Mainstream political philosophy has been sharply criticized in recent years for focusing on ideal justice theories to the exclusion of practically-useful, real-world policy recommendations (Farrell 2007; Sen 2009). One area where this criticism would nonetheless seem not to apply is health policy. Numerous political philosophers have applied the principles of ideal justice theories to practical health policy questions in order to generate practically-useful recommendations about health care justice (Beauchamp and Childress 2001; Buchanan 2009; Daniels 1985; 2008; Powers and Faden 2006; Ruger 2010). Norman Daniels (1985; 2008), for example, has extended Rawls’s theory of justice to elaborate a theory of just health care and just health, and Jennifer Ruger (2010) has similarly used the capabilities approach to draw out a number of specific conclusions about justice and health policy.

Despite the practical focus of these theories, most accounts of health care justice remain somewhat ideal and vague. Most theories of health justice do not, for example, adequately account for the social determinants of health. Consequently, the justifications they provide for publicly-funded health care are open to significant objections. Most theories of health justice likewise remain indeterminate at a system or institutional level. Daniels frankly admits that the form of institutional organization implied by his theory of just health – public or private administration and financing – “is not a question to which [my theory of] just health provides a unique answer” (2008, 144). While he argues that his theory does require some sort of “universal
comprehensive health care,” he notes that there are “probably an array of ‘just-enough’ institutional structures” that fall within this framework (96, 234-73). Ruger’s theory similarly falls short on concrete system-level recommendations. While she, too, endorses universal comprehensive health insurance, she remains vague about its organization and administration. Arguing that both wholly public and wholly private health systems are subject to problems, she suggests that a “mixed public-private systems might be optimal” (170). What she has in mind for this public-private mix, however, is never clearly delineated.¹

Most political philosophers and even many philosophically-minded health policy analysts further tend to frame their arguments about health care justice in mostly speculative terms. Numerous philosophers have argued, for example, that markets are poorly suited for allocating health care in a fair manner (Buchanan 2009, chapter 4; Dworkin 2000, 310-311; Powers and Faden 2006, chapter 5; Ruger 2010, 30-33). A number of policy analysts claim, however, that regulated systems of managed competition can avoid the problems of a pure market system and deliver high quality health care at lower costs (Enthoven and Kronick 1989a; 1989b; Emanuel 2008; Pauly 2008). Daniel Shapiro (2007) has argued, by contrast, that a market-based health system can (at least hypothetically) outperform national health systems in terms of equity, access, fairness, freedom, and other commonly-held values. Shapiro’s arguments, however, just

¹ Even the nine practical benchmarks that Daniels offers for assessing the justice of health policy reforms are not intended for system-level or “cross-country comparisons of fairness” but instead are meant only to function as loose rules of thumb for policy-makers within different countries when thinking about trade-offs between different health policies (256, 267, 243-73).

² I focus here on Daniels and Ruger because of the prominence of their theories, but a similar critique can be applied to other theorists as well (e.g., Buchanan 2009; Beauchamps and Childress 2001; Dworkin 2000; Powers and Faden 2006). While each offers arguments that narrow down the range of acceptable health policies and systems, all leave off with somewhat vague institutional prescriptions.
like those of other philosophers, are for the most part logical and philosophical. The conclusions of these arguments thus remain tentative or hypothetical at best.

In this paper, I address these shortcomings in the normative literature on health care in order to outline a contextually-sensitive, empirically-grounded, and institutionally-oriented theory of health care justice. I begin by discussing the literature on the social determinants of health and draw out the implications of this literature for a theory of health care justice. The social determinants of health literature has convincingly shown that health care plays a relatively small role overall in saving and extending lives and promoting good health. As such, I argue that theories of health justice that attempt to justify universal public health care in terms of saving and extending lives and promoting good health are weak and potentially counter-productive. I then offer an alternative rationale for health care systems rooted not so much in health as in care. The main justification for a publicly-supported, comprehensive public health care system, I suggest, is not so much to save and extend lives (i.e., cure individuals) as provide individuals with everyday care, including treating minor and chronic illnesses, alleviating discomfort and pain, and helping individuals to cope with their ailments.

Building on this insight, I next develop a justification for publicly-funded health insurance based on care ethics and outline the major aims and characteristics of a caring health care system with particular attention to concrete measures that can be used to assess the justice of actually existing health care institutions and policies. Drawing on a growing body of statistical data on health care systems, I then examine the performance of health care systems in eleven industrialized countries in achieving these outcomes. I categorize these eleven states into three

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3 Shapiro does make some limited use of empirical studies. However, he ultimately defends an ideal market system that has no close real-world counterpart. Even the United States, which is generally held up as an exemplar of a market-based health system, is by his account too subject to government regulation, public programs (Medicare and Medicaid), tax subsidies, and the like to provide a good test of whether market ideals can support just health care.
main groups (national health systems, social insurance/managed care states, and private insurance/Medicaid states), and investigate whether any group performs best overall in providing just (or caring) health care to individuals. In the final pages of my paper, I analyze this data in order to outline an empirically-informed account of the basic institutions of a just (or caring) health care system.

*Health Care and the Social Determinants of Health*

Political and moral philosophers are just beginning to come to terms with the implications of the social determinants of health literature for a theory of health care justice (Barry 2005; Brock 2000; Daniels 2008; Powers and Faden 2006; Ruger 2010; Segall 2007; 2010; Sreenivasan 2007). Traditionally, normative theorists assumed that medical care was the major determinant of health and health equity and justified universal access to quality health care by pointing to its purported central role in realizing these goods (see, for example, Daniels 1985). Recent epidemiological research on the social determinants of population health has, however, upended these assumptions and largely undermined traditional justifications for publicly-subsidized health insurance and health care.\(^4\)

Public health experts have long recognized the importance of social and environmental factors such as sanitation and nutrition for population health. Beginning in the 1970s, however, researchers began studying the impact of a wider variety of social factors on people’s health, including social class and status, education, wealth and poverty, social inequality, unemployment, workplace stress, and racism, and to compare the relative significance of these

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\(^4\) Health care, or medical care, is defined here as primary care, specialist care, acute or hospital care, mental health care, rehabilitative care, and primary and secondary preventive services such as screenings and immunizations. Excluded from my definition are non-clinical public health measures such as water chlorination, anti-smoking campaigns, food safety regulation, and the like.
social factors with medical treatments in promoting health. The conclusion of this research has been that medical care has had a quite limited impact on people’s health (Barry 2005; Brock 2000; Blank and Burau 2007; Heymann et al. 2006; Goldman and Lackdawalla 2010; Mann 1997; Marmot and Wilkinson 2006; Wilkinson 1996). People’s health and lifespan is determined overwhelmingly by social factors such as their income, education, social status, and occupation, (as well as their genetic predispositions). While medical care can no doubt sometimes play a major role in saving lives, it does so for a relatively small percentage of most individuals. On average, medical care plays very little role in saving lives, promoting longevity, or significantly enhancing the health of individuals. For example:

-Researchers estimate that only about one-sixth of the years of life expectancy gained in the United States during the 20th century (about 5 years out of a total 30 year increase) can be attributed to preventive or therapeutic medical care. The remainder is due primarily to improvements in nutrition, education, sanitation, living conditions, and other social factors (Barry 2005, 71; Mann 1997, 7). Similar estimates have been provided for European countries (Nolte, Bain, and McKee 2009, 30).

-Only about 10 percent of preventable premature deaths in the United States are associated with a lack of medical care (Mann 1997, 7). Worldwide, the figure rises only to somewhere between 11 and 24 percent.

-Greater utilization of medical care resources does not necessarily lead to better health outcomes. In the United States, for example, some regions spend significantly more on Medicare and
provide more services than others, but patients in high-spending, high-service regions do not live longer or otherwise experience better health outcomes than individuals in low-spending, low-service areas (Goldman and Lakdawalla 2010, 2). Canadian researchers further found that, over time, health status actually worsened for groups who received the most medical care and improved for those who received the least care (Roos, Brownwell, and Menec 2006, 121). The same researchers found that a 24 percent reduction in acute hospital bed supply and a substantial decrease in hospital spending in Winnipeg during the 1990s had no detectable impact on mortality. In fact, health status among Winnipeg residents actually improved during this period (Roos, Brownwell, and Menec 2006, 119-120).

Providing the least advantaged members of society with easy access to quality health care services does very little to close the health gap between them and the most advantaged members of society (Roos, Brownwell, and Menec 2006; Sreenivasan 2007). Significant health disparities exist between the least and most advantaged members of society even in countries with universal health systems (Wilkinson 1996). The introduction of national health care in countries such as the United Kingdom made no difference to the social gradient in health between poor, middle class, and rich individuals (Sreenivasan 2007). Even if the richest 5 percent of Americans were denied all access to health care and the poorest 10 percent were granted unlimited access to the best treatments and technologies, the richest would still live on average about four years longer than the poor (Barry 2005, 76).

The long-term effectiveness of many expensive and intensive, high-tech medical procedures appears to be modest at best. Elderly patients in the U.S., for example, are much more likely than
Canadian patients to receive coronary angiography, angioplasty, or artery bypass surgery for acute myocardial infarction (i.e., heart attacks). While thirty-day mortality rates among U.S. patients are slightly lower than those in Canada, one year mortality rates are virtually the same for the two groups (Roos, Brownwell, and Menec 2006, 123).

Summarizing the major findings of the social determinants of health literature, Daniel Brock writes: “The crucial point is that differences in the incidence of illness and injury from social causes swamp the effects on health of differences in access to and use of medical care to treat that illness and injury” (Brock 2000, 31). Norman Daniels (2008, 79) more colorfully characterizes medical care as “the ambulance waiting at the bottom of the cliff.” It does what it can to treat the injuries and illnesses that are caused by a combination social, environmental, and biological factors, but often represents little more than a last ditch effort to extend life just a bit or reduce pain and suffering after the social determinants of health have taken their toll.

Imagine, for example, a 40-year-old man who grew up in and continues to live in a polluted and unsafe neighborhood, works at a low-income and stressful job, eats an unhealthy diet, rarely exercises, and is overweight. One day he is rushed to the hospital with a heart attack. The emergency room doctors may or may not be able to save the man’s life, but even if they do save his life, they are unlikely to be able to do much to improve his overall health. Without major changes to his life, the man will be lucky to live to age 50. The power of medical care is in this case swamped by social factors. Now imagine that the $200,000 dollars or more that are spent in trying to save this man’s life with medical care were invested over the course of his life in making sure that he lived in a good home in a safe and clean neighborhood, received a good education, and had access to a good job and a regular income. Barring any major biological
predispositions to disease, the man might easily live to 75 or 80 years without ever suffering a major medical trauma.

The implications of the social determinants of health literature for a theory of health justice are significant. Political and moral theorists have traditionally considered health care to be important because of its presumed contribution to health. Yet, if health care is only one relatively small factor in the production of health, then normative appeals to the value of health can provide only weak support for the special social importance of health care. Indeed, given the relatively greater weight that social factors have in determining the health status of individuals, some writers have argued that states should as a matter of justice divest from public health care and instead put their money into social programs such as education that appear to have a greater overall effect in promoting good health. Blank and Burau (2007, 217) argue, for example, “If a system really wants to achieve the goal of maximizing the health of its population, resources would better be directed towards alleviating poverty, reducing crime, changing lifestyles and so forth. A healthy person does not need medical care!...[R]ecent efforts to reform health care systems may be misguided because no amount of restructuring health care along the lines proposed by the reformers will have a major impact on the health of their populations.” Discussing recent health care reform efforts in the United States, Goldman and Lakdawalla (2010, 3) similarly assert: “The first step is to invest – not in the healthcare system, but in education. We should take the $120 billion it might cost for universal coverage, and use it, instead, to provide earlier education and to improve the quality of education. Better-educated people live longer, are less likely to be disabled, and engage in healthier behavior.” Sreenivasan (2007, 27) adds that at least insofar as we are interested in improving health for the sake of
promoting equality of opportunity, a theory of justice “requires that society spend none of its health budget on health care and all of it on ameliorating the social determinants instead.”

Even if health care plays a relatively small role in promoting health, there are nonetheless still some good reasons for continuing to regard it as a socially valuable activity. Although medical care may be responsible for only about one-sixth of the years of life expectancy gained over the last century and can potentially prevent only about 10 percent of preventable premature deaths in industrialized countries, these accomplishments are not insignificant.5 They may not justify the high levels of expenditure on health care currently found in most industrialized countries or support public expenditure on health care rather than education or poverty relief, but they do provide some reason for continuing to value health care services. Health care might potentially save our lives or the lives of loved ones in an emergency or crisis. Perhaps more importantly, many of the measures that researchers have used to demonstrate the relative insignificance of health care for individual and population level health (mortality rates, life expectancy) do not effectively capture much of what medical care contributes to individual well-being. They do not register, for example, all the small ways that medical care can enhance individuals’ well-being short of saving or extending their lives: setting a broken arm, prescribing antibiotics for a sore throat or respiratory illness, reassuring an individual that her sickness is not serious and will pass. Similarly, the social determinants of health literature takes little account of the contribution that health care can make in helping individuals to cope with their ailments, injuries, and bodily decay. A doctor may prescribe an arthritis drug to help a patient manage her

5 Nolte and McKee and colleagues (Nolte and McKee 2004; Nolte, Bain, McKee 2009) argue that the impact of medical care on health may be somewhat greater than the social determinants of health literature has recognized. By their account, deaths amenable to medical care now account for roughly 25 percent of all deaths in advanced industrialized countries (2011, 48). Of course, not all these lives could be saved even with high quality medical treatment, and social factors still play a dominant role in generating the conditions that lead to many of these deaths. But medical care realistically may be able at present to prevent somewhat more than 10 percent of premature deaths in industrialized countries.
pain; a physical therapist may recommend exercises to help a patient regain some strength and flexibility in his knee; a nurse may work closely with a patient to help her manage a chronic skin condition or asthma. Even though these treatments do not restore patients to good health, they do help individuals to carry on with their lives - albeit oftentimes in a diminished state of health. In these respects, medical care may be considered morally and socially important regardless of its impact on mortality or longevity. Although modern medicine is most frequently lauded for its life-saving cures, much of its real contribution to individual and social well-being comes from the old-fashioned everyday caring that it provides to individuals: treating minor illnesses and injuries, preventing illnesses from developing or becoming worse, informing and assuring patients about their health, and helping individuals to alleviate or cope with pain and discomfort. Even if all the social determinants of poor health were optimized, medical care would still be needed to perform these mundane caring tasks.

While a case can thus be made for the continuing importance of health care, the social determinants of health literature does have important implications for the ways we think about the social function of and justification for health care services. Some of the most prominent philosophical justifications for universal health care are, for example, greatly weakened by the social determinants of health literature. Take Daniels’s (1985, 2008) defense of publicly-funded universal comprehensive health care. Building on Rawls’s theory of justice, Daniels argues that society should provide high quality health care to all individuals because high quality health care is key to good health, and good health is essential to providing individuals with a fair range of opportunities to carry out their life plans and pursue their conceptions of the good life. In his most recent work (2008), Daniels acknowledges the dominant role that social factors play in determining individuals’ health status and expands his theory of health justice to incorporate
these factors (2008, chapter 3). He now argues that a theory of “just health” must go beyond discussing the nature of “just health care” (the title of his first book) and address all the socially controllable factors that may affect health status, including occupational safety issues, poverty, education, nutrition, housing, inequality, racism, and so forth (12-13). Yet, despite this broader perspective, Daniels does not adjust his understanding of health care to account for the social determinants of health. Rather, he continues to assume that medical care has a large impact on health outcomes, while adding that occupational safety issues, poverty, education, nutrition, housing, inequality, racism, and other factors also all have a large impact on health. But not all determinants can have a large impact on health. By nearly all accounts, the social determinants of health are much more important than health care – particularly where the ultimate goal is to promote equal opportunity (Sreenivasan 2007). Given Daniels’s ultimate concern with health for the sake of promoting equal opportunity, it would seem to follow that he should favor social spending on poverty alleviation, education, nutrition, and other social determinants of health over social spending on health care. As Segall (2010, 345) poignantly asks, “Why should one pay any attention to health care if in any case the focus is on opportunities, which are in turn shaped by our health, which in turn is not much affected by health care?” By orienting his theory around the promotion of health and equal opportunity, Daniels’s theory provides only limited support for the public provision of health care.

Ruger’s (2010) attempt to justify universal health care in terms of the capabilities approach runs up against similar problems. Ruger argues that society should provide all individuals with the highest quality health care that resources permit because quality health care is one of the “most influential determinants” of individuals’ health capabilities (2010, 9, 99). As noted above, however, most health analysts do not share this view. The health capability
paradigm “does recognize a relationship between health policy and other public policies affecting health,” Ruger continues, “but it regards these domains as distinct and defines health capabilities as the central goal of health policy” (99). Thus, Ruger chooses to focus her analysis on the impact of health care on health, setting aside the other social determinants of health. While this decision to focus narrowly on the contribution that health care can make to health capability is justifiable, it does not justify ignoring the greater relative importance of social factors in developing a theory of health care justice. Indeed, if the goal of Ruger’s theory is to maximize health capability, one must ask (as Segall asks in regard to Daniels’s theory) why one should pay any attention to health care at all? Health capability can be promoted far more effectively by devoting resources to education, poverty alleviation, social equality, and other non-medical social programs than by spending public resources on health care. Ruger, however, for the most part ignores these implications of the social determinants of health literature and argues as if health care has a major impact on health capability.

The above criticisms are not meant to impugn the value of Daniels’s and Ruger’s theories, both of which contain numerous insights about health justice. They do indicate, however, the need for an alternative rationale to justify public expenditure on health care (Brock 2000, 35-36; Sreenivasan 2007, 30). The problem with Daniels’s and Ruger’s theories (and others like them) is that they attempt to justify medical care in terms of a productivist paradigm that ties the value of a medical system to its contribution to health, and the value of health to its

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6 Ruger further justifies her decision to set aside the social determinants of health on the grounds that we do not fully understand how they work or their relative importance (2010, 6). While this in part is true, there is fairly strong evidence that social spending on poverty alleviation and education have a greater impact dollar-for-dollar than spending on health care.

7 Powers and Faden (2006) offer an interesting alternative justification for health care. They argue that ensuring equal access to health care is important regardless of health care’s limited contribution to health on the grounds that access to health care contributes to other important values such as a sense of self-respect, affiliation, and self-determination (140). Their argument nonetheless leaves unanswered the question of whether there might be a better and cheaper way for states to foster these values (e.g., education) other than by providing all individuals with comprehensive access to health care.
contribution to equal opportunity (Daniels) or human flourishing (Ruger). Yet, as the social
determinants of health literature demonstrates, medical care is swamped by other social forces in
the overall production of health. Moreover, the contribution that medical care can make to health
often does little to foster equal opportunity, promote human flourishing, or support other such far
reaching goals. Rather, medical care more often simply treats minor illnesses and injuries, helps
individuals to manage chronic illnesses or cope with their diminished capacities, slows down
bodily or mental deterioration, mitigates pain, provides information and advice, and/or relieves
informal caregivers (e.g., family members) of partial responsibility for the care of an individual
whose health needs may exceed their capacities. By casting the value of health care primarily in
terms of its contribution to the production of health, and tying the value of health to equal
opportunity and flourishing, Daniels and Ruger offer only very limited support for a system of
state-supported health care.

Although political philosophers have generally focused on health in outlining their
theories of just health care, the best justification for a system of public health care actually
appears to lie with care. Care is the other half of health care that has been almost completely
ignored in normative discussions of health policy. If care rather than health is posited as the main
goal of health care, then health care can be said to have a unique purpose apart from the
production of health (which it shares with innumerable other social forces). The reason for
having, maintaining, and perhaps reforming and expanding a health care system is to enhance the

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8 Daniels and Ruger might answer this criticism by expanding their account of health and health capability to
include much of what I mean by care. My aim here is simply to highlight the productivist elements that underlie
their current approaches. Daniels argues that health care should aim to promote normal species functioning, and
Ruger argues that it should aim to achieve a realistic optimal average of health for individuals given what is
possible. Neither of these views adequately accounts for the role of health care in alleviating pain, slowing
deterioration, helping individuals to get by with diminished or sub-normal abilities, and so forth. The goals in both
cases are positive and productivist: enabling opportunity and capability.
care that it provides to individuals. The production of health represents only one component of this care.

**Care Ethics and Health Care**

The concept of care referred to above is broader than notions of health opportunity or health capability. It encompasses not only the productivist goals of health care systems (saving lives, curing diseases, restoring and repairing bodies and minds), but also the quasi-productivist goals (prevention, tending to minor sicknesses and injuries) and non-productivist goals (alleviating pain, providing information, comforting individuals, helping individuals to cope with their conditions, staving off as much as possible the further deterioration of a person’s body or mind, and relieving family and friends of some of the responsibility of caring for their loved ones). All these goals are well-supported by existing definitions of care. Tronto and Fisher (Tronto 1993, 103), for example, define caring as “everything that we do to maintain, continue, and repair our ‘world’ so that we can live in it as well as possible,” and Engster (2007, 28-29) defines it as “everything we do directly to help individuals to meet their vital biological needs, develop or maintain their basic capabilities, and avoid or alleviate unnecessary or unwanted pain and suffering.” Nearly all care theorists further emphasize the relational, non-productive aspects of caring. Caring is said to involve attentiveness, responsiveness, and respect, openness to others, and simply ‘being there’ for others (Engster 2007; Friedman 1993; Noddings 2002; Held 2006.; Tronto 1993; Walker 2007; White 2000). More than anything else, it is this emphasis on non-productive interpersonal values that distinguishes care ethics from most other ethical theories.

When care in this sense is made the central goal of health care, it might be wondered whether publicly-funded health care can still be morally justified or individuals can plausibly be
said anymore to have a right to health care. It is one thing, after all, to say that society has a responsibility to provide everyone with access to health care when it is assumed that health care is integral to survival, equal opportunity, or human flourishing. But can society still be said to have a responsibility to provide everyone with health care when its major aims include the treatment of minor illnesses and injuries, the management of chronic diseases, the alleviation of pain and suffering, or even just providing attentive, responsive, and respectful care for the self-identified ailments that individuals may want diagnosed and treated?

The simple answer is yes. As numerous care theorists have argued, we all have a duty to care for others rooted in our universal dependency on others for care. From the moment of birth, we all rely upon others to help us meet our basic physical needs, foster our basic capabilities, and avoid as much as possible harms or blights to our development and well-being including unnecessary pain and suffering. At least indirectly, we all continue to rely on others for these goods throughout our lives, and during periods of sickness, disability, and frail old age, we often return to a state of direct and heavy dependency on others. Since we all directly appeal to others for care during these periods of dependency, we all may be said to have a moral responsibility to care for others when they are in a similar state of need for our care. Failing to care for others in need may be condemned as: 1) failing to contribute back into a cooperative scheme of care that we have all drawn upon in times of need (childhood, sickness, injury, disability); (Baier 1997; 29-31); 2) not doing unto others as we would want them to do unto us if we were in need (Fineman 2004; Kittay 2001; 535); 3) hypocritically refusing to abide by a general moral principle of caring for others in need that we have all necessarily made use of in calling on others to care for us during our own times of need (Engster 2007, 45-54); or 4) violating the Kantian moral imperative of helping others in need (Miller 2011). More intuitively, refusing to extend
care to another in need may be said to reflect a lack of empathy, compassion, or sociability. It means doing nothing when we could do something (usually at no great cost to ourselves) to ease the pain, suffering, discomfort, fear, or sometimes real danger of others. However exactly one wants to frame this moral argument, the general point is that there are good moral grounds for thinking that we have a moral responsibility to care for others beyond just providing them with life-saving treatments. Since in most cases we can most effectively provide this care for others only through collective public policies, our responsibility to care for others carries with it the duty to support and abide by collective caring policies such as a system of public health care when we cannot competently and effectively provide direct care for others at an individual level (Engster 2007, 70-75).

Some care theorists further specify that we only have a moral responsibility to care for others when they cannot reasonably meet their needs on their own (Engster 2007, 63-4). This is an important qualification because it guards against the exploitation of good-natured caregivers by individuals who might otherwise demand all kinds of help and support for activities and goods that they could reasonably obtain on their own with relatively little effort. Medical care, however, clearly constitutes a form of care that most individuals cannot provide for themselves. Most individuals do not have the knowledge to properly diagnose most illnesses, prescribe proper medications, operate medical technology, or perform even minor forms of surgery (especially on themselves!). Moreover, individuals usually seek medical care only when they think they have a real medical need (Riche and Unruh 2009, 74-110; Roos, Brownwell, and Menec 2006, 124). Medical care thus represents a form of care that we all rely on others to provide for us and that we generally seek only when we have a perceived need for it. As such, it

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9 Doctors, nurses, and other medical professionals might, of course, be able to better address their medical needs than non-medical professionals. Yet, given the high level of specialization within the medical field, even most medical professionals rely heavily on others to meet their medical needs.
represents a domain of care that we can all plausibly be said to have a social responsibility to provide for others.

Even if individuals cannot reasonably provide effective medical care to themselves, it might nevertheless be argued that they can reasonably purchase private health insurance on the free market to ensure their access to effective medical care. In this way, the duty of individuals to provide others with access to medical care might be seen as quite limited. While this argument has some merit, it does not entirely obviate the state’s responsibility for providing health insurance or health services to at least some individuals. As even the most ardent supporters of private market-based health care acknowledge, many individuals are unlikely to be able to purchase even basic health insurance in a pure competitive market system (Shapiro 2007). In a pure market system, for example, children whose parents choose not to purchase health insurance or cannot afford it will lack access to health care. Yet, children ought not to be held responsible for the circumstances or choices of their parents, particularly when they negatively impact their well-being and development. Many poor individuals are further unlikely to be able to purchase even the most basic health insurance plan without some sort of government subsidy or regulation of premiums. A majority of the chronically ill (roughly 1-2 percent of the population), persons with severe disabilities (about 12 percent of the population), and the elderly (about 13 to 20 percent of the population in most industrialized countries) are also likely to have difficulty purchasing health insurance without state subsidies or regulations, since these groups tend to have high utilization rates of medical services and are therefore costly for private insurers. If it is acknowledged, then, that we as a society have even a minimal duty to guarantee

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10 Moreover, childhood appears to be one area where health care can have important effects on health through vaccinations, early management of chronic conditions, and so forth (Nolte, Bain, and McKee 2009, 33).
11 Prior to the introduction of Medicare in the United States in the 1960s, private insurers had virtually stopped offering insurance to elderly persons (Powers and Faden 2006, 120).
individuals some measure of health care – e.g., emergency care in the event of an accident, pain relief and medical treatment for a broken hip or leg – then the state will necessarily have to play some role in regulating, subsidizing, and/or providing health insurance for some fairly large percentage of the population. A purely private, market-based health system can reasonably be expected to meet the health needs of only about half the population – those individuals 18 to 64 who are relatively healthy, able-bodied, and well-off financially.\textsuperscript{12}

Daniel Shapiro (2007), who endorses a predominately private market-based approach to health insurance and health care, agrees that the state must play a substantial role in subsidizing health insurance for the poor and needy if a just health care system is to be achieved. He nonetheless argues that the government ought to subsidize only catastrophic health insurance but not comprehensive insurance for everyday health needs and preventive care. Acknowledging that his plan will effectively bar the poor (and many children, individuals with disabilities and chronic illnesses, and elderly persons) from having access to everyday medical care, he suggests that the government \textit{might} provide the poor with medical savings accounts to pay for their everyday medical expenses (2007, 101-2). Unless these mandatory state-subsidized medical insurance accounts are very generous, however – which does not seem to be Shapiro’s intention – the poor (and others with limited resources) will be discouraged from utilizing medical care when necessary (Rice and Unruh 2009, chapter 4). Many working class and middle class individuals, who will have to pay for routine medical expenses through their own privately-funded medical savings accounts, are also likely to skimp on medical care. Shapiro’s plan therefore creates a health care system that discourages many individuals from utilizing health care even for effective or necessary care. Insofar as one of the main goods that health care can

\textsuperscript{12} Rice and Unruh (2009) further outline in great detail the numerous problems with a private, market-based approach to health care.
provide to individuals is everyday care, this seems a misguided proposal. Our moral obligation to others, at least under care ethics, is not just to provide access to life-saving and emergency medical services, but also to provide access to a fairly comprehensive package of medical services: diagnostic visits to general practitioners and specialists; medical tests; in-patient and out-patient medical procedures; hospitalization; preventive care and screenings; maternity care; prescription drugs; medical aids and devices; physical and occupational therapy; mental health care; and some dental care. Shapiro’s proposal at best guarantees individuals access to catastrophic services and protection against financial hardship from catastrophic health problems.

The above arguments suggest that the state ought to subsidize comprehensive health insurance at least for children, the poor, the chronically ill, individuals with disabilities, elderly persons, and others who are not likely to be able to afford health insurance or necessary health services on the open market. Since all Western industrialized states provide some subsidies for most of these groups, however, this conclusion does not carry us very far toward an institutional theory of a just (or caring) health care system. Even the highly privatized and market-oriented health care system in the United States offers state-subsidized insurance for the elderly (Medicare), poor (Medicaid), and low-income children (SCHIP). In order to identify the basic institutions of a just health care system, it is therefore necessary to further specify the main characteristics and goals of a just (or caring) health care system. Care ethics identifies seven such goals: good health outcomes; effective treatment of everyday illnesses; preventive care; ready access to a doctor or nurse; high patient confidence and choice; equitable health services; and

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13 Most European states offer coverage of all or most of these services.
efficient and reasonable costs. A health care system can be considered more or less just (or caring) to the extent that it realizes these goals.

Like other theories of health justice, care ethics identifies good health outcomes as one important goal of a health care system. Caring means curing illnesses, repairing injuries, and saving lives whenever reasonably possible. In light of the social determinants of health literature, however, one must be sensible about what a health care system can be reasonably expected to achieve. Many of the measures that have traditionally been used to measure the quality of health care systems (e.g., average life expectancy) are influenced far more by the social determinants of health than they are by the quality of a country’s health care system. Taking these considerations into account, Nolte, McKee, and colleagues have developed a better measure of health system effectiveness: mortality amendable to medical care (Nolte and McKee 2004; 2011; Nolte, Bain, and McKee 2009). This measure counts the number of deaths each year in a country from conditions that an effective health care system should be able to prevent (e.g., appendicitis, diabetes, asthma).14 Other more particular measures of health care effectiveness, such as neonatal mortality rates, the 30-day survival rate of individuals admitted to hospitals with heart attacks or strokes, and the 5-year survival rates for individuals with common types of cancer, provide further evidence of the efficacy of different health care systems in those particular areas where they have the greatest impact on life and health.15

Just as important as a medical system’s ability to cure major diseases from the perspective of care ethics is its ability to provide individuals with effective everyday care.

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14 As Nolte and McKee admit, mortality amendable to medical care is far from perfect as a measure of health care effectiveness (Nolte and McKee 2004, 42-52). It does not adequately control for the role of the social determinants of health in generating diseases, for example, and consequently understates the effectiveness of medical care in states with poor population health and overstates it in states with relatively good population health.
15 There measures are mentioned because coronary artery disease and strokes are leading causes of death in most industrialized countries. Lung, breast, and colorectal cancers are the most commonly diagnosed cancers worldwide.
Everyday care may include such activities as diagnosing illnesses or injuries, dispensing antibiotics and other medications, prescribing pain killers and physical therapies, and helping individuals to manage their chronic illnesses. This last set of activities provides perhaps the clearest indicator of the effectiveness of different health care systems in providing everyday care to individuals in need. Chronic conditions such as asthma, chronic obstructive pulmonary disease (chronic bronchitis, emphysema), and diabetes are all manageable through proper primary care interventions. High hospital admission rates for these conditions indicate a failure on the part of a health care system to provide accessible and effective routine care for people.

Another important goal of a caring health care system is delivering effective preventive health care services. Preventive health care, including immunizations for children, flu vaccines for the elderly, and screenings for common and curable types of cancers, is a key component of care. Much of the care that individuals provide for one another is intended (at least implicitly) to help them to avoid injury, illness, pain, and suffering. A caregiver who does nothing to prevent his or her partner or child from becoming sick or suffering an injury (particularly when effective prevention is available) but then lavishes care on them once they become sick or injured must be considered a lesser caregiver than one who prevents the illness or injury in the first place.

As noted above, interpersonal values such as attentiveness, responsiveness, and respect are also very important in measuring the morality of a health care system from the perspective of care ethics. Probably the most important indicator of a medical system’s attentiveness, responsiveness, and respect is patient access. In order for health systems to attend and respond to the needs of individuals, they must be easily accessible to them. As Powers and Faden emphasize, access to medical care is also an important sign of respect. Individuals who lack ready access to important health care services “experience an increased degree of vulnerability to
harm, additional stress, and feelings of powerlessness and social disrespect” (Powers and Faden 2006, 139).

A medical system’s accessibility can be measured in a number of different ways. The percent of the population with access to comprehensive health coverage (private or public) represents one broad measure of access to medical services since uninsured individuals tend to forego medical care more frequently than insured individuals (Powers and Faden 2006, 136; Ruger 2010, 152). Access can also be measured in terms of personal costs and waiting times. High out-of-pocket expenses (high deductibles, co-pays, or other forms of cost sharing) tend to have a significant negative effect on health care utilization, especially among lower income individuals (Rice and Unruh 2009, 57-119, 361-3). Long-waiting times likewise represent an important limit on access. The value of universal health insurance coverage and low cost-sharing for individuals may be severely mitigated if they have to wait a week or more to see a doctor or nurse for routine illnesses or months for many medical procedures. The most caring health care systems will provide quick and easy access to medical services for all individuals at relatively low personal cost, thereby manifesting a high level of attentiveness, responsiveness, and respect at a system or institutional level.

A medical system’s responsiveness may also be measured in a number of more particular ways. The percentage of patients who feel confident that they will receive the most effective if they are injured or sick provides a fair straightforward indicator of the level to which individuals believe a health care system will effectively respond to their needs. The ability of individuals to see a specialist directly without a referral is also an important because it shows that individuals can dictate in part the type of medical care they receive.
Equity represents an important indicator of the respectfulness of a health care system - and to a certain extent also its attentiveness and responsiveness. Equity is achieved when individuals receive the same, high quality medical treatment and access regardless of income or other personal characteristics. One broad measure of equity is the percentage of total health care expenditures that come from private insurance or out-of-pocket expenses. Countries that rely heavily on private insurance and out-of-pocket costs tend to provide more inequitable care than countries that rely more heavily on public funding (Rice and Unruh 2009, 358). Equity can also be measured more directly by the different experiences of above-average and below-average individuals with the medical system – for example, whether below-average income individuals have to wait longer to see a specialist than above-average income individuals. Measures of raw equity nonetheless must be tempered by performance outcomes. Although one medical system may be perfectly equitable in terms of outcomes – say, the percentage of patients who have to wait two months or longer to see a specialist - the value of this equity is greatly diminished if both rich and poor have to wait inordinately long times. The most attentive and respectful health care systems will be those with high equity between rich and poor individuals and low percentages of individuals who receive poor quality care.

A final important measure of a caring health system is cost and efficiency. While care ethics is primarily concerned with the care that a medical system provides to individuals, it nonetheless recognizes that public resources are always limited and any resources devoted to health care will not be available for other important public services, such as family policies, education, and elder and disability support. Just how much a country should spend on health care is nonetheless difficult to say. A country can obviously spend too little on health care with the result that the quality of care suffers, or too much with the result that other domains of care
(including the right of individuals to use their resources for their own care) are unjustifiably limited. Low administrative costs may also be considered desirable, since they indicate that most health expenditures are going directly to care-related activities. As with total health care costs, however, lower administrative costs are not always absolutely better. Since good administration is necessary to manage a health care system effectively, very low administrative costs can sometimes mean worse health care services (Emanuel 2008, 158-162). Care ethics therefore does not identify low medical and administrative costs as an absolute or independent goal for health care systems, but it does suggest that attention should be given to these matters and that costs should be kept within reasonable limits.

A Caring Health System in Comparative Perspective

Over the past decade, the OECD, Commonwealth Fund, and other organizations have collected extensive data on the health care systems of industrialized countries. While these organizations have not for the most part used this data to assess the justice of different health care systems, they have used them to assess the “quality” of different systems. Building on the normative framework outlined above, I go further here by exploring whether any general type of health care system (national health system, social insurance system, private insurance system) consistently performs best in achieving the goals of a just (or caring) health care system.

The comparison below focuses on eleven Western industrialized countries: Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. These countries were selected in part on the basis of

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16 The OECD primarily collects data on various outcomes but generally does not engage in normative analyses. The Commonwealth Fund periodically produces cross-national comparisons of the performance of a number of national health care systems. Yet, the normative underpinnings of their categories and measures are not very fully explained or justified (See for example Davis, Schoen, and Stremikis 2010).
data availability and in part because they represent examples of three most common ways of organizing health care systems in the industrialized world: national health insurance, social insurance, and private insurance with medicare.

Under the national health insurance model, the state provides universal health coverage to all citizens funded out of general tax funds. In most cases, the state also owns and manages a large percentage of hospitals and clinics. The social insurance model provides universal or near universal health insurance coverage to individuals by mandating that all individuals purchase or be provided with health insurance through private and non-profit insurance funds. Costs are usually paid through a combination of employer and individual contributions, and a large percentage of health care providers are usually private. In the private insurance/medicare model, individuals are generally responsible for purchasing their own health insurance from the market or securing it through their employers (or at least strongly encouraged to do so). The state nonetheless usually provides public insurance coverage for vulnerable groups such as the elderly and poor and sometimes to all individuals who do not have private insurance. The countries included in this comparison may be categorized into these three models as follows:¹⁷

**National Health Insurance Model:** Canada, New Zealand, Norway, Sweden, the United Kingdom.

**Social Insurance Model:** France, Germany, the Netherlands, Switzerland

**Private Insurance/Medicare Model:** Australia, the United States.

¹⁷ The typology below and subsequent descriptions of the different health care systems are drawn from the following sources: Amelung, Glied, and Topan 2003; Blank and Burau 2007; Cheng 2010; Enthoven and Wynand 2007; Rodwin 2006; Thomson et al. 2011.
While the above typology provides a decent general description of the health care systems of these different countries, a number of finer points should be noted. Canada stands apart from other countries using the national health insurance model by relying almost entirely on private hospitals and medical clinics to provide medical services to individuals. While all Canadians are thus insured under a common public plan, they receive medical attention primarily from private providers. In Canada, the United Kingdom, and New Zealand, a significant percentage of individuals further have private insurance that entitles them to extra benefits and (in the latter two countries) quicker access to specialists and elective surgery.

The social insurance countries, in turn, have all introduced reforms in recent years (largely in response to the changing labor market) that have decoupled insurance from paid employment and transformed their traditional employment-based social insurance schemes into systems of managed care or managed competition. In the Netherlands and Switzerland, for example, individuals are now required to purchase private health insurance from one of several competing private insurance groups. The state defines a standard benefit package that insurers must offer, requires insurers to accept all applicants, and provides lower- and middle-income individuals with subsidies to help pay for their insurance coverage. In order to avoid penalizing insurers for insuring high-risk individuals, both countries operate risk equalization funds that compensate insurers for the number of high-risk individuals in their plans. The result in both countries is a publicly-subsidized health care system administered by private insurers who

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18 Amelung, Glied, and Topan (2003) argue that changes to the German health care system were driven in large part by changes in the nature of work and the labor market in Germany. Their analysis is equally well explains some of the pressures that have motivated reforms of the Dutch, French, and Swiss systems. I define managed care loosely here to refer to states that rely upon private and non-profit organizations to provide insurance to individuals, but closely regulate these organizations and subject them to numerous requirements. All these states further include important elements of market competition in their systems. Germany, the Netherlands, and Switzerland encourage competition between insurance funds, and France encourages competition between private insurers and also between providers.
compete in a highly-regulated competitive market to attract customers primarily by offering better services, better care, and lower premiums.

The French health care system has been described as a system of “state-led managed care” (Rodwin 2006). In France, nearly everyone is automatically enrolled in one of the major employment-based insurance funds based on their occupational status. The French state regulates these insurance funds and (as distinct from the Netherlands and Switzerland) directly negotiates with doctors and hospitals to set reimbursement fees. Since state-mandated reimbursement rates cover only a portion of health costs in France – usually between 70 and 80 percent of most services and procedures (with exceptions for the poor and chronically ill) - most French residents (93-94 percent) further carry complementary private insurance to help offset the medical costs not covered by public insurance. Private insurance is provided by some employers or purchased independently by individuals on the competitive market, with the state providing subsidies to low-income individuals to defray private insurance costs.

Germany remains the most traditional of the social insurance states, continuing to organize health insurance around multiple self-governing sickness funds administered primarily by representatives of labor unions and businesses. Since the 1990s, however, individuals have been able to choose freely between the various health insurance funds in Germany. The funds, which are required to accept all applicants, compete for customers based on their benefits and services but not premium levels (which are set by the government). While nearly all Germans receive insurance coverage through the mandatory insurance scheme, high-income individuals have the option of opting out of the public program for alternative private coverage. Roughly ten percent of the German population is thus covered by private insurance.

19 All contributions to funds are centrally pooled by a central reallocation body which allocates resources to each sickness fund based on a risk-adjusted capitation formula including age, sex, and morbidity tables.
The two representatives of the private insurance model, Australia and the United States, further approach health care funding in very different ways. Australia offers national public health insurance – Medicare – to all citizens and permanent residents, but strongly encourages individuals to purchase private insurance by offering tax breaks and rebates. About 50 percent of the population in Australia has private insurance. The United States, by contrast, offers tax incentives for employers to provide private health insurance to employees, and offers public plans for the poor, elderly, and low-income children. Roughly 56 percent of the population in the U.S. has private insurance, 27 percent is covered by Medicare, Medicaid, and other public programs, and another 16 percent is uninsured.

These eleven countries may be ranked on each of the measures of care discussed above with the exception of costs and efficiency, which do not lend themselves well to linear rankings. For each of the measures, I have selected the most important and relevant indicators of good care from among the available data. While I would have liked to include some other measures such as data on mental health care, good comparable data was not available for many countries. Since my main interest is on institutional organization, I have further chosen measures that appear most likely to be impacted by different institutional arrangements. The degree to which patients find their doctors to be friendly or open to answering questions may be important, for example, but would seem to have little direct relation to institutional organization.

I have used a simple ranking system for each measure of care (listing the countries from first to last), and have compiled an overall ranking by adding together the rankings from each measure for each country. In cases where countries are missing data, I have ranked them in

\[20\] Measures of long-term care services (nursing homes, home health care) are set aside for another study.
relation to other countries solely on the basis of the available variables. All rankings for countries with missing data are indicated by an asterisk (*) next to the final ranking. If a country with missing data ranked first, I also ranked in first place the highest scoring country with complete data.

Although a more sophisticated ranking system could have been utilized, the simple ranking system that I have used has the advantage of transparency. Moreover, it suits my purposes. My goal here is not to crown one country as the most caring medical system, but instead to determine whether one type of health care system – the national insurance model, the social insurance/managed care model, or the private insurance model – generally performs best in promoting good care across countries. In short, I am looking for clusters and trends in the rankings rather than fine-tuned distinctions.

Table 1 provides the rankings for health outcomes based on six separate measures. In calculating the final rankings for this measure (listed in the last column), I have weighted the amenable mortality rate heaviest (50 percent), and each of the more particular measures of medical outcomes at 10 percent each. Neonatal mortality (infant deaths in the first 28 days after birth) is included rather than infant mortality (deaths during the first year) because the former is greatly affected by the quality of medical care while the latter depends more on social factors (Nolte, Bain, and McKee 2009, 33). Based on limited data, France receives a number one ranking on this measure because of its low amenable mortality and neonatal mortality rates. Norway scores best among countries with complete data. The United Kingdom scores uniformly low marks on all outcomes, earning the lowest overall ranking for this measure. The United States, which finishes second to last, actually does quite well on the last four measures, all of

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21 In tables where several countries were missing data and it was possible to compare a country only against five or six others, I further lowered these countries by one or two spots, since otherwise their rankings would be inflated (e.g., if they are compared against only six other countries, they could finish no worse than sixth).
which largely reflect areas of intense medical care. Its tenth place ranking is due primarily to its poor scores in the areas of amenable mortality and neonatal mortality.

### TABLE 1: HEALTH OUTCOMES

<table>
<thead>
<tr>
<th></th>
<th>Amenable Mortality (per 100,000) 2006-2007</th>
<th>Neonatal Mortality (per 1,000 live births) 2007-2009</th>
<th>Case Fatality Rates within 30 days after admission for Acute Myocardial Infarction (per 100 patients) 2009</th>
<th>Case Fatality Rates within 30 days after Admission for Ischemic Stroke (per 100 patients) 2009</th>
<th>Breast Cancer Five-Year Survival Rate (per 100 diagnosed cases) 2004-2009</th>
<th>Colorectal Cancer Five-Year Survival Rate (per 100 diagnosed cases) 2004-2009</th>
<th>RANK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>56.92 (2)</td>
<td>3 (7)</td>
<td>3.2 (3)</td>
<td>5.7 (7)</td>
<td>------</td>
<td>------</td>
<td>4*</td>
</tr>
<tr>
<td>Canada</td>
<td>------</td>
<td>3.8 (10)</td>
<td>3.8 (5)</td>
<td>6.3 (9)</td>
<td>86.6 (2)</td>
<td>63.4 (2)</td>
<td>6*</td>
</tr>
<tr>
<td>France</td>
<td>55.00 (1)</td>
<td>2.6 (4)</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>1*</td>
</tr>
<tr>
<td>Germany</td>
<td>76.42 (6)</td>
<td>2.3 (3)</td>
<td>6.8 (10)</td>
<td>4.0 (4)</td>
<td>83.3 (7)</td>
<td>60.4 (7)</td>
<td>9</td>
</tr>
<tr>
<td>Netherlands</td>
<td>65.55 (5)</td>
<td>2.8 (6)</td>
<td>5.3 (9)</td>
<td>5.7 (7)</td>
<td>84.4 (6)</td>
<td>61.0 (5)</td>
<td>7</td>
</tr>
<tr>
<td>New Zealand</td>
<td>78.64 (7)</td>
<td>2.6 (4)</td>
<td>3.2 (3)</td>
<td>5.4 (6)</td>
<td>84.5 (5)</td>
<td>62.1 (4)</td>
<td>5</td>
</tr>
<tr>
<td>Norway</td>
<td>63.63 (4)</td>
<td>1.8 (2)</td>
<td>2.5 (1)</td>
<td>2.8 (1)</td>
<td>86.5 (3)</td>
<td>63.1 (3)</td>
<td>1</td>
</tr>
<tr>
<td>Sweden</td>
<td>61.25 (3)</td>
<td>1.6 (1)</td>
<td>2.9 (2)</td>
<td>3.9 (3)</td>
<td>86 (4)</td>
<td>60.7 (6)</td>
<td>3</td>
</tr>
<tr>
<td>Switzerland</td>
<td>------</td>
<td>3.5 (9)</td>
<td>4.5 (7)</td>
<td>4.3 (5)</td>
<td>------</td>
<td>------</td>
<td>8*</td>
</tr>
<tr>
<td>UK</td>
<td>82.54 (8)</td>
<td>3.2 (8)</td>
<td>5.2 (8)</td>
<td>6.7 (10)</td>
<td>81.3 (8)</td>
<td>53.3 (8)</td>
<td>11</td>
</tr>
<tr>
<td>USA</td>
<td>95.54 (9)</td>
<td>4.3 (11)</td>
<td>4.3 (6)</td>
<td>3.0 (2)</td>
<td>89.3 (1)</td>
<td>64.5 (1)</td>
<td>10</td>
</tr>
</tbody>
</table>

Data on amenable mortality is taken from Nolte and McKee 2011. Neonatal mortality data is taken from OECD Stat Extracts, “Health,” 2012. All the other data is taken from OECD, Health at a Glance (2011). For case fatality rates for acute myocardial infaction and ischemic stroke, rates are standardized for the age and sex composition of countries. For breast and colorectal cancer survival rates, rates are standardized for the age composition of countries.

As argued above, medical care is about more than just curing patients. Much of the value of medical care actually comes from the everyday continuous care it provides to individuals – whether for minor colds and flues or lifelong chronic conditions. Table 2 provides the rankings of health care systems based on their success in managing three common chronic conditions: asthma, chronic obstructive pulmonary disease (chronic bronchitis, emphysema), and diabetes.

Each variable is treated equally in the final rankings. Canada, Sweden, and Switzerland all receive uniformly high marks on these measures of on-going care, while the United States,
Australia, and New Zealand all receive uniformly low rankings. New Zealand’s low ranking on this measure is notable since other national health systems do relatively well in treating chronic conditions.

**TABLE 2: EFFECTIVE TREATMENT OF CHRONIC CONDITIONS**

|                      | Asthma Hospital Admission Rates, population aged 15 and over, (per 100,000) 2009 | Chronic Obstructive Pulmonary Disease Hospital Admission Rates, population aged 15 and over (per 100,000) 2009 | Uncontrolled Diabetes Long-term Complications Hospital Admission Rates, population aged 15 and over (per 100,000) 2009 | RANK
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>66.6 (8)</td>
<td>311.7 (10)</td>
<td>198.87 (10)</td>
<td>10</td>
</tr>
<tr>
<td>Canada</td>
<td>15.7 (1)</td>
<td>183.3 (5)</td>
<td>45.22 (4)</td>
<td>1</td>
</tr>
<tr>
<td>France</td>
<td>43.4 (6)</td>
<td>79.1 (1)</td>
<td>-------</td>
<td>4*</td>
</tr>
<tr>
<td>Germany</td>
<td>20.8 (3)</td>
<td>200.6 (6)</td>
<td>145.45 (9)</td>
<td>7</td>
</tr>
<tr>
<td>Netherlands</td>
<td>27.5 (4)</td>
<td>154.4 (4)</td>
<td>50.8 (6)</td>
<td>5</td>
</tr>
<tr>
<td>New Zealand</td>
<td>80.7 (10)</td>
<td>319.5 (11)</td>
<td>135.74 (8)</td>
<td>11</td>
</tr>
<tr>
<td>Norway</td>
<td>47.6 (7)</td>
<td>243 (9)</td>
<td>33.14 (2)</td>
<td>7</td>
</tr>
<tr>
<td>Sweden</td>
<td>19.3 (2)</td>
<td>137.5 (3)</td>
<td>48.45 (5)</td>
<td>1</td>
</tr>
<tr>
<td>Switzerland</td>
<td>30.9 (5)</td>
<td>91.5 (2)</td>
<td>34.91 (3)</td>
<td>1</td>
</tr>
<tr>
<td>UK</td>
<td>73.7 (9)</td>
<td>213.4 (7)</td>
<td>18.56 (1)</td>
<td>6</td>
</tr>
<tr>
<td>USA</td>
<td>120.6 (11)</td>
<td>229.8 (8)</td>
<td>118.35 (7)</td>
<td>9</td>
</tr>
</tbody>
</table>

Table 3 provides the rankings of countries in four types of preventive health services: vaccinations for children, flu vaccinations for the elderly, and cervical cancer and mammography screenings. Each is weighted equally in the final rankings. France and the Netherlands score at the top of the rankings with fairly high scores for both vaccinations and screenings. New Zealand and Australia come out at the bottom. The United States interestingly scores very well on screenings but below average on vaccinations, placing it in the middle of countries overall on preventive health services.

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24 France ties for third with Switzerland based on the available data. But since Canada and Sweden (which both score above France on the available data) and Switzerland all tie for first in the general rankings, I have ranked France 4th.
**TABLE 3: PREVENTIVE HEALTH CARE SERVICES**

<table>
<thead>
<tr>
<th>Country</th>
<th>Vaccination Rates for Pertussis and Measles (average), Children aged 2, (percent) 2009 (or nearest year)</th>
<th>Influenza Vaccination Coverage, Population Aged 65 and older, (percent) 2009 (or nearest year)</th>
<th>Cervical Cancer Screening, Percentage of Women Screened aged 20-69, 2009 (or nearest year)</th>
<th>Mammography Screening, Percentage of Women Aged 50-69 Screened, 2009 (or nearest year)</th>
<th>RANK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>92.85 (7)</td>
<td>74.6 (2)</td>
<td>61.2 (9)</td>
<td>54.9 (8)</td>
<td>7</td>
</tr>
<tr>
<td>Canada</td>
<td>92.7 (8)</td>
<td>66.5 (6)</td>
<td>75.3 (6)</td>
<td>72.5 (6)</td>
<td>7</td>
</tr>
<tr>
<td>France</td>
<td>94.5 (4)</td>
<td>71 (4)</td>
<td>72.4 (7)</td>
<td>76.7 (3)</td>
<td>4</td>
</tr>
<tr>
<td>Germany</td>
<td>96.35 (2)</td>
<td>61.1 (9)</td>
<td>------</td>
<td>53.6 (9)</td>
<td>9*</td>
</tr>
<tr>
<td>Netherlands</td>
<td>95.7 (3)</td>
<td>77 (1)</td>
<td>66.1 (8)</td>
<td>82.1 (1)</td>
<td>1</td>
</tr>
<tr>
<td>New Zealand</td>
<td>90.5 (10)</td>
<td>66.4 (7)</td>
<td>77.4 (5)</td>
<td>66.9 (7)</td>
<td>11</td>
</tr>
<tr>
<td>Norway</td>
<td>93.5 (5)</td>
<td>------</td>
<td>78.5 (3)</td>
<td>74.1 (4)</td>
<td>2*</td>
</tr>
<tr>
<td>Sweden</td>
<td>97.35 (1)</td>
<td>64 (8)</td>
<td>78.4 (4)</td>
<td>------</td>
<td>3*</td>
</tr>
<tr>
<td>Switzerland</td>
<td>93 (6)</td>
<td>56 (10)</td>
<td>------</td>
<td>------</td>
<td>10*</td>
</tr>
<tr>
<td>UK</td>
<td>91 (9)</td>
<td>73.3 (3)</td>
<td>78.7 (2)</td>
<td>74 (5)</td>
<td>5</td>
</tr>
<tr>
<td>USA</td>
<td>86.95 (11)</td>
<td>66.7 (5)</td>
<td>85.9 (1)</td>
<td>81.1 (2)</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 4 gauges the access of different health care systems by looking at coverage, financial access, and waiting times. All variables are weighted equally in the final ranking. The bracketed rankings in the final column indicate the ranking for waiting times only. Nearly all countries cover 100 percent of their population, and thus tie for first in the ranking of coverage. I have assigned the Netherlands a rank of 5 because its health care system tends to leave about 1-2 percent of the population without coverage at any time. The United States receives a bottom ranking on this variable because of the very large number of uninsured and underinsured individuals. In terms of financial access, the national health systems perform on average pretty well, while in terms of waiting times, these systems tend to do relatively poorly. The social insurance states, by contrast, do relatively well on both measures, while the private insurance...
states of Australia and the United States somewhat predictably do very poorly on cost access but better on waiting times. Overall, the United Kingdom ranks highest on overall access, followed by the social insurance states which hold four of the following five positions in the rankings.

Table 4: ACCESS

<table>
<thead>
<tr>
<th></th>
<th>Health Insurance Coverage for a Core Set of Services (percent of total population) 2009</th>
<th>Did not fill a prescription or skipped doses; had a medical problem but did not visit a doctor; or skipped a test, treatment, or follow-up in the past year due to costs (percent) 2010</th>
<th>Out of pocket medical expenses more than $1000 in the past year, US$ equivalent, (percent of total population), 2010</th>
<th>Patient had same-day or next-day access to a doctor or nurse when sick or needed care (percent of total population), 2010</th>
<th>Patient had to wait two months or more to see a specialist (percent) 2010</th>
<th>Patient had to wait four months or more for elective/non-emergency surgery (percent) 2010</th>
<th>RANK (The first figure is the overall rank. The second figure is the rank for waiting times only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>100 (1)</td>
<td>22 (9)</td>
<td>21 (9)</td>
<td>65 (6)</td>
<td>28 (7)</td>
<td>18 (7)</td>
<td>8 [8]</td>
</tr>
<tr>
<td>Canada</td>
<td>100 (1)</td>
<td>15 (8)</td>
<td>12 (7)</td>
<td>45 (10)</td>
<td>41 (11)</td>
<td>25 (11)</td>
<td>11 [11]</td>
</tr>
<tr>
<td>France</td>
<td>99.9 (2)</td>
<td>13 (6)</td>
<td>4 (3)</td>
<td>62 (7)</td>
<td>28 (7)</td>
<td>7 (3)</td>
<td>6 [6]</td>
</tr>
<tr>
<td>Germany</td>
<td>100 (1)</td>
<td>25 (10)</td>
<td>8 (5)</td>
<td>66 (5)</td>
<td>7 (2)</td>
<td>0 (1)</td>
<td>4 [2]</td>
</tr>
<tr>
<td>Netherlands</td>
<td>98.8 (5)</td>
<td>6 (2)</td>
<td>9 (6)</td>
<td>72 (3)</td>
<td>16 (4)</td>
<td>5 (2)</td>
<td>3 [3]</td>
</tr>
<tr>
<td>New Zealand</td>
<td>100 (1)</td>
<td>14 (7)</td>
<td>7 (4)</td>
<td>78 (2)</td>
<td>22 (6)</td>
<td>8 (6)</td>
<td>5 [4]</td>
</tr>
<tr>
<td>Norway</td>
<td>100 (1)</td>
<td>11 (5)</td>
<td>16 (8)</td>
<td>45 (10)</td>
<td>34 (10)</td>
<td>21 (8)</td>
<td>9 [10]</td>
</tr>
<tr>
<td>Sweden</td>
<td>100 (1)</td>
<td>10 (3)</td>
<td>2 (2)</td>
<td>57 (8)</td>
<td>31 (9)</td>
<td>22 (10)</td>
<td>7 [9]</td>
</tr>
<tr>
<td>Switzerland</td>
<td>100 (1)</td>
<td>10 (3)</td>
<td>25 (10)</td>
<td>93 (1)</td>
<td>5 (1)</td>
<td>7 (3)</td>
<td>1 [1]</td>
</tr>
<tr>
<td>UK</td>
<td>100 (1)</td>
<td>5 (1)</td>
<td>1 (1)</td>
<td>70 (4)</td>
<td>19 (5)</td>
<td>21 (8)</td>
<td>2 [6]</td>
</tr>
<tr>
<td>USA</td>
<td>81.3 (11)</td>
<td>33 (11)</td>
<td>35 (11)</td>
<td>57 (8)</td>
<td>9 (3)</td>
<td>7 (3)</td>
<td>10 [4]</td>
</tr>
</tbody>
</table>

A medical system’s responsiveness to patients is measured here by patients’ confidence that they will receive the most effective treatment if they become sick and the extent to which they can determine their own care by choosing their own doctors and directly accessing specialists. The final rankings are achieved by adding the rankings from the first column with the square root of the measure in the second column. In terms of responsiveness, the social insurance

Data on health insurance coverage is taken from OECD, Health at a Glance (2011). All other data is drawn from Schoen et al. (2010).
states clearly come out on top – occupying the four top ranks. The national health and private insurance systems fill the remaining spots, with the private insurance systems performing on average slightly better than the national insurance states. Particularly notable is Sweden’s bottom ranking. The low percentage of Swedes who have confidence in their medical system is unusual given their general trust in government institutions and the generally high rankings that the Swedish medical system receives in the areas of health outcomes and effective treatments. One explanation might be that this relatively low figure reflects many Swedes’ dissatisfaction with the relatively long waiting times and restrictive choices available to them in their health care system.

Table 5: PATIENT CONFIDENCE AND CHOICE

<table>
<thead>
<tr>
<th>Country</th>
<th>Patients who are confident that they will receive the most effective treatment if they become sick (percent of total population) 2010</th>
<th>Extent of Patient Choice/Patients Have Direct Access to Specialists (1=High; 2=Medium; 3=Low) 2009</th>
<th>RANK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>76 (7)</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Canada</td>
<td>76 (7)</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>France</td>
<td>85 (4)</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Germany</td>
<td>82 (6)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Netherlands</td>
<td>88 (3)</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>New Zealand</td>
<td>84 (5)</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Norway</td>
<td>70 (9)</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Sweden</td>
<td>67(11)</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Switzerland</td>
<td>89 (2)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>UK</td>
<td>92 (1)</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>USA</td>
<td>70 (9)</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 6 provides the rankings of health systems in terms of equity. Equity is measured by the percentage of total health care expenditures from private insurance and out-of-pocket

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expenses (lower here means more equitable) and differences in treatment of below-average and above-average income patients. In calculating equity rankings, I have also taken into account the level of good care provided to below-average income individuals. In each of the last four columns, I have ranked the countries both in terms of the gap between below- and above-average patients and the percent of below-average patients reporting good care, and then averaged these two figures to achieve a ranking for each variable. The reason for doing this is because equity means very little if rich and poor have to share equally in poor care. In the percentage of patients who waited two months or longer for a special appointment, for example, Norway achieves perfect equity between rich and poor. Thirty-five percent of both groups have to wait two months or longer to see a specialist. While it ranks high in terms of pure equity (3rd) on this measure, it ranks poorly on the level of care provided to those with below-average incomes (10th). Thus, its overall rank for this measure is 6th.

The United Kingdom ranks first overall on equity, followed by all four of the social insurance states: Switzerland, the Netherlands, France, and Germany. Both the private insurance states, Australia and the United States, fall (not surprisingly) toward the bottom of the rankings. Somewhat surprisingly, aside from the United Kingdom, all the national insurance states rank in the middle or below average on equity. Although these countries do tend to treat above- and below-average patients more or less the same, their equity scores are marred by the fact that in many cases they provide both rich and poor with poor services.
Table 6: EQUITY

<table>
<thead>
<tr>
<th>Australia</th>
<th>Canada</th>
<th>France</th>
<th>Germany</th>
<th>New Zealand</th>
<th>Norway</th>
<th>Sweden</th>
<th>Switzerland</th>
<th>UK</th>
<th>USA</th>
<th>RANK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of Total Health Care Expenditures from Private Insurance or Out-of-Pocket 2009 (or nearest year)</td>
<td>Patients who are Confident They Will Receive the Most-Effective Treatment if Sick (percent of above-average income patients/per cent of below-average income patients) 2010</td>
<td>Patients who Rated Their Doctor Fair/Poor (percent of above-average income patients/per cent of below-average income patients) 2007</td>
<td>Patients who did not fill or skipped a prescription; did not visit a doctor with a medical problem, and/or did not get recommended care due to costs in the past year (percent of above-average income patients/per cent of below-average income patients) 2010</td>
<td>Patients who waited two months or longer for a specialist appointment (percent of above-average income patients/per cent of below-average income patients) 2010</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26.3 (8)</td>
<td>27.3 (9)</td>
<td>20.6 (6)</td>
<td>22.4 (7)</td>
<td>11.7 (2)</td>
<td>18.2 (5)</td>
<td>15.1 (3)</td>
<td>16.7 (4)</td>
<td>11.6 (1)</td>
<td>45.1 (11)</td>
<td></td>
</tr>
<tr>
<td>79/73 (6)</td>
<td>80/71 (8)</td>
<td>88/85 (2)</td>
<td>82/78 (4)</td>
<td>88/81 (5)</td>
<td>87/78 (6)</td>
<td>72/63 (9)</td>
<td>70/58 (10)</td>
<td>95/92 (1)</td>
<td>82/65 (11)</td>
<td></td>
</tr>
<tr>
<td>4/9 (3)</td>
<td>5/10 (6)</td>
<td>--------</td>
<td>3/6 (2)</td>
<td>4/9 (3)</td>
<td>3/3 (1)</td>
<td>--------</td>
<td>5/14 (3)</td>
<td>7/10 (3)</td>
<td>4/13 (7)</td>
<td></td>
</tr>
<tr>
<td>12/22 (7)</td>
<td>6/18 (8)</td>
<td>8/17 (6)</td>
<td>17/27 (8)</td>
<td>3/13 (5)</td>
<td>8/15 (3)</td>
<td>4/21 (10)</td>
<td>32/31 (4)</td>
<td>7/3 (1)</td>
<td>20/39 (11)</td>
<td></td>
</tr>
<tr>
<td>26/31 (8)</td>
<td>40/45 (11)</td>
<td>29/30 (5)</td>
<td>8/9 (2)</td>
<td>15/24 (6)</td>
<td>14/26 (9)</td>
<td>35/35 (6)</td>
<td>32/31 (4)</td>
<td>18/28 (9)</td>
<td>7/10 (3)</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>10</td>
<td>4*</td>
<td>5</td>
<td>3</td>
<td>6</td>
<td>3</td>
<td>7*</td>
<td>1</td>
<td>11</td>
<td></td>
</tr>
</tbody>
</table>

Table 7 provides data on costs and the efficiency of different health care systems, as well as a ranking based on total health care expenditures per capita and administrative expenditures (each equally weighted). These rankings are not included in the overall rankings of health systems because, as noted above, very low spending on a health system and administration is not always desirable. It is nonetheless fairly clear from Table 7 that the United States, which spends roughly 50 percent more per capita on health care than the next closest country, is spending too much for the care it receives.

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28 Data on the percent of health expenditures from private insurance or out-of-pocket are taken from OECD, Health at a Glance (2011). Data on patients who rate their doctor fair/poor are taken from Davis, Schoen, and Stremikis (2010). All other data are taken from Schoen et al. (2010).
Table 7: COSTS/EFFICIENCY

<table>
<thead>
<tr>
<th>RANK</th>
<th>Country</th>
<th>Total Health Expenditure as a Percentage of GDP, Public and Private, 2009 (or nearest year)</th>
<th>Total Health Care Expenditure Per Capita, Public and Private, 2009 (or nearest year) in US$ equivalent</th>
<th>Percent of health care expenditure allocated to health care administration, 2009 (or nearest year)</th>
<th>RANK</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Australia</td>
<td>8.7</td>
<td>3445 (2)</td>
<td>3.6 (3)</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Canada</td>
<td>11.4</td>
<td>4363 (7)</td>
<td>3.7 (4)</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>France</td>
<td>11.8</td>
<td>3978 (5)</td>
<td>7 (8)</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Germany</td>
<td>11.6</td>
<td>4218 (6)</td>
<td>5.4 (7)</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Netherlands</td>
<td>12</td>
<td>4914 (8)</td>
<td>4 (5)</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>New Zealand</td>
<td>10.3</td>
<td>2983 (1)</td>
<td>7.2 (10)</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Norway</td>
<td>9.6</td>
<td>5352 (10)</td>
<td>0.8 (1)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Sweden</td>
<td>10</td>
<td>3722 (4)</td>
<td>1.4 (2)</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Switzerland</td>
<td>11.4</td>
<td>5144 (9)</td>
<td>4.9 (6)</td>
<td></td>
</tr>
<tr>
<td>3*</td>
<td>UK</td>
<td>9.8</td>
<td>3487 (3)</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>USA</td>
<td>17.4</td>
<td>7960 (11)</td>
<td>7 (8)</td>
<td></td>
</tr>
</tbody>
</table>

The final, overall rankings are provided in Table 8. The rankings from each of the previous tables, with the exception of costs and efficiency, are included and weighted equally.

As a group, the social insurance states clearly perform the best, with the Netherlands, France, and Switzerland all clustering together in the top three positions and standing some distance from the next closest states. The lowest ranking social insurance state, Germany, finishes in the middle cluster of states and ranks sixth overall. The private insurance states of Australia and the United States both fall in the bottom cluster of states, ranking ninth and eleventh respectively. The national insurance states fall mainly in the middle cluster of states (UK: fourth; Sweden: fifth; Norway: seventh) but Canada and New Zealand both rank in the bottom cluster (eighth and tenth, respectively).

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29 All data in this table are taken from OECD, *Health at a Glance* (2011), except for administrative expenditures for New Zealand which is taken from OECD Stat Extracts, “Health.”
Table 8: FINAL RANKINGS (Ordered from first to last)

<table>
<thead>
<tr>
<th>Country</th>
<th>Health Outcome Rank</th>
<th>Effective Treatment Rank</th>
<th>Preventive Care Rank</th>
<th>Access Rank</th>
<th>Patient Confidence and Choice Rank</th>
<th>Equity Rank</th>
<th>Overall Rank [Number in parentheses is cumulative score]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Netherland</td>
<td>7</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>1 (21)</td>
</tr>
<tr>
<td>France</td>
<td>1*</td>
<td>4*</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>4*</td>
<td>2 (23)</td>
</tr>
<tr>
<td>Switzerland</td>
<td>8*</td>
<td>1</td>
<td>10*</td>
<td>1</td>
<td>1</td>
<td>2*</td>
<td>2 (23)</td>
</tr>
<tr>
<td>UK</td>
<td>11</td>
<td>6</td>
<td>5</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>4 (30)</td>
</tr>
<tr>
<td>Sweden</td>
<td>3</td>
<td>1</td>
<td>3*</td>
<td>7</td>
<td>11</td>
<td>7*</td>
<td>5 (32)</td>
</tr>
<tr>
<td>Germany</td>
<td>9</td>
<td>7</td>
<td>9*</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>6 (36)</td>
</tr>
<tr>
<td>Norway</td>
<td>1</td>
<td>7</td>
<td>2*</td>
<td>9</td>
<td>10</td>
<td>8*</td>
<td>7 (37)</td>
</tr>
<tr>
<td>Canada</td>
<td>6*</td>
<td>1</td>
<td>7</td>
<td>11</td>
<td>9</td>
<td>10</td>
<td>8 (44)</td>
</tr>
<tr>
<td>Australia</td>
<td>4*</td>
<td>10</td>
<td>7</td>
<td>8</td>
<td>7</td>
<td>9</td>
<td>9 (45)</td>
</tr>
<tr>
<td>New Zealand</td>
<td>5</td>
<td>11</td>
<td>11</td>
<td>5</td>
<td>8</td>
<td>6</td>
<td>10 (46)</td>
</tr>
<tr>
<td>USA</td>
<td>10</td>
<td>9</td>
<td>5</td>
<td>10</td>
<td>5</td>
<td>11</td>
<td>11 (50)</td>
</tr>
</tbody>
</table>

Discussion

So what can we learn about the nature of a caring health care system from this comparative analysis? First, private insurance models, whether of the variety found in Australia or the United States, are ill-equipped to provide good medical care to individuals. There are, no doubt, some positive aspects of these systems. Australia does relatively well in achieving good health outcomes and the United States appears to provide pretty good in-hospital trauma care and cancer treatments. For those with private health insurance, both Australia and the United States further provide relatively short waiting times and (depending on the health plan) a fair degree of patient choice. But in areas such as effective routine treatment, access, and equity, private
insurance systems perform very poorly. Interestingly, this is true not just of the United States, where many individuals have no insurance at all, but also of Australia where all individuals have access to a basic national health plan. The experience of Australia should serve as a cautionary tale to reformers in the United States who believe the American medical system might be effectively reformed by expanding Medicare (or Medicaid) to cover all uninsured individuals. Although a reform along these lines would improve health care access, it would not otherwise greatly improve the system. As commentators have long pointed out, where parallel private and public systems exist, the tendency is to compromise on costs and quality in the public system, driving those who can afford it into the private system, and leading over time to two separate, unequal systems of health care.

The finding that the private insurance model does not provide high quality health care for all individuals may come as no surprise to analysts who have argued that private markets are ill-suited for justly allocating health care resources. As noted at the outset of this paper, however, these arguments are usually framed in speculative and philosophical terms. Daniel Shapiro (2007, 97-106), for example, has argued on the basis of very limited empirical evidence that market-based health care systems may actually be more accessible and equitable than national and social insurance health systems because they rely on simple supply and demand whereas national and social insurance health systems leave room for the rich and powerful to game the system in order to gain quicker access to care. The above analysis challenges this claim. The United States and Australia rank eighth and tenth on access, and ninth and eleventh on equity. Nearly all countries with national health systems or social insurance models rank higher on access and equity than these private insurance countries.
A second important lesson from the above analysis is that a national health system is not necessarily synonymous with a just (or caring) health care system. Political philosophers often conclude their arguments about just health care by endorsing a system of universal, comprehensive, public health care. Since there are a variety of ways to deliver universal, comprehensive, public health care, however, this endorsement tells us very little about the basic institutions of a just health care system. Some writers further conflate universal comprehensive health care with a national health system, arguing as if national health systems represent the only effective way to provide universal comprehensive health care. Yet, as the above analysis indicates, national health systems (or single-payer systems) are not the best way to provide universal health services to individuals. Although national health systems generally outperform private or quasi-private systems, they generally finish second to social insurance/managed care systems. The national health systems of the United Kingdom and Sweden perform relatively well overall in providing their populations with good health care, ranking fourth and fifth respectively, but each of these systems also rank last on one measure: the United Kingdom on health outcomes, and Sweden on patient confidence and choice. Sweden also ranks ninth on waiting times. All the remaining countries with national health systems (Norway, Canada, and New Zealand) fall in the bottom half of the final rankings.

These rankings should not be taken to mean that national health systems cannot provide good health care. If Sweden could achieve the levels of access, patient confidence, and equity that the United Kingdom achieves, or the United Kingdom could achieve the health outcomes and treatment effectiveness of Sweden, these countries would rank in the top tier of medical systems overall. However, the on-average mediocre ranking of countries with national health systems does indicate that there are some elements of these systems that incline them to provide
less caring health care than social insurance/managed care health systems. A couple of explanations are possible.

National health systems utilize top-down, centralized (at the national and regional levels), and fairly rigid approaches to distributing health care resources. Because they are funded by general tax revenues, policy-makers further tend to emphasize cost efficiency and containment as main priorities of these systems (Blank and Burau 2007, 75-76). One result is that fairly hard caps tend to be placed on the supply of various medical services and goods. Social insurance/managed care states, by contrast, tend to use softer forms of rationing (higher cost-sharing, limited reimbursements for new technologies) that allow for more flexibility and choice in the distribution and use of medical resources. Because of the harder caps on supply in national health systems, patients are sometimes unable to get the care they want or need in these systems or more often are subjected to lengthy waiting times for non-emergency procedures. From a rational, centralized management perspective, it does make sense for states to ration medical resources so that they are used most efficiently for medical emergencies and preventive care. There is nonetheless an obvious drawback to this approach. The ability of individuals to have their medical needs addressed quickly and the medical system’s responsiveness to patient demands is traded off for a presumably more efficient allocation of medical resources. The presence of long waiting lists for specialists and non-emergency procedures in many national health systems further indicates that resources are either being misallocated or are insufficient for the types of the medical care that many people desire.

National health systems also generally attempt to contain costs by imposing greater limitations on patient choice than other systems. With the partial exception of Canada, all the national health models discussed here require patients to register with a general practitioner who
generally acts as a gatekeeper in providing access to specialist. The main purpose of the general practitioner model is to limit patients’ overuse of specialists and hence to lower costs, but several studies have found that it may actually generate extra costs since a large number of consultations simply result in referral to a specialist (Imai, Jacobzone, and Lenain 2006, 94; Van Merode, Paulus, and Groeneegen 2000). The general practitioner model also increases real waiting times for access to effective treatments when individuals have injuries or ailments that require the attention of a specialist. While the general practitioner model is not unique to national health systems, it is (at least in the sample studied here) most common to them.³⁰ The restrictions this model places on patient choice limits access and responsiveness and may play some role in undermining patient confidence that the health system’s primary concern is to provide them with the best treatments for their health needs.

A couple of other features of national health systems may be relevant in explaining their on-average lesser performance than social insurance states. Although some national health systems delegate a good deal of decision-making authority to the local level, they are all ultimately unified systems with broad responsibility for the health of the entire population of a country. In countries with social insurance systems, by contrast, a number of different private insurers perform the task of providing insurance, paying reimbursements, and offering other services to patients. The smaller relative size of these private organizations may make them easier to manage and more responsive to patient demands (Björnberg, Cebolla Garrofé, and Lindblad 2009). Similarly, even though social insurance states heavily regulate social insurance funds and private insurers, insurance funds are still somewhat autonomous from the government and solely focused on providing accessible, quality health care to patients. In national health

³⁰ Patient choice is further limited in several national health systems (e.g., Canada, Sweden) by rules that prevent private payment for services and procedures covered under the national plan.
systems, by contrast, decision-makers at both the national and local levels are more likely to be subject to political pressures in making health care decisions, and may, for example, choose to maintain a hospital or preserve medical jobs in a region for non-health related reasons (Imai, Jacobzone, and Lenain 2006). Where a larger percentage of doctors are civil servants and hospitals are publicly owned and operated, health administrators are further likely to face more rules regarding recruitment, promotion, and wage-setting that may constrain their ability to make decisions that improve patient care (Imai, Jacobzone, and Lenain 2006).

As a group, the social insurance states rank highest among health care systems in realizing the goals of a just (or caring) health care system. These states are particularly strong in access, patient confidence and choice, and equity, with all four social insurance states ranking in the top five in all three of these categories with only one exception: France ranks sixth on access. The social insurance/managed care states also perform very well in the everyday treatment of chronic conditions, with Switzerland, France, and the Netherlands ranking in the top five and Germany ranking seventh. The two weak spots for the social insurance/managed care states are health outcomes, where aside from France all states rank in the middle lower part of the rankings, and preventive care. While the Netherlands and France both rank highly on preventive care (first and fourth, respectively), Germany and Switzerland both perform poorly. This split in the rankings may reflect some small but important differences between the French and Dutch health care systems, on the one hand, and the Swiss and German ones, on the other hand. In both France and the Netherlands, the state plays a stronger role in setting priorities for the insurance funds, whereas both the Swiss and German systems allow more autonomy for these funds. The better performance of the Dutch and French systems in the area of preventive care may reflect these institutional differences, as both the Dutch and French state emphasize preventive care
measures. By contrast, without a state mandate, the private insurance funds in Germany and Switzerland have little incentive to emphasize preventive care, particularly since individuals can change plans from year-to-year (Cheng 2010, 1447-49).31

The strong performance of the social insurance/managed care medical systems lends some support to the views of health care analysts who have argued (mostly in speculative terms) that managed competition represents the best way to organize a health care system (Enthoven 1989a; 1989b; Emanuel 2008; Pauly 2008). It is nonetheless important to be clear about the reasons for the success of the managed care states. While competition among insurers appears to have had some positive impact on health care services in the Netherlands and Switzerland, it is noteworthy that France, with no competition between insurance funds, finishes in a tie for second in the rankings. The high performance of the French health care system would seem to indicate that competition among insurance funds is not essential to a high quality managed care system. Moreover, although the Dutch system is moving toward greater autonomy and competition for insurers, it, too, at present remains heavily regulated (Okma, Marmor, and Oberlander 2011). Even Switzerland, which has gone the furthest in fostering managed competition between insurers, continues to rely heavily on government regulation and subsidies to guide its medical system (Cheng 2010). Overall, then, the success of managed competition states owes at least as much (and perhaps more) to effective management as to competition. Managed care systems are successful because they structure a system of incentives and constraints that require and/or encourage insurers and/or providers to deliver high quality, accessible medical care in relatively

31 Whereas preventive services used to be directly mandated by the state in Germany, for example, they are now delivered under the same regulations as curative services which means that their exact definition is subject to negotiations between the sickness funds and the physicians’ associations. The shift in responsibilities has had the result that immunization rates are rather low by international comparison (European Observatory on Health Care Systems 2000, 58-9).
flexible and responsive ways. The risk equalization schemes in countries such as the Netherlands, for example, provide an incentive for insurers to recruit and provide better care to individuals with chronic conditions and other special medical needs. Other regulations such as coverage requirements similarly direct insurance funds to compete largely by offering better services for individuals rather than by cutting prices and care.

Managed care further should not be seen as a panacea for all that ails contemporary health care systems. Contrary to the expectations of its advocates, for example, managed care has thus far not been very effective in lowering health care costs. As Table 7 shows, the four social insurance/managed care states have the highest total (public and private) health expenditures as a percentage of GDP of any states other than the United States (they rank somewhat lower in spending per capita). These states further rank in the middle-bottom (occupying positions five through eight) in terms of the percentage of health care expenditure allocated to health administration. These expenditure levels are not necessarily a problem in themselves since they support good medical care. Yet, the expenditure information does indicate that managed care is not the cheapest way to organize a health care system. Where the main concern is controlling costs and lowering administrative expenditures, a single-payer national health system is clearly the best choice. Sweden, Norway, the United Kingdom, and New Zealand all spend much less on medical care as a percentage of GDP than most other countries, and Norway and Sweden both also have very low administrative costs.

Even though the managed care states of the Netherlands, Switzerland, and France (and to a lesser extent Germany) generate the best overall outcomes, their generally high performance likewise does not mean that they have no room for improvement. Because the government subsidy for health insurance in the Netherlands and Switzerland is means-tested, middle-income
families can have difficulty paying for health insurance and unexpected financial hardships can leave individuals temporarily uninsured (Emanuel 2008, 142-48). In the Netherlands, for example, roughly 1.5 percent of individuals currently do not have health insurance and an additional 1.5 percent have not paid their insurance premiums in the past six months (Van de Ven and Schut 2008).\(^{32}\) Means-tested benefits also greatly add to the administrative complexity and costs of these systems (Okma, Marmor, and Oberlander 2011, 288). One solution to these problems, proposed by Ezekiel Emanuel (2008), is to provide all individuals with a health care voucher or certificate that would cover the average cost of a comprehensive insurance plan.\(^{33}\) As with the current Dutch and Swiss plans, individuals would still be free to purchase comprehensive coverage from the private or non-profit provider of their choice, and could purchase extra coverage with their own money. A universal subsidy (or voucher or certificate) would increase public expenditures, but expand coverage, lower personal costs, and reduce administrative expenses and complexity. Overall, then, it probably would not increase the overall (public and private) expenditures of a country on health care.

Another potential pitfall of the social insurance/managed care medical systems in countries such as France, Germany, and the Netherlands is their continued reliance on employers to fund a good part of their employees’ health insurance. While this funding arrangement does not affect the quality of medical care, it may create some disincentive for employers to hire new or additional workers. A better approach thus might be to fund health care through a general tax on individuals and businesses or a dedicated sales tax (Emanuel 2008). Other reforms might also

\(^{32}\) Some people, of course, may not pay their premiums for reasons other than financial distress.

\(^{33}\) A universal voucher or certificate would also avoid debates currently underway in the United States about the legality and morality of an individual insurance mandate and the ability for force employers to pay for insurance coverage that they may find morally objectionable.
be undertaken to improve health outcomes and (in Germany and Switzerland) the delivery of preventive care.

One final issue that has not yet been addressed merits attention: the challenge of providing good medical care to the growing elderly population. Demographic projections show that most advanced industrialized countries will experience substantial population ageing over the next 30 years. At present, elderly individuals account for anywhere between 30 to 50 percent of total health expenditures in most industrialized countries, and by 2040, they are projected to consume somewhere between 40 and 60 percent of total expenditures (or slightly more in countries such as Sweden and the United States) (Blank and Burau 2007, 20-23). Meanwhile, due in part to population ageing, overall health care expenditures are projected to increase markedly (Pauly 2008, 4-6). In the near future, all health systems will thus need to introduce more cost control measures to contain medical expenditures, and the elderly will be the population most greatly affected by any cost control measures that are introduced. The question, then, is: Which health system appears best suited for allocating increasingly limited medical resources to a growing elderly population in the most just (or caring) manner?

At first glance, a national health system might seem the best solution. National health systems can unilaterally set limits on the medical care and uniformly impose these limits. The main drawback to national health systems, however, is that they tend to utilize one-size-fits-all hard rationing decisions on services and procedures. At the extreme, a national health system might even impose a system of age rationing whereby coverage for some set of procedures is limited or prohibited for individuals over a certain age limit (e.g., 75 years or older).34 A

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34 Age-rationing has been defended most strongly by Callahan (1987), and somewhat more tepidly by Daniels (1988; 2008). It is already used as a criterion for rationing health resources by the National Health Service in the United Kingdom (Blank and Burau 2007, 124). While there are a number of possible objections to age-rationing, the obvious one is its failure to adequately take account of important health differences between similarly aged
managed care system, by contrast, can avoid some of these drawbacks. If all elderly individuals were provided a voucher that they could use to purchase basic medical insurance from private providers and providers were allowed to vary their plans somewhat beyond some set of required coverage, individuals themselves could play a more direct role in determining how medical services were rationed (Pauly 2008). Specifically, individuals could choose plans that reflected their own medical preferences (e.g., a plan covering high technology treatments, or alternative medicines, or a chronic treatment plan). If individuals were further permitted to purchase supplementary coverage with their own resources, and the government provided subsidies to low income individuals for this supplemental insurance, the overall rationing of medical resources would reflect in large part the cumulative individual preferences of the community. The system would, once again, not be a panacea. It would be less effective than a single-payer system in controlling costs and would allow some measure of inequity (though social insurance/managed care states actually perform quite well on equity measures). Public costs would nonetheless be limited under this plan, and the system as a whole would likely deliver better and more responsive care to elderly individuals than a single-payer system. As health analysts frequently emphasize, no system is perfect; every system involves some trade-offs. A (strongly state regulated) managed care system nonetheless appears to be the most caring solution to the adaptations that states will have to make in coming years in order to continue providing quality medical care to the elderly (Pauly 2008, 61-63).

CONCLUSION:

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individuals. Surely a strong case can be made for age rationing where the rationing in question applies to a person in very bad health. But some individuals who are 75 may enjoy levels of good health comparable to individuals 20 years younger. To cut off service or procedures to these individuals based on age alone is difficult to justify.
Although political philosophers have discussed in some detail the nature of a just health care system, they have generally failed to account adequately for the social determinants of health, have remained vague about the basic institutions of a just health care system, and have relied primarily on theoretical speculation rather than empirical data in making their arguments. This paper has aimed to address these shortcomings by outlining a more socially-sensitive and empirically-grounded account of the basic institutions of a just health care system. In light of the recent literature on the social determinants of health, I have suggested that the central justification for a public health care system should be the delivery of everyday medical care to individuals, with health outcomes representing only one dimension of this care. Based on this normative perspective, I identified seven characteristics or goals of a caring health care system and investigated the performance of eleven health care systems in terms of these seven characteristics or goals. Overall, social insurance/managed care systems perform the best in providing caring health care to individuals based on these measures. These systems particularly excel in the areas of access, responsiveness, and equity and do very well in treating chronic conditions. Although these systems are not perfect, they perform better than other systems in delivering quality care to all individuals. By adiotubg the reforms discussed above, these systems could further enhance the care they provide to their people. Given the realistic goals of a health care system, and the performance of various real-world systems in generating just outcomes, a managed-care system may thus be identified as the most just (or caring) health care arrangement.
Works Cited


