the smallest firms (less than 10 employees) offered health benefits, down from 54% in 2001.²⁷
- **Uninsured workers are found in every industry:** agriculture, service, wholesale and retail trade, manufacturing, and the public sector each have a sizeable portion of uninsured employees.²⁸
- **Firms that employ union workers are much more likely to provide health benefits:** 96% of firms with union workers offered benefits, versus 61% of firms without union workers.²⁹ In addition, union workers paid an average flat monthly contribution for medical insurance of \$174.60 for family coverage in 2003 and \$196.60 in 2006; nonunion workers paid \$234.35 in 2003 and now pay \$308.88.³⁰
- **In 2005, the number of full-time workers without health insurance rose to 17.7%,** up from 17.3% in 2004.³¹
- **Only 23% of all firms offer benefits to part-time workers.** Moreover, firms with a large number of part-time employees, with high employee turnover rates, and with lower overall wage levels, are less likely to offer benefits to any of their employees. **Only four percent of all workplaces offered health insurance to temporary employees.**³²
- **More than three out of five Americans of working age rely on employment-related health insurance for themselves and their families,³³ but the number of jobs providing health coverage is decreasing.** The percentage of firms that provide employees with health benefits has decreased from 69% in 2000 to 61% in 2006.³⁴ Only five percent of people under 65 purchased health insurance on their own in 2005, down from 6.6% in 2002.³⁵ The rise in uninsured people shows a decline in both employer-sponsored health and private insurance.
- **Eighteen to 24 year-olds are most likely to be uninsured, as 30.6% were uninsured in 2005.**³⁶ A Commonwealth Study found that nearly 60% of employers who offer coverage do not insure dependent children over the age of 18 or 19 if they do not attend college.³⁷ Twenty-five to thirty-four year olds were the second most likely age group to be uninsured: 26.4% were without insurance in 2005.³⁸

Minorities and Children Have Less Access to Health Insurance

- **Racial and ethnic minorities are disproportionately likely to be uninsured:** compared to 13% of whites, one third of Hispanics and Native Americans as well as 21% of African Americans and 19% of Asian Americans are uninsured.³⁹
- African American adults are more likely (35%) to use the emergency room for conditions that could have been treated by a primary care doctor.⁴⁰

- In the past year, 27% of uninsured Hispanic adults with health problems did not visit a doctor, while 17% of white and African American adults did.⁴¹
- Between 2004 and 2005, there was no increase in Medicaid/SCHIP coverage to offset declines in employer-sponsored insurance. As a result, **300,000 more children are uninsured**. This reverses the decline (400,000) that happened between 2000 and 2004.

Less Coverage Means Fewer Healthy Americans

- In 2002, 1,930 people between the ages of 25-34 had deaths due to uninsurance. From ages 35-44, there were 3,431 related deaths, and between 45-54, there were 4,734. While a greater number of young people are uninsured, it appears that larger numbers of older adults without insurance may die because they lack it.⁴²
- The Institute of Medicine (IOM) reports that uninsured people receive too little medical care, too late. As a result, **some 18,000 unnecessary deaths each year are attributable to a lack of health insurance coverage**. In 2003, 43% of adults without health insurance did not seek medical help for health problems, compared with 10% who were insured. Uninsured individuals with diabetes, HIV, cardiovascular disease, and mental illness have been consistently shown to have less access to preventative care and worse clinical outcomes. Uninsured car crash victims have been found to have a mortality rate 37% higher than people with insurance, and uninsured women with breast cancer have a 30–50% higher risk of dying.⁴³

Quality of U.S. Health Care in an International Context

- **The U.S. ranked 37th out of 191 member states in terms of “overall health system performance” in the World Health Organization’s (WHO) 2000 World Health Report.** The rankings were based on measures of the health of the population, the level and distribution of respect and attention shown to patients, and the fairness of financial contribution, all in relation to overall health system expenditures. **A ranking of 37th places the U.S. below such countries as Colombia, Saudi Arabia, and Portugal.**⁴⁴
- **The U.S. has the seventh highest infant mortality rate of the 30 OECD member countries.** The countries with higher infant mortality than the U.S. are Hungary, South Korea, Mexico, Poland, Turkey, and the Slovak Republic.⁴⁵
- **The U.S. also has the ninth lowest life expectancy of the OECD member countries.**⁴⁶
- **The U.S. ranks lower than the OECD median in all three categories of physicians, nurses, and hospital beds per capita, despite its high level of spending.**⁴⁷ Low nurse-to-patient ratios have been linked to higher instances of medical errors and patient complications, including death.⁴⁸
- 28 percent of Americans find it is extremely difficult to get care when needed, as compared to 21% of Canadians, 18% of New Zealanders, and 15% of the U.K.⁴⁹
- There are **14,000 AIDS-related deaths in the U.S. each year**—more than in Russia, Canada, France, Germany, Italy, and the U.K. *combined*.⁵⁰
- A recent study in *Health Affairs* compared the quality of care in five countries: the U.S., the U.K., New Zealand, Canada, and Australia.⁵¹ No country scored consistently best or worst, and each country had at least one best and one worst rating. The U.S. had the best five-year survival rate for breast cancer, for instance, but the worst survival rate for kidney transplants, and an increasing rate of mortality among asthmatics.
- The following chart provides a few key statistics from single-payer nations and the United States.

	Canada	Denmark	Sweden	United States
Total Health Expenditure, Per Capita (2004)	\$3,165	\$2,881	\$2,825	\$6,102
Annual Growth Rate of Total Health Expend. Per Capita (2003–2004) ⁵²	1.9	2.9	0.8	4.1
Life Expectancy At Birth (2006)	80.2	77.8	80.5	77.8
Infant Mortality (per 1,000 births, 2006) ⁵³	4.7	4.5	2.7	6.4
Maternal Mortality (per 100,000 births, 2003)	4.2	(data unavailable)	4.2	8.9

¹ Woolhandler, S. and Himmelstein, S., Paying for National Health Insurance – and Not Getting It, *Health Affairs*, July/August 2002.

² Carrawquillo, Himmelstein, D., Woolhandler, S. and Bor, A Reappraisal of Private Employers Role in Providing Health Insurance. *New England Journal of Medicine*, January 1999.

³ *Ibid.*

⁴ Physicians for a National Health Program, *International Health Systems*, 2003.

⁵ Reinhart, U., P. Hussey and G. Anderson, “U.S. Health Care Spending in an International Context,” *Health Affairs*, 23 (3): 10, 2004; Levit, K., et al., “Health Spending Rebound Continues in 2002,” *Health Affairs*, 23 (1): 147, 2004.

⁶ Reinhart, U., P. Hussey and G. Anderson, “U.S. Health Care Spending in an International Context,” *Health Affairs*, 23 (3): 10, 2004.

⁷ OECD, *Rising health costs put pressure on public finances*. June 2006.

⁸ Anderson, G., P. Hussey, B. Frogner, and H. Waters, “Health Spending in the United States and the Rest of the Industrialized World,” *Health Affairs* 24(4): 903-915, July/August 2005.

⁹ *Ibid.*

¹⁰ *Ibid.*

¹¹ Kahn, James G., Kronick, Richard, Kreger, Mary, and Guns, David N., “The Cost of Health Insurance Administration in California: Estimates for insurers, physicians, and hospitals.” November/December 2005.

¹² *Ibid.*

¹³ Sheils, John F. and Haught, Randall A., *The Health Care for All Californians Act: Cost and Economic Impacts Analysis*, January 2005.

¹⁴ Commonwealth Fund, *Seeing Red: Americans Driven into Debt by Medical Bills*, August 2005.

¹⁵ Physicians for a National Health Program, Slideset, 2007.

¹⁶ *Ibid.*

¹⁷ U.S. Census Bureau, “Income, Poverty, and Health Insurance Coverage in the United States: 2005” August 2006.

¹⁸ Kaiser Family Foundation, *Employer Health Benefits*, 2005.

¹⁹ *Ibid.*

²⁰ Bureau of Labor Statistics, *Employee Benefits in Private Industry*, August 2006.

²¹ Kaiser Family Foundation, *Who Are the Uninsured?* August 2006.

²² *Ibid.*

²³ *Ibid.*

²⁴ *Ibid.*

²⁵ *Ibid.*

²⁶ Kaiser Commission on Medicaid and the Uninsured, “Changes in Employer-Sponsored Health Insurance Coverage: 2001–2005.” October 2006.

²⁷ Kaiser Family Foundation, *Employer Health Benefits*, 2005.

²⁸ Institute of Medicine, “Uninsurance Facts and Figures: Fact Sheet 1,” *Insuring America’s Health: Principles and Recommendations*, January 2004.

- ²⁹ *Ibid.*
- ³⁰ The Labor Research Association, “The Growing Gap in Benefits.” September 15, 2006.
- ³¹ U.S. Census Bureau, “Income, Poverty, and Health Insurance Coverage in the United States: 2005” August 2006.
- ³² *Ibid.*
- ³³ Kaiser Family Foundation, *Employer Health Benefits*, 2004.
- ³⁴ Kaiser Family Foundation, *The Uninsured: A Primer*, October 2006.
- ³⁵ *Ibid.*
- ³⁶ U.S. Census Bureau, “Income, Poverty, and Health Insurance Coverage in the United States: 2005” August 2006.
- ³⁷ The Commonwealth Fund, *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help*, May 2006.
- ³⁸ *Ibid.*
- ³⁹ Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer*, October 2006.
- ⁴⁰ The Commonwealth Fund, *The Health Care Disconnect: Gaps in Coverage for Minority Adults*, August 2006.
- ⁴¹ *Ibid.*
- ⁴² Institute of Medicine, *Care Without Coverage*, 2002.
- ⁴³ Institute of Medicine, “Uninsurance Facts and Figures: Fact Sheet 5,” *Insuring America’s Health: Principles and Recommendations*, January 2004.
- ⁴⁴ World Health Organization, *World Health Report 2000 – Health Systems: Improving Performance*, 2000.
- ⁴⁵ U.S. Department of Commerce, Bureau of the Census, *International Data Base*, 2004, Table 010.
- ⁴⁶ *Ibid.*
- ⁴⁷ *Ibid.*
- ⁴⁸ Aiken, L., et al., “Hospital Staffing and Patient Mortality, Nurse Burnout and Job Dissatisfaction,” *Journal of the American Medical Association*, 228 (16): 1,987, 2002; Institute of Medicine, *Keeping Patients Safe: Transforming the Work Environment of Nurses*, 2003.
- ⁴⁹ Commonwealth Fund Survey, 1998.
- ⁵⁰ Central Intelligence Agency, *The World Fact Book*, 2004.
- ⁵¹ Anderson, G., et al., “How Does the Quality of Care Compare in Five Countries?,” *Health Affairs*, 23 (3): 89, 2004.
- ⁵² OECD, Health Data, 2006.
- ⁵³ CIA World Factbook, 2006.

For further information on professional workers, check out DPE’s Web site: www.dpeaflcio.org.

The Department for Professional Employees, AFL-CIO (DPE) comprises 23 AFL-CIO unions representing over four million people working in professional, technical and administrative support occupations. DPE-affiliated unions represent: teachers, college professors and school administrators; library workers; nurses, doctors and other health care professionals; engineers, scientists and IT workers; journalists and writers, broadcast technicians and communications specialists; performing and visual artists; professional athletes; professional firefighters; psychologists, social workers and many others. DPE was chartered by the AFL-CIO in 1977 in recognition of the rapidly-growing professional and technical occupations.

Source: DPE Research Department
1025 Vermont Avenue, N.W., Suite 1030
Washington, DC 20005

Contact: Pamela Wilson
(202) 638-6684
pwilson@dpeaflcio.org

November 2006