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Cost, Quality and Access: An Analysis of Health Care in the United States, Canada and the United Kingdom

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COST, QUALITY AND ACCESS: AN ANALYSIS OF HEALTH CARE IN THE UNITED STATES, CANADA AND THE UNITED KINGDOM

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Abstract

Comparing international health care systems assists in identifying effective reforms to address three constant problems within health care around the globe: cost, quality and access. Until recently, the United States health care scheme has been administered through private enterprise while Canada and the United Kingdom have implemented national forms of health care. In order to determine which system more effectively deals issues related to cost, quality, and access, statistical information was gathered to compare each system based on cost, quality and access. Such statistics include but are not limited to waiting times for specialized care, financial expenditures for each country per person, life expectancy rates, infant mortality rates, obesity levels, and immunization rates. The findings conclude that the United States performs poorly when compared to Canada and the United Kingdom. However, recently enacted health care legislation will implement public health care reforms in the United States which are similar to those of the U.K. and Canada. As a result of this legislation, the United States may be able to more effectively control health care costs, increase access and consequently improve the quality of its health care system.

Introduction

Health care systems throughout the world continuously struggle to increase accessibility while maintaining a high quality of care at a low cost. Recent history has shown a worldwide trend towards major progress in the expansion of health care services, the advancement of technology, improving quality, and raising the health status of populations (Blank and Burau 2007). However, policy makers continue to struggle with reforms that will allow for improvement in health status while containing costs.

Throughout the world various systems have been developed to organize and administer health care. Some countries rely on government-sponsored and administered health care whereas others rely on private enterprise to manage health care (Lassey, Lassey and Jinks 1997). While no system is perfect, there are systems that experience a higher rate of success than others. Such success rates can be determined by the culmination of three factors: a high level of accessibility, low costs, and reasonable quality.

Comparing international health care systems and their success rates allows policy makers throughout the world to identify effective reforms. As the United States embarks on a new national policy, an assessment of its former system, as compared to the national systems of Canada and the United Kingdom, sheds light on effective types of reform.

The United States health care system has been dubbed a "paradox of excess and deprivation," because it is defined by both very high costs and inaccessibility to good quality health care for a substantial portion of its population (Lassey, Lassey, Jinks 1997, 27). The American health care system is organized and administered primarily through an insurance industry run through private enterprise (Blank and Burau 2007). On the other hand, Canada and

the United Kingdom have national forms of health care administered through their respective governments. While each system experiences various issues related to accessibility, costs, and quality, a comparison of the outcomes of each system may help to identify successful reforms.

Problem

The United States health care system has come under fire in recent years because the nation faces a low-quality system with a growing number of uninsured individuals and an ever increasing rise in cost. As a result of health care's direct impact on the quality life in a country, the issues surrounding it including cost, quality, and access are at the forefront of the political agenda today. Subsequently, health care has become the focus of politicians and constituents across the board as concern for the effects of a dysfunctional system become even more apparent.

The development of adequate health care in the United States has been in the works since the 1830s when the problems accompanying industrialization and urbanization became so acute that they called for social welfare reform (Behan 2006). The movement was spurred on by a middle class who felt threatened by the increasing rift between the wealthy and the impoverished. Consequent political pressure resulted in the broadening of public health laws at the turn of the century (Behan 2006). While this development was minor, it was one of the first movements towards reforming the sphere of health care within the United States. Throughout the Twentieth Century the United States would see health care policy move in and out of the political spotlight, with minor improvements throughout the years. The result of such progress was the enactment of government policies meant to address perceived deficiencies in health

care delivery, which are the high cost of care, limited access to care, and the overall quality of care (Mueller 1993).

Today, health care within the United States is organized and administered through private insurance organizations throughout the nation. However, those individuals who cannot afford the rising costs of health insurance often go without any at all. The startling number of individuals without health insurance in the United States is at 47 million or almost 20% of the population as of 2008 (NCHC-Costs 2008). The uninsured are those groups that are most likely to have major problems in accessing necessary health care services. For example, a recent study shows that two out of every five uninsured American adults end up going without needed care (Kronenfeld and Kronenfeld 2004). A lack of health insurance has been linked to numerous negative side effects such as decreased access to all health care services, increased morbidity and mortality, and an increased rate of hospitalization among other things (Silverman 2008). On a much larger scale being, uninsured has also been linked to a decrease in workforce productivity, educational and developmental deficits for children, and stress (Silverman 2008).

As stated before, most private health insurance is purchased through employer-based group insurance policies. Yet, all workers are not insured as some only work part-time and are not guaranteed health-care benefits, while most work in service industries that provide lower levels of health care coverage compared to manufacturing industries (Kronenfeld and Kronenfeld 2004). Some individuals without health insurance are those who have a history of serious health problems. Employers who hire individuals with health care problems may experience an increase in health insurance costs, a major deterrent. The most current development in growing rates of uninsured individuals results from the recent economic

downturn. More individuals are being laid off and thus have no access to health care or financial ability to pay for private health care as the costs skyrocket (Kronenfeld and Kronenfeld 2004). While these individuals are uninsured, even those who are underinsured continue to find it increasingly difficult to bear the burden of escalating health care costs. Furthermore, working individuals who are not uninsured often remain underinsured as they opt for low-coverage plans in order to afford the high out-of-pocket expenses associated with employers' health plans that shift costs to the employees (Haugen 2008). Altogether, access to health care has become a major issue in America as the gap widens and the rate of individuals without care continues to increase rapidly.

Over the past decade, the United States has experienced a rapid increase in health care costs resulting in numerous problems (Brailer 2007). First, a recent study has shown that in 2007, almost 62% of all bankruptcies filed were associated with medical expenses (NCHC- Costs 2008). Furthermore, nearly 80% of those individuals who filed bankruptcies had health insurance. In addition, 1.5 million families will lose their homes due to foreclosures every year as a result of being unable to afford medical costs. The negative effects of rising health care costs are reflected in the drastic disintegration of health insurance coverage. A national survey has shown that this is the primary reason why so many individuals are uninsured (NCHC- Costs 2008).

After years of minor adjustments the United States government stepped in once again to implement an overhaul of America's health care system in passing "The Patient Protection and Affordable Care Act," on March 23, 2010 (New York Times 2010). The act addresses all three issues of cost, quality, and access by allowing the government more centralized control

over the health care system. Such centralized management is also seen in the systems of Canada and the United Kingdom, both of which have implemented varying forms a national health care plans within the last century. Consequently, this study focuses on comparing the three systems of the United States, Canada, and the United Kingdom in terms of cost, quality and access.

Materials and Methods

In order to compare the three health care systems of the United States, Canada, and the United Kingdom, it is necessary to identify the variables by which to measure their performance. As noted earlier, there are three components which define the health care systems of each state: cost, quality and access. Cost is the amount of money spent on health care for each individual country. In order to compare and contrast the various expenditures from each country, all currency values have been converted to U.S. dollars. Quality of health care for this study will focus on the outcomes of each system in terms of life expectancy, infant mortality rates, obesity levels, and immunization rates. Access refers to the number or rate of individuals per population which have access to regular health care services such as regular doctor visits and checkups. This study focuses on two primary types of access: financial access and physical or geographical access (Blank and Burau 2007, 94). Financial access means an individual's ability to afford health care services while physical or geographical access refers to one's ability to physically acquire such services (Blank and Burau 2007, 94).

The focus of this study is to compare health care policies and resulting statistics from each country in order to draw conclusions regarding cost, quality and access. All of the

information used for this study has been obtained through government-regulated agencies to rely on the most accurate evidence. Furthermore, each of the following graphs has been designed using statistics obtained through each country's individual websites and as such, are original to this study.

Research Expectations

Due to the vast majority of problems associated with America's health care system, the results of this study are expected to highlight the advantages of a public health care system as seen in Canada and the United Kingdom. In regards to access, the United States has encountered many obstacles to providing access to a majority of its citizens. Thus, Canada and the United Kingdom are expected to show a higher rate of accessibility to health care services. In addition, because the United States administers its health care through private insurance enterprises, there is no cap on individual expenditures on such services, so the costs are expected to be much higher than in Canada and the United Kingdom. Furthermore, due to America's low rate of access to health care services, the outcome quality measurements taken in this study are expected to show an overall lower quality of care in the United States. In the end, the expected results of this study intend to show that while the United States spends more on its privately funded health care system, it has a lower rate of accessibility and provides care that is of a substantially lower quality then the United Kingdom and Canada, which have national forms of health care.

Literature Review

A. Canada

The Canadian health care system is a compilation of provincially operated programs that abide by a set of common principles (Kane 1995). For instance, the key principals of the system are universal access is a key operator, comprehensive coverage of hospital and medical services, portability across provinces, the fact that it is publicly administered and there is no extra billing (Kane 1995).

The cost of the Canadian health care system is funded primarily by taxes. Collected by the federal government, these taxes are evenly distributed among the provinces and from there, the individual provinces can set their own taxes in order to defray health care costs (Irvine, Ferguson and Cackett 2005). In 2004, the public sector accounted for around 70% of total health spending, the rest coming from the private sector. Furthermore, the total health care expenditure that year was $130 billion which translates into roughly 10% of their GDP (Irvine, Ferguson and Cackett 2005). As such, it is apparent that a significant portion of Canadian finances are moved to the health care system, and it is a substantial investment for the country as a whole.

B. United Kingdom

The United Kingdom health care system also covers all individuals within the United Kingdom who are ordinarily residents, thus making the coverage universal (Boyle 2010). The United Kingdom Health Service Act was enacted in 1948 and allows for equal access to medical care, the availability of comprehensive preventive and curative care, as well as providing service at no cost at the point of service (Lassey, Lassey, and Jinks 1997). The National Health Service covers medical expenses for the following services: preventative services; both inpatient and

outpatient hospital care; ambulatory care; general practitioner services; dental care; mental health care; rehabilitation; both inpatient and outpatient drugs; and learning disabilities(Boyle 2010).

The costs of health care is covered only when an individual receives services from a hospital that has been organized as an NHS trust and is directly responsible to the government through the Department of Health (Boyle 2010). There are still private insurers within the U.K. who provide their customers with health care services from a range of both private and NHS hospitals. Yet, health care provided by the National Health Service seems to be a more popular option, because it accounts for 86% of the total health expenditure. This expense is covered by taxation which accounts for 76%, while 19% is derived from national insurance contributions and the few charges applied account for 5% (Boyle 2010).Private health insurance covers only 12% of the total population and of the money spent on private health, 90% of it comes directly from out-of-pocket payments. In an attempt to control the costs of health care, the National Health Service has instituted a capped budget which rotates on a three-year cycle (Boyle 2010).

Data Analysis

A. Accessibility

There are two types of access that surface as the focal points of health care systems throughout the world: financial access and physical or geographical access (Blank and Burau 2007, 94). Financial access refers to the funding and subsequent provision of health care to individuals. Reform of financial access is usually done by restructuring health care so as to

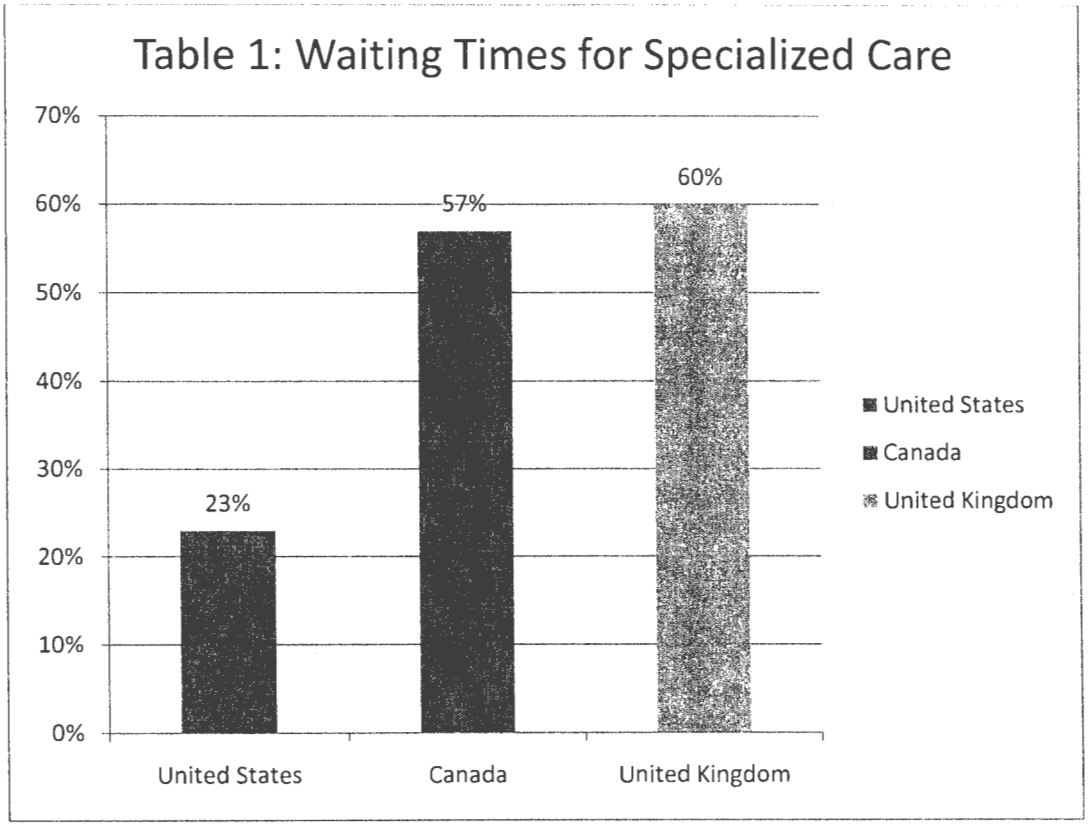
provide a higher degree of government funding to at least a minimum level of health care services (Blank and Burau, 2007).

One of the most noticeable differences between the three health care systems of the United States, Canada, and the United Kingdom is the variation in financial accessibility. In both Canada and the United Kingdom, all citizens within the country have access to health care financed by the government. On the other hand, as stated before, the United States is most widely noted for the large portion of citizens who have no access to regularly provided health care services. A large number of individuals who are from low-income families especially in urban areas or who are a member of the minority population are largely cut out of the health care delivery system within the United States (Lassey, Lassey, and Jinks 1997).

The second type of access is physical or geographical access, which refers to an individual's ability to physically obtain health care services (Blank and Burau 2007). This type of access has proven to be increasingly problematic because medical technology is often concentrated in urban areas where a larger portion of the population who has financial access is located and thus a higher demand is to be found (Richmond and Fein 2005). As a result, isolated, rural communities are consistently undersupplied in terms of skilled medical personal and facilities causing a lower level of access to specialized health care services.

The United States and Canada have populations that are spread out throughout an extremely large geographical area. However, due to variations in their respective health care delivery systems, it is Canada that experiences a higher rate of physical inaccessibility to health care services. Furthermore, the United Kingdom, which is comprised of a small geographical area, would be assumed to have a lower level of inaccessibility to specialized health care

services. Yet as seen in Table 1, in a study done by the Commonwealth Fund in 2007, individuals within the United Kingdom had the highest waiting time of 60% of its total population waiting for more four or more weeks to obtain specialty care. Canada came in at a close second with 57% of its population waiting for more than four weeks to see a specialist while the United States came in substantially lower with 23% (Commonwealth Fund 2010).



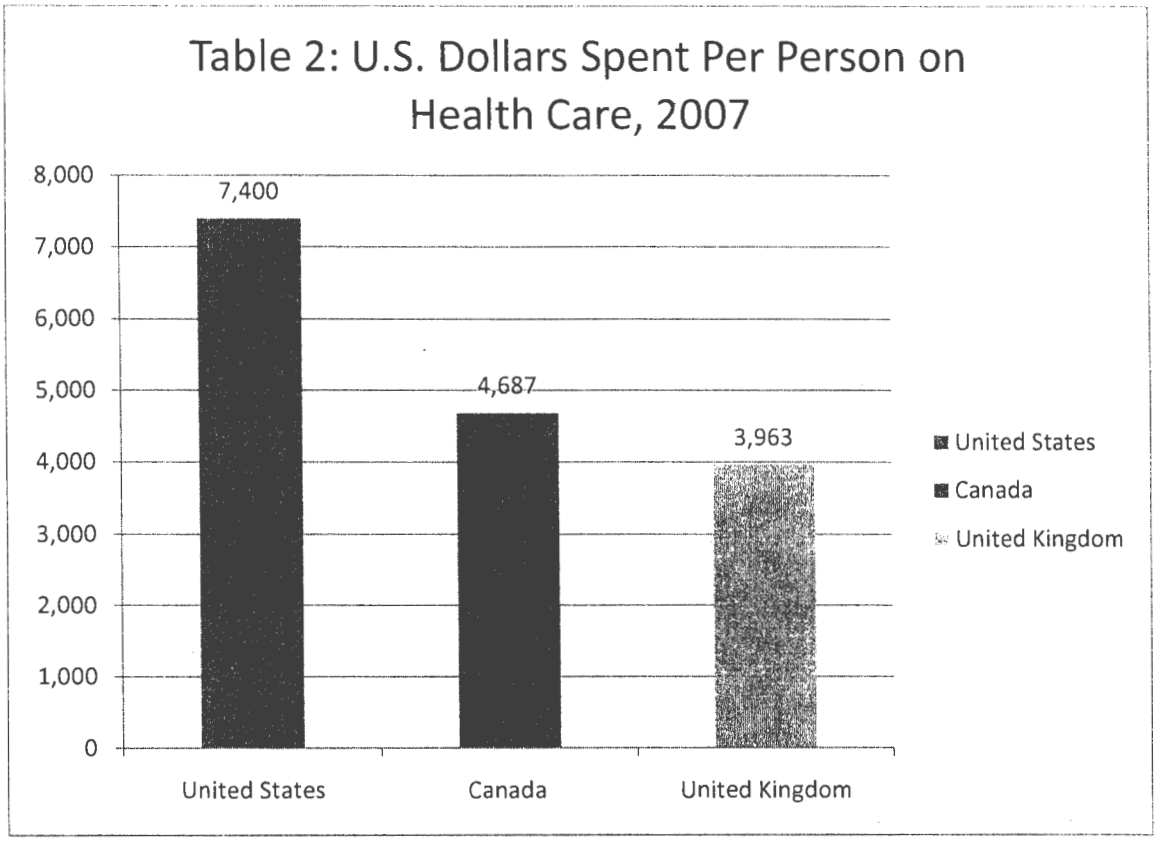
Source: Data adapted from Commonwealth Fund. "International Comparisons: Access and Timeliness." *The Commonwealth Fund.* http://www.commonwealthfund.org/Content/Performance-Snapshots/International-Comparisons/International-Comparison--Access---Timeliness.aspx (accessed on February 28, 2010).

In any event, while the United States does outperform both Canada and the United Kingdom when it comes to delivery of specialty care, its overall lower rate of access to health care for a majority of its population provides a limitation in comparing the systems. Individuals who have no access to primary care and thus regular doctor visits are not going to be receiving recommendations to see a specialist for their medical problems. More often than not, the

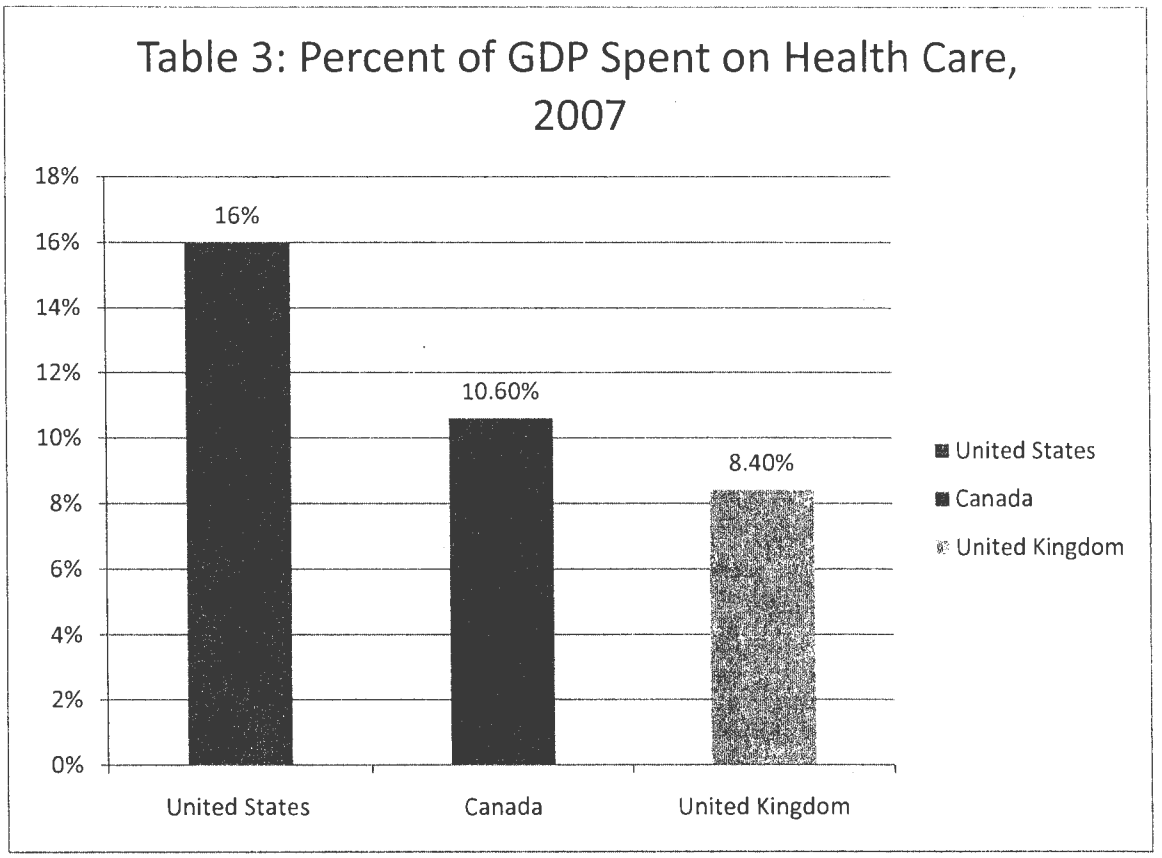
individual will have to wait for a substantially long period of time until his or her health situation becomes so acute as to necessitate emergency medical care. So, while individuals in Canada and the United Kingdom may have longer waiting lines than the United States, they provide an altogether higher level of accessibility.

B. Cost

The costs of health care services around the world have been escalating for quite some time and now represent a large portion of every country's annual expenses. As seen in Table 2, the United States in 2007 spent approximately $7,400 per person on health care, the total of which accounted for more than 16% of its gross domestic product as seen in Table 3 (NCHS 2009). Such spending represents a greater share than any other developed country in the world (NCHS 2009). Looking to its northern neighbor, Canada spent approximately $4,867 US dollars per person in 2007. While the cost of health care has been rising in Canada in recent years, it still only represents 10.6% of their total GDP (Statistics Canada 2010). On the other hand, in the same year the United Kingdom only spent roughly $3,963 per person (UKHS 2008). This total expenditure cost the UK government the least in comparison to its counterparts in that it only spent 8.4% of its GDP on health care (UKHS 2008).



Sources: Data adapted from (1) National Center for Health Statistics. *Health, United States, 2009: With Special Feature on Medical Technology.* Hyattsville, MD. 2010; (2) Statistics Canada. "Health in Canada." http://www4.statcan.gc.ca/health-sante/index-eng.htm (accessed on February 20, 2010); (3) United Kingdom Health Statistics. *United Kingdom Health Statistics.* 3rd Ed. New York: Palgrave Macmillan, 2008.



Sources: Data adapted from (1) National Center for Health Statistics. *Health, United States, 2009: With Special Feature on Medical Technology.* Hyattsville, MD. 2010; (2) Statistics Canada. "Health in Canada." http://www4.statcan.gc.ca/health-sante/index-eng.htm (accessed on February 20, 2010); (3) United Kingdom Health Statistics. *United Kingdom Health Statistics.* 3rd Ed. New York: Palgrave Macmillan, 2008.

In comparing the costs statistics of the United States, Canada, and the United Kingdom, it is quite clear that the United States spends the most on its health care system. This is an interesting conclusion given that such a large portion of the country has little to no access to health care while on the other hand both Canada and the United Kingdom provide service for all citizens. The U.S. is spending more per person and a higher percent of its GDP on health care than both Canada and the United Kingdom. As a result, one would assume that because more money is being spent on health care that a positive correlation could be shown in that the quality of health care would also be superior.

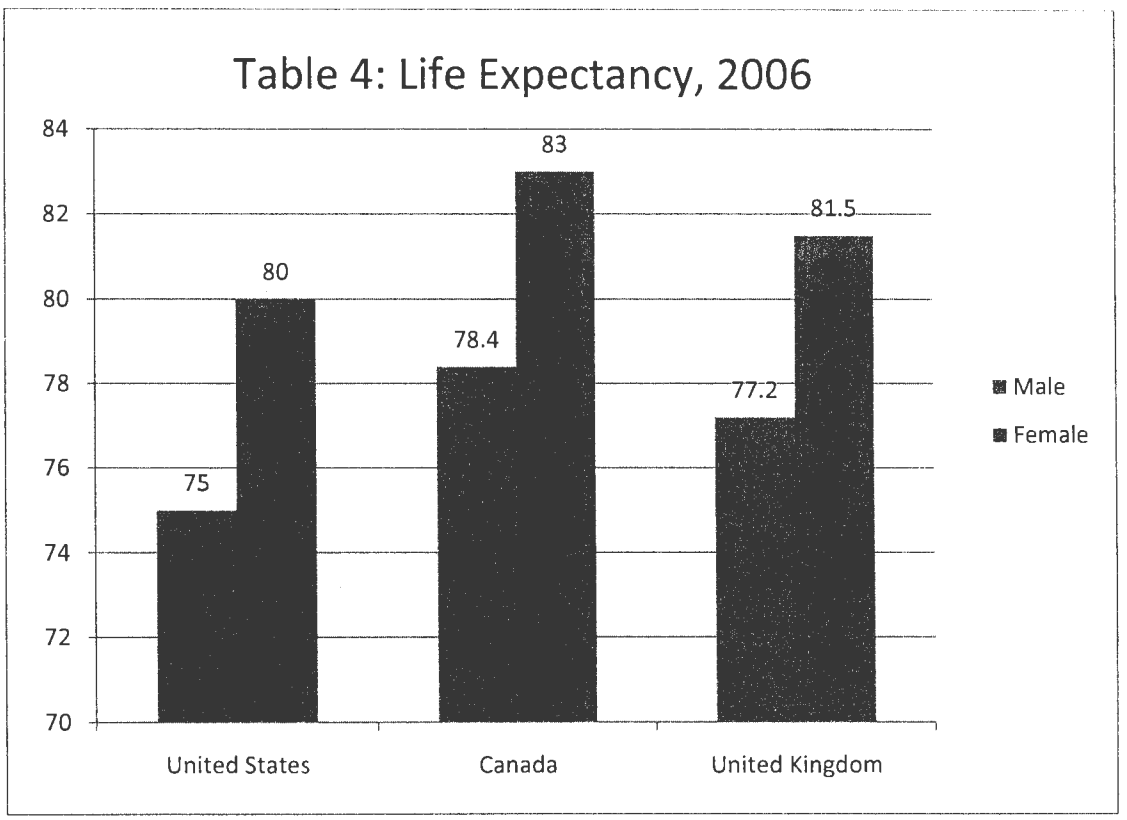
C. Quality

The health status of a population is at the core of life quality for all citizens of every nation regardless of its health care system (Lassey, Lassey and Jinks 1997). As a result, the quality of health care services is a major issue for policy makers in every country. While this issue has remained problematic over the years, policy makers have also found it very difficult to define what "quality" in regards to health care really means. International comparisons have largely relied on costs comparisons, usage figures, and other readily quantifiable figures to determine quality (Blank and Burau 2007). However, this study will rely on comparable data reflecting health outcomes and improvements attributable to medical care delivery. The following statistics focus on health outcomes in four different areas: life expectancy, infant mortality rates, obesity levels, and immunization rates.

1. Life Expectancy

Life expectancy at birth is the number of years an individual within a specific population would be expected to live given that the current age-specific mortality rates continued throughout his or her lifetime (UKHS 2010, 87). Life expectancy is vital in determining the quality of health care in a country because it indicates the general or overall level of care that individuals within a country receive. It would be assumed that an individual who has access to health care would be more likely to live longer due to the assistance that such care would provide. As stated before, because the populace of the United States experiences a significantly lower accessibility rate to health care as compared to Canada and the United Kingdom, it would not be surprising that its life expectancy rates would be lower.

In looking at the statistics for each country, it is most commonly broken down into male and female life expectancy rates as seen in Table 4. Furthermore, the most recent statistics released from each country for life expectancy are from 2006. The highest rate for life expectancy for both genders is from Canada whose male populace has an expected life span of 78.4 years while its female populace has a projected 83 year life span (Statistics Canada 2010). The United Kingdom rates second amongst the three countries with a male life expectancy rate of 77.2 years and a female rate of 81.5 years (UKHS 2010, 87). Finally, the United States has the lowest life expectancy rates for both genders with a male life expectancy rate of 75 years and a female rate of only 80 years (NCHS 2010, 44).



Sources: Data adapted from (1) National Center for Health Statistics. *Health, United States, 2009: With Special Feature on Medical Technology.* Hyattsville, MD. 2010; (2) Statistics Canada. "Health in Canada." http://www4.statcan.gc.ca/health-sante/index-eng.htm (accessed on February 20, 2010); (3) United Kingdom Health Statistics. *United Kingdom Health Statistics.* 3rd Ed. New York: Palgrave Macmillan, 2008.

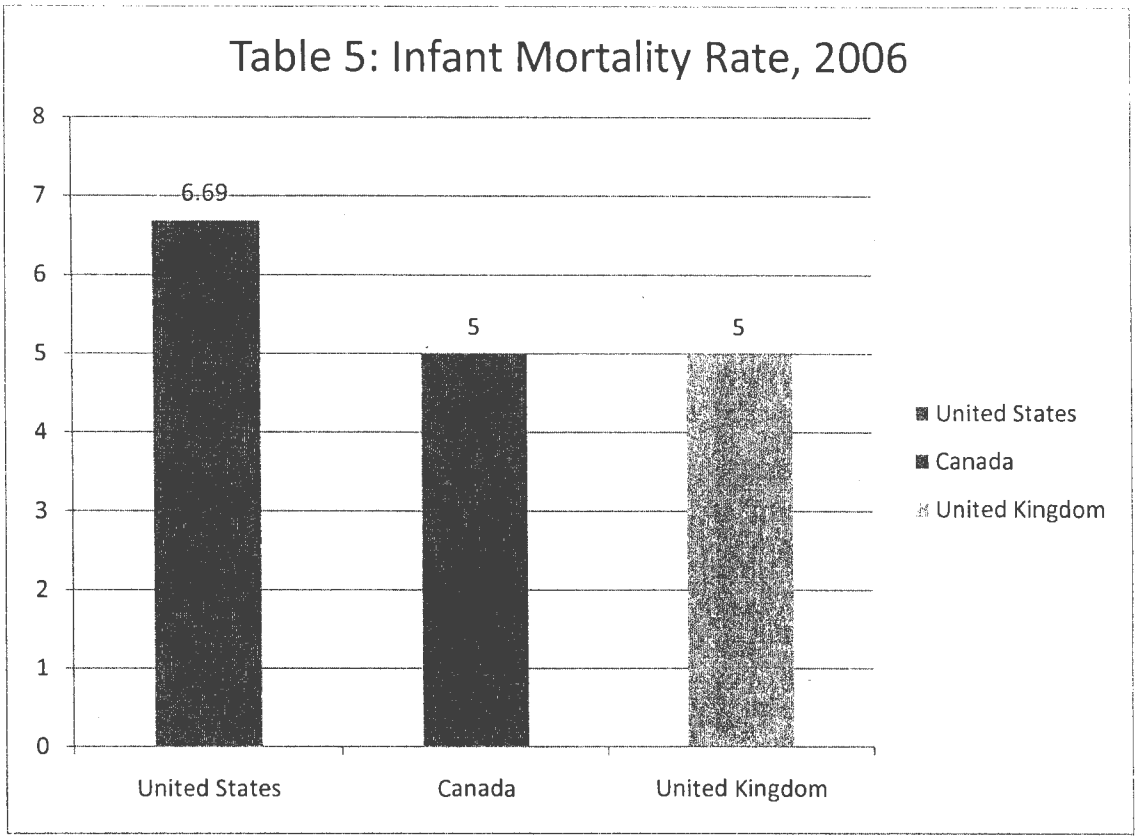
As predicted, the United States' life expectancy rate is substantially lower than both Canada and the United Kingdom. So while the United States spends a significantly larger sum of money on its health care system every year it does not seem to be providing the population with a higher standard of care as measured by the life expectancy of the average individual. Furthermore, because the life expectancy data represents all of the United States and the health care system only addresses the health needs of a fraction of that it can be concluded that the low rate of accessibility has negatively impacted the country's life expectancy rate and thus the quality of its health care system.

2. Infant Mortality

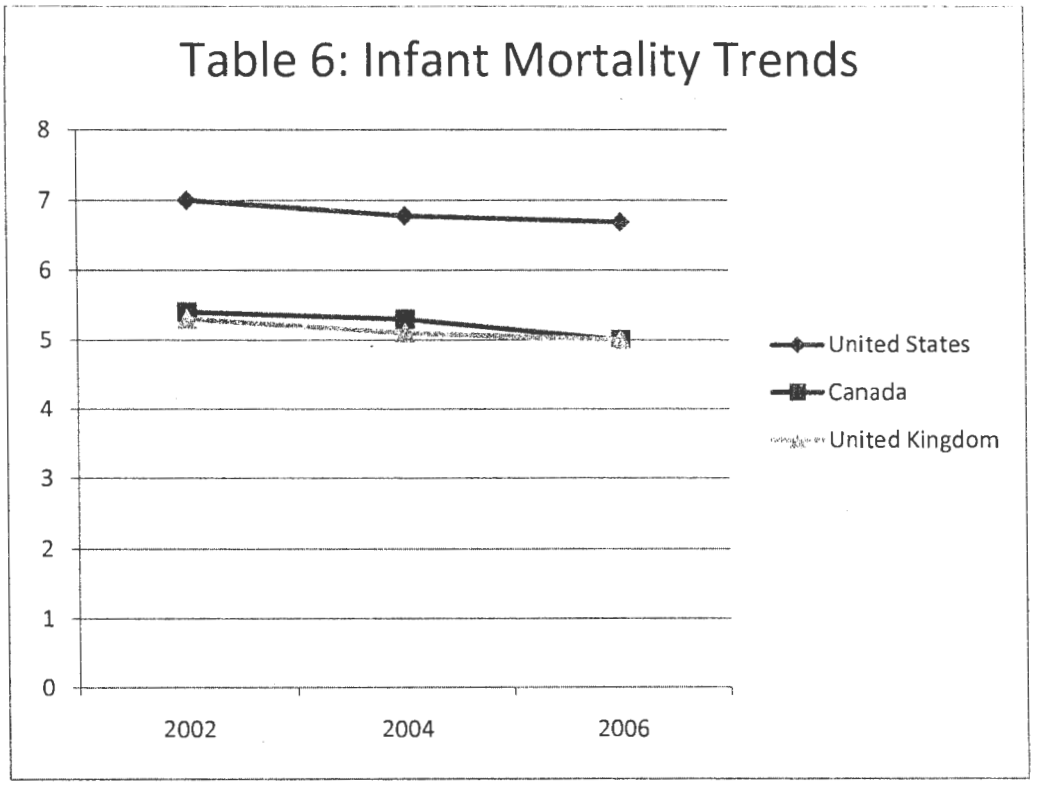
Infant mortality rate is considered to be risk of death during the first year of life (UKHS 2010, 17). It is related to the health of the mother, socioeconomic conditions within each country, public health practices, and the availability and use of appropriate health care for infants and pregnant women (NCHS 2010, 46). Thus an infant and mother in a country who have access to health care services should have a higher chance of survival. In addition, infant mortality rates are also a good indication of the effects of health care accessibility because one would expect that a higher accessibility rate to health care would lower the rate of infant mortality. Again, because the health care system of the United States is not available to the entire population, it would be expected that this factor would have a negative effect on the country's infant mortality rate.

The following statistics are represented in two different tables. Table 5 shows a comparison between the infant mortality rates of each country in 2006, while Table6 shows the trends of infant mortality rates for each country between the years of 2002-2006. Over the past

few years Canada has experienced only minor fluctuations in its infant mortality rate. In 2002, the rate was 5.4 and represents the average number of deaths of children under the age of one year per 1,000 live births (Statistics Canada 2010). For the next few years Canada would see a substantial decrease in the number of infant deaths as the rate decreased to 5.3 in 2004 and further declined to 5.0 in 2006 (Statistics Canada 2010). Likewise, the United Kingdom has experienced a slightly more consistent decline over the past few years beginning in 2002, the rate was 5.3 deaths per 1,000 live births (UKHS 2010, 17). The rate dropped to 5.1, in 2004 and from there continuously declined to 5.0, in 2006 (UKHS 2010, 17). The United States presents a much different rate. Studies released have shown that since 1995, the United States has had difficulty in lowering the infant mortality rate, due in large part to a significant number of racial minorities who have lower access to health care services (NCHS 2010, 46). In 2002, the infant mortality rate for the United States was 7 (Mathews, Menacker and MacDorman 2004). Over the next two years that rate dropped only slightly to 6.87 deaths per 1,000 infants and finally in 2006 would come to rest at 6.69 (NCHS 2010). The infant mortality rate for the United States is consistently higher than both Canada and the United Kingdom and while it is decreasing, it is doing so at a much slower rate.



Sources: Data adapted from (1) National Center for Health Statistics. *Health, United States, 2009: With Special Feature on Medical Technology.* Hyattsville, MD. 2010; (2) Statistics Canada. "Health in Canada." http://www4.statcan.gc.ca/health-sante/index-eng.htm (accessed on February 20, 2010); (3) United Kingdom Health Statistics. *United Kingdom Health Statistics.* 3rd Ed. New York: Palgrave Macmillan, 2008.



Sources: Data adapted from (1) National Center for Health Statistics. *Health, United States, 2009: With Special Feature on Medical Technology.* Hyattsville, MD. 2010; (2) Mathews TJ, Menacker F, MacDorman MF. Infant mortality statistics from the 2002 period linked birth/infant death data set. National vital statistics reports; vol 53 no 10. Hyattsville, Maryland: National Center for Health Statistics. 2004;(3) Statistics Canada. "Health in Canada." http://www4.statcan.gc.ca/health-sante/index-eng.htm (accessed on February 20, 2010); (4) United Kingdom Health Statistics. *United Kingdom Health Statistics.* 3rd Ed. New York: Palgrave Macmillan, 2008.

The recent history of each countries' experience with infant mortality rates helps to represent the quality of care expected in each country. Unfortunately, the United States has consistently measured a much higher infant mortality rate, and they have also experienced constant difficulties in trying to lower that number. In the United States, particular disorders relating to short gestation, low birth weight, and congenital malformations are among the leading causes of death for infants (NCHS 2010, 14). Most of these conditions can be attributed to health care precautions taken during pregnancy. A recent study has shown that preterm-related causes of death are responsible for 37% of all infant deaths (NCHS 2010, 14). As such,

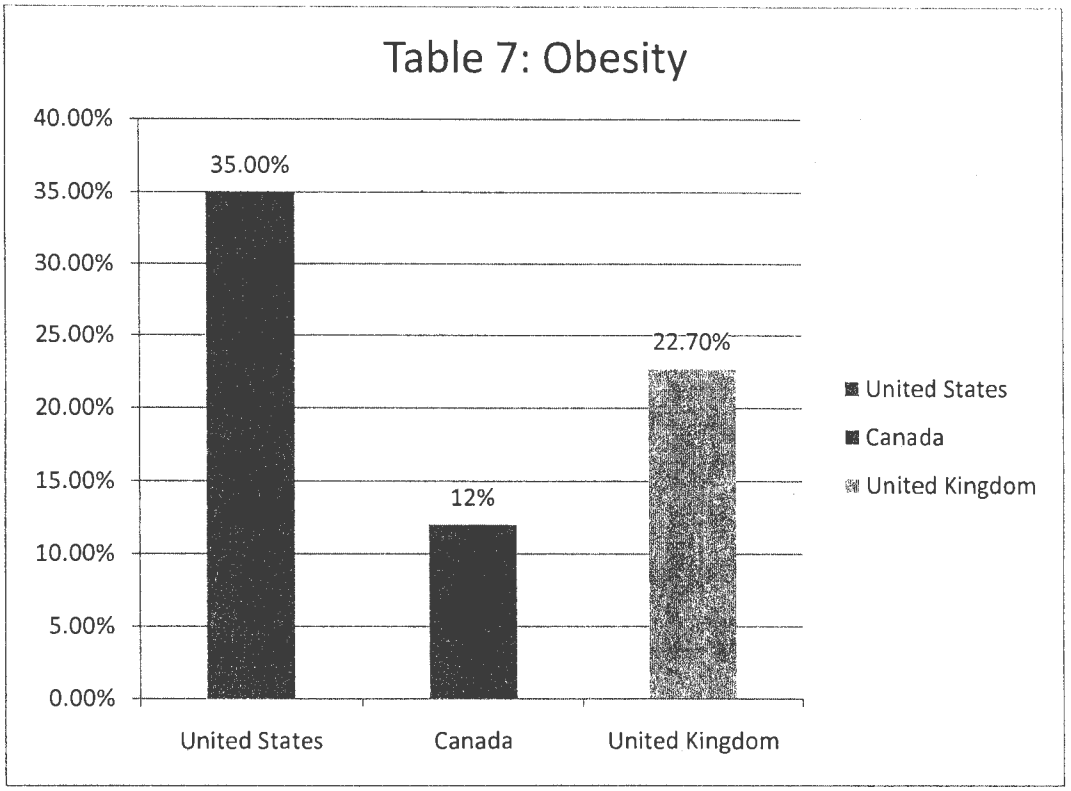
the higher rate of infant deaths experienced in the United States may be attributed to a lack of accessibility of health care services.

3. Obesity

Another indication of overall health conditions within a country is the obesity rate. An individual who is overweight incurs minor health problems while an individual who is considered obese is faced with excess mortality and has an increased risk of stroke, heart disease, diabetes, some cancers, osteoarthritis, hypertension, and other disabilities (NCHS 2010). An individual's body mass index or BMI is the most common measurement used to determine obesity (UKHS 2010, 134). In order to determine an individual's BMI, his or her weight is divided by the square of that person's height. An overweight individual has a BMI of greater than or equal to 25 while an individual who is obese has a BMI greater than or equal to 30 (UKHS 2010, 134). Being obese is a more advanced stage of weight gain and as mentioned presents a wide variety of health risks. Regular doctor visits would allow an individual who is obese to not only be aware of their condition but also, the possible risks associated with it. Accessibility to regular doctor visits, which is available in both Canada and the United Kingdom, should result in lower rates of obesity in these countries compared to the United States where access is limited primarily to those with insurance.

According Table 7, which represents statistics gathered from 2005, Canada has the lowest rate of adults who are obese with 12%, yet that number remains a concern for the country as BMI levels have increased consistently over the past 30 years (Statistics Canada 2010). Even so, in the United Kingdom that percentage level almost doubles as 22.7% of the

population is reportedly obese (UKHS 2010, 134). As is consistent with other data, the United States shows the worst measurement for obesity at 35%. (NCHS 2010, 26).



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While obesity rates in each country vary widely, it is obvious that the United States fares far worse than its counterparts. High levels of obesity are a major concern to all countries because of the previously mentioned associated risk factors that substantially decrease an individual's health. In Canada and the United Kingdom where health care is accessible to all citizens, annual checkups allow individuals to observe their weight and provide an opportunity for a doctor to educate them on how to maintain a healthy lifestyle. Unfortunately, individuals in the U.S. are not given this opportunity and so many may go without knowing the possible side effects of obesity. Furthermore, an individual living a life as on obese person is more likely

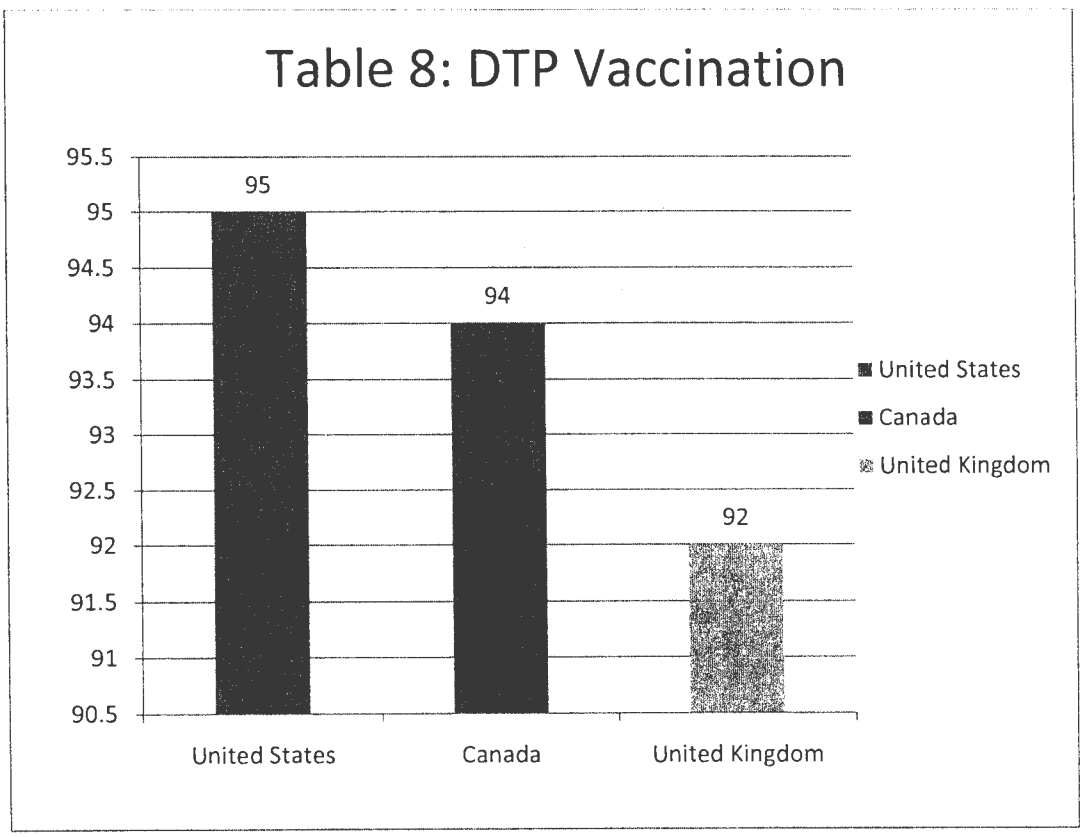
to have a poorer quality of life due to the limitations presented by weight gain. In short, the United States has incurred the highest levels of obese individuals due to a lack of health care accessibility, which has resulted in a poor and deteriorating quality of life.

4. Immunization

One of the most notable differences between a national form of health care and the private form that the United States utilizes is its effect on the use of preventative medicine. Preventive health care measures work to improve the overall health of individuals, thus improving the quality of life. Throughout the world children are protected from a number of childhood diseases through the use of routine vaccinations that help to ensure their health and survival. Furthermore, immunization statistics are an extremely important aspect of determining preventative health care measures for the nation as whole because of the concept of herd immunity. The idea is that if a majority of the population is vaccinated from an infectious disease then the group as a whole is less likely to be susceptible because so few members are capable of transmitting the disease (NHS- Immunisation 2010). By preventing a child or susceptible populations like the elderly from contracting infectious diseases like influenza, health care systems take proactive approach to medicine and improve the quality of life (NCHS 2010, 9).

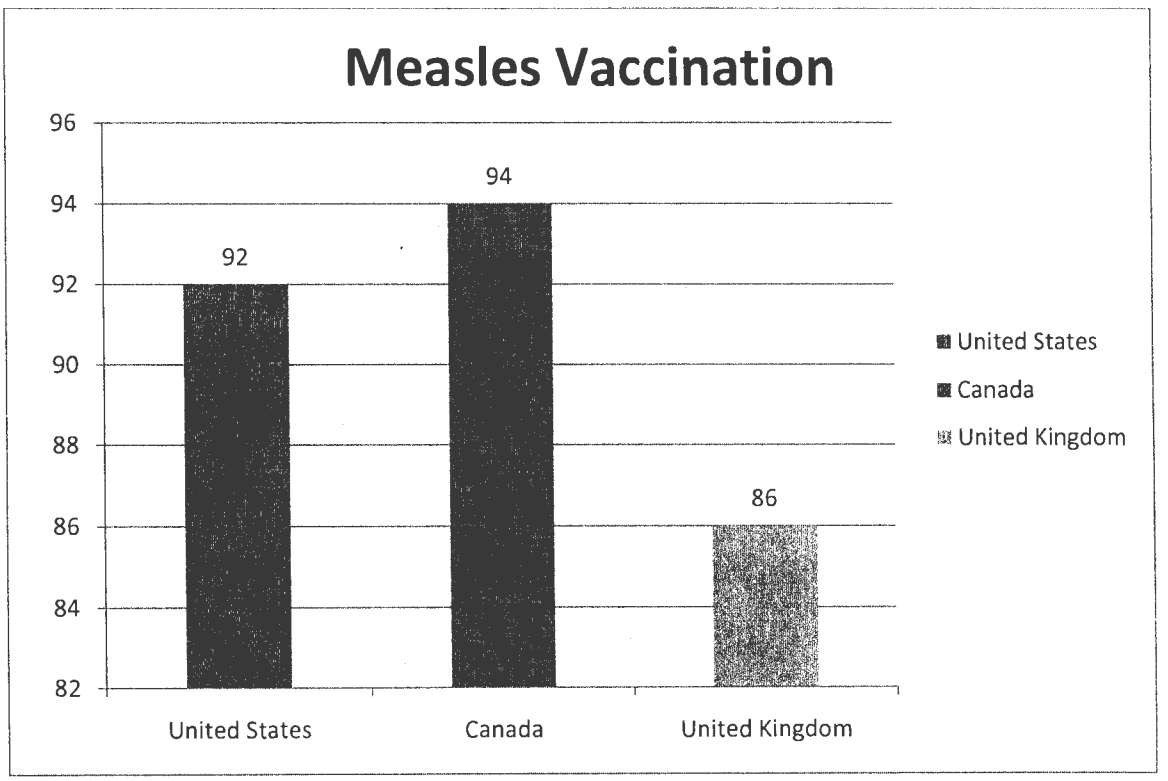
Given the differences between the three systems of the United States, Canada, and the United Kingdom, it would seem that a higher rate of accessibility to primary care physicians would increase the rate of immunizations in countries where all citizens have such access. As such, the statistics will show that the United States has a lower rate of immunizations as compared to Canada and the United Kingdom.

There a few types of major vaccines that help in the prevention of some major life threatening diseases and that are common to all three countries under examination. In 2002, the World Health Organization estimated that approximately 14% of children around the world died from infectious diseases that could have been prevented through the administration of vaccinations (WHO 2009). One of the most common vaccines is the diphtheria toxoid, tetanus toxoid, and pertussis vaccine or DTP, which is commonly administered through a set of three doses given every few years and completed before the age of 5 (WHO 2009). As seen in Table8, the World Health Organization in 2007 estimated that 94% of the Canadian population had received all three doses of DTP (WHO 2009). The United Kingdom estimated that 92% of the population was vaccinated while the United States came in with the highest rate at 95% (WHO 2009).



Sources: Data adapted from World Health Organization. "WHO vaccine-preventable diseases: monitoring system - 2009 global summary."

Another dangerous infectious disease is measles which is considered to be the most readily transmitted communicable disease and in 2002, claimed the lives of 35% of all children who died under the age of 5 (WHO 2009). The measles-containing vaccine is normally administered in one dose and is extremely effective in the prevention of measles. In 2007, it is estimated that 94 percent of the Canadian population had received a measles-containing vaccine (WHO 2009). The United Kingdom estimated that only 86% of the population had received the vaccine, while 92 percent of the United States population was reported to have been vaccinated (WHO 2009).



Sources: Data adapted from World Health Organization. "WHO vaccine-preventable diseases: monitoring system - 2009 global summary."

In comparing the immunization rates for each of the countries it is obvious that the United States does in fact measure up to its national health care counterparts. In light of other comparisons this can be considered a success for the United States health care system.

However, upon further examination immunizations within the U.S. are widely available through a public health care program known as the Vaccines for Children Program which was established in 1994 (USDHHS 2010). This program allows for children from low income families to receive vaccinations at no cost. Furthermore, each state has immunization laws which are commonly referred to as "School Laws", requiring that children attending school must be vaccinated from a list of infectious diseases (USDHHS 2010). As a result, it is quite clear that the United States government feels that preventing infectious diseases is so important as to require a special public health program that has been implemented so successfully that some of its results outshine those of the public health programs in both Canada and the United Kingdom.

Summary

In the end, issues within the United States health care system have surfaced as major issues resulting in political intervention. In reforming its health care system, United States politicians and policy makers can look abroad to other countries in order to determine what policies may be the most effective for reform. As such, this study has focused on comparing the private insurance based system of the United States to the public health care systems of Canada and the United Kingdom in terms of cost, quality and access.

The United States has the lowest level of financial access to its health care system as almost 20% of its population, or 47 million individuals remain uninsured and so have little to no access to primary care (NCHC- Costs 2008). On the other hand, Canada and the United Kingdom provide financial access to all citizens but experience difficulties with physical access to health care as their waiting lines for specialized care are substantially higher than the United States.

Yet, because the United States health care system does not provide financial access to its entire population it consequently decreases the number of individuals who would acquire referrals to seek specialized care. As a result, the limited financial access Americans experience results in a lower level of all around access to health care services.

In any case, health care costs have been increasing around the world for quite some time. However, the United States spends far more per person than both Canada and the United Kingdom. Furthermore, the U.S. attributes a much higher percentage of its total GDP towards health care costs than both other countries yet its system offers less access to its total population. Altogether, while the United States relies on private insurance enterprises to administer its health care system it spends more money on health care than either of the public systems administered by Canada and the United Kingdom.

Finally, the statistics undoubtedly show that the United States private health care system is not delivering quality care as compared to the public programs implemented in Canada and the United Kingdom. In terms of life expectancy, infant mortality rates, and obesity rates the United States outcomes are inferior to those of its counterparts in this study. Immunization rates were the only area in which the United States performed well, but it is also the only area in which the U.S. has developed a comprehensive public policy. As such, the United States has proven that it can create and administer effective public health care programs. In the end, the United States is spending more money every year to pay for a system which does not provide services to all of its citizens and provides a lower quality of care compared to less expensive public health programs in Canada and the U.K.

Implications

The United States health care system has been reformed numerous times in order to address escalating deficiencies associated with cost, quality and access. However, recently passed legislation calling for an overhaul of the health care system will allow Americans the opportunity to implement public reforms similar to those in Canada and the United Kingdom. This study has shown that the national health systems operating in these two countries has consistently outperformed the United States private health care scheme.

The Patient Protection and Affordable Care Act, allows for a greater number of individuals to have financial access to health care services. More specifically, it would provide or subsidize health care coverage for an estimated 31 million people who are currently uninsured (Open Congress 2010). As seen in Canada and the United Kingdom a higher rate of access to health care service may potentially increase life expectancy rates, allowing individuals to live longer lives. Furthermore, one would expect to see a decrease in infant mortality rates as pregnant mothers would have access to the necessary prenatal medical attention. Additionally, access to regular doctor visits would allow obese individuals the opportunity to receive education regarding weight reduction and information on health lifestyles and choices. As a result, such improvements in health care may substantially increase the quality of life as a byproduct of expanding access through public health care legislation.

However, one of the most daunting aspects of the newly passed legislation is the price ticket that is attached. It is estimated that over the first 10 years of being enacted, the total cost of the bill will come in at approximately $940 billion dollars (Open Congress 2010). In order to fund this new legislation the government will be raising taxes, attaching fees to health

industries across the board, and cutting projected spending for current government health programs like Medicare (Open Congress 2010). Given the current economic climate, this is a scary alternative to leaving the health care system alone. However, the Congressional Budget Office predicts that this new bill will actually cut the deficit over the next 10 years, meaning that it will raise more money than it will spend. Between the years 2010-2019, the enactment of the newly passed health care legislation would produce a net reduction in federal deficits of $118 billion (U.S. Congress 2010). So while the initial price tag for the new health care legislation may seem to increase the costs it will in fact be reducing the federal deficit over a period of time.

In the end, the United States new venture to overhaul its health care system provides it with an opportunity to implement some of the reforms seen in the public health systems of Canada and the United Kingdom. By providing financial access to a larger portion of the population the U.S. could see a substantial increase in overall quality of life. Overtime access to health care services may result in quality of life indicators that are more comparable to those seen in Canada and the United Kingdom. In addition, although this newly enacted legislation will increase the costs of health care services it could potentially reduce the federal deficit over a period of time. Regardless, the American private health care system experienced greater difficulties in addressing issues related to cost, quality and access than the national systems of Canada and the United Kingdom. Altogether, the current legislation to overhaul America's health care presents an opportunity to effectively reform the system by increasing access in an effort to improve quality while regulating costs.

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