The U.S. health care system is unique among advanced industrialized countries. The U.S. does not have a uniform health system, has no universal health care coverage, and recent legislation mandating coverage is not yet fully implemented. Rather than operating a national health service, a single-payer national health insurance system, or a multi-payer universal health insurance fund, the U.S. health care system can best be described as a hybrid system. In 2010, 50 percent of U.S. health care spending came from private funds, compared to 38 percent from federal funds and 12 percent state and local funds. Most health care, even if publicly financed, is delivered privately.

In 2012, 263.2 million people in the U.S., 84.6 percent of the U.S. population had some type of health insurance, with 63.9 percent of workers covered by a private health insurance plan. Among the insured, 101.5 million people, 32.6 percent of the population, received coverage through the U.S. government in 2012 through Medicare (48.9 million), Medicaid (50.9 million), and/or VA or other military care (13.7 million) (people may be covered by more than one government plan). In 2012, nearly 48 million people in the U.S. had no health insurance.

This fact sheet will compare the U.S. health care system to other advanced industrialized nations, with a focus on the problems of high health care costs and disparities in insurance coverage in the U.S. It will then outline some common methods to lower health care costs in other countries, examine the German health care system as a model for non-centralized universal care, and put the quality of U.S. health care in an international context.

In Comparison to Other OECD Countries

The Organization for Economic Co-operation and Development (OECD) is an international forum committed to global development that brings together 34 member countries to compare and discuss government policy in order to “promote policies that will improve the economic and social well-being of people around the world.” The OECD countries are generally advanced or emerging economies. Of the member states, the U.S. and Mexican governments play the smallest role in overall financing of health care. However, public (i.e. government) spending on health care per capita in the U.S. is greater than all other OECD countries, except Norway and the Netherlands.

This seeming anomaly is attributable, in part, to the high cost of health care in the U.S. Indeed, the U.S. spends considerably more on health care than any other OECD country.

- The OECD found that in 2011, the U.S. spent $8,508 per person or 17.7 percent of its GDP on health care—far higher than the OECD average of 9.3 percent per person.
U.S. were the Netherlands, which allocated 11.9 percent of its GDP, then France at 11.6 percent and Germany allocated 11.3 percent of its GDP to health care in 2011. In North America, Canada and Mexico spent respectively 11.4 percent and 6.2 percent of their GDP on health care.

On a per capita basis, the U.S. spends more than double the $3,322 average of all OECD countries (see chart below).

### Drivers of Health Care Spending in the U.S.

Cost is the primary reason Americans give for problems accessing health care. Americans with below-average incomes are much more likely than their counterparts in other countries to report not: visiting a physician when sick; getting a recommended test, treatment, or follow-up care; filling a prescription; and seeing a dentist. Fifty-eight percent of physicians in the U.S. acknowledge their patients have difficulty paying for care. In 2012, 32 percent of uninsured adults reported not getting or delaying medical care because of cost, compared to five percent of

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1. In the Netherlands, it is not possible to clearly distinguish the public and private share related to investments.
2. Current health expenditure.
privately insured adults and 27 percent of those on public insurance, including Medicaid/CHIP and Medicare.\textsuperscript{11}

While there is no agreement as to the single cause of rising U.S. health care costs, experts have identified three contributing factors. The first is the cost of new technologies and prescription drugs. Some analysts have argued “that the availability of more expensive, state-of-the-art medical technologies and drugs fuels health care spending for development costs and because they generate demand for more intense, costly services even if they are not necessarily cost-effective.”\textsuperscript{12} In 2011, the U.S. spent $985 per capita on pharmaceuticals and other nondurable medical care, more than double the OECD average of $483.\textsuperscript{13}

Another explanation for increased costs is the rise of chronic diseases, including obesity. Nationally, health care costs for chronic diseases consume huge proportions of health care costs, particularly during end of life care. “Patients with chronic illness in their last two years of life account for about 32% of total Medicare spending, much of it going toward physician and hospital fees associated with repeated hospitalizations.”\textsuperscript{14} The National Academy of Sciences found that among other high-income nations the U.S. has a higher rate of chronic illness and a lower overall life expectancy. Their findings suggest that this holds true even when controlling for socio-economic disparity.\textsuperscript{15} Experts are focusing more on preventative care in an effort to improve health and reduce the financial burdens associated with chronic disease.\textsuperscript{16} One provision of the Patient Protection and Affordable Care Act, commonly referred to as simply the Affordable Care Act, implemented in 2013 provides additional Medicaid funding for states providing low cost access to preventative care.\textsuperscript{17}

Finally, high administrative costs are a contributing factor to the inflated costs of U.S. health care. The U.S. leads all other industrialized countries in the share of national health care expenditures devoted to insurance administration. It is difficult to determine the exact differences between public and private administrative costs, in part because the definition of “administrative” varies widely. Further, the government outsources some of its administrative needs to private firms.\textsuperscript{18} What is clear is that larger firms spend a smaller percentage of their total expenditures on administration, and nationwide estimates suggest that as much as half of the $361 billion spent annually on administrative costs is wasteful.\textsuperscript{19} In January 2013, a national pilot program implemented under the Affordable Care Act began. The aim is to improve administrative efficiency by allowing doctors and hospitals to bundle billing for an episode of care rather than the current ad hoc method.\textsuperscript{20}
Health Insurance in the U.S.: Uneven Coverage and Rising Premiums

While the majority of U.S. citizens have health insurance, premiums are rising and the quality of the insurance policies is falling. A report from the Commonwealth Fund found premiums for families went up 62 percent across states from 2003-2011. “At the same time, deductibles more than doubled in large and small firms.” This has a profound impact on the U.S. economy. The Center for American Progress estimated in 2009 that the lack of health insurance in the U.S. cost society between $124 billion and $248 billion per year. While the low end of the estimate represents just the cost of the shorter lifespans of those without insurance, the high end represents both the cost of shortened lifespans and the loss of productivity due to the reduced health of the uninsured. Forty million workers, nearly two out of every five, do not have access to paid sick leave. Experts suggest that the economic pressure to go to work even when sick can prolong pandemics, reduce productivity, and drive up health care costs.

- There were 48 million uninsured Americans in 2012. Most, 63 percent, had one or more full-time workers in the family and 16 percent had one or more part-time workers in the family. Just 43.3 percent of American adults reported getting health insurance from an employer in 2013. Employer-provided coverage has been steadily declining since 2009.

- Coverage by employer-provided insurance varies considerably by wage level. Firms with higher proportions of low-wage workers are less likely to provide access to health insurance than those with low-proportions of low-wage workers.

- In 2012, 15.5 percent of full-time workers were without health insurance, which was statistically similar to the 2011 percentage. However, the percentage of part-time workers without insurance was unchanged at 27.7 percent and those who had not worked at least one week decreased from 26.7 percent to 25.8 percent.

- Smaller firms are significantly less likely to provide health benefits to full or part-time workers. Among all small firms (3-199 workers) in 2012, only 61 percent offered health coverage in 2012, compared to 98 percent of large firms.

- After the Affordable Care Act allowed for many young adults (19-25) to remain on their parents’ health plans there was a statistically significant increase in the percentage of

Although it is not fully implemented, the 2010 Patient Protection and Affordable Care Act seeks to address some gaps in the U.S. private-public insurance system. The new law will require most Americans to have health insurance, will require insurance coverage of preexisting conditions, and will expand Medicaid eligibility, subsidizing private coverage for individuals with incomes up to 400 percent of the federal poverty level starting in 2014.
insured young people from 68.3 percent in 2009 to 73.5 percent in 2012. Over the same period, the percentage of young people aged 26-29 with insurance dropped from 70.8 percent to 70.2 percent.29

- Minorities and children are disproportionately uninsured. In 2012, 11.1 percent of non-Hispanic whites were uninsured, 19 percent of Blacks were uninsured, 15.1 percent of Asians, and 29.1 percent of people of Hispanic origin were uninsured.30 The Kaiser Family Foundation has found that about 80 percent of the uninsured are U.S. citizens.31 Among children, 9.2 percent were uninsured in 2012.32 These children are 10 times more likely than insured children to have unmet medical needs and are five times as likely as an insured child to go more than two years without seeing a doctor.33

- Women in the individual market often faced higher premiums than men for the same coverage. Beginning in 2014, the Affordable Care Act banned this practice, as well as denying coverage for pre-existing conditions.34

- Among families with incomes below the federal poverty level ($22,050 a year for a family of four), 40 percent are uninsured. According to the Kaiser Family Foundation, 90 percent of the uninsured have family incomes within 400 percent of the federal poverty level making them eligible for either subsidized coverage through tax credits or expanded Medicaid eligibility once the Affordable Care Act implementation is complete.35

Health insurance premiums in the U.S. are rising fast. From 2003 to 2013, average annual health insurance premiums for family coverage increased 80 percent, while worker contributions to those plans increased 89 percent in the same period. This rate of increase outpaces both inflation and increases in workers’ wages36

- In 2000, the average annual premiums for employer-sponsored health insurance were $2,471 for single coverage and $6,438 for family coverage. In 2013, premiums more than doubled to $5,884 for employer-sponsored single coverage and $16,351 for employer-sponsored family coverage.37

- A growing number of workers face a deductible of $1,000 or more for individual plans. In 2013, 38 percent (compared to 22 percent in 2009 and 10 percent in 2006) of workers were enrolled in a plan with an annual deductible of $1,000 or more. Employees at small firms are more likely than those at large firms to have a deductible greater than $1,000.38
Across states, there are significant disparities in both the availability and the cost of health care coverage.

- In 2010, Medicare reimbursements per enrollee varied from $6,976 in Alaska to $11,670 in Louisiana. Annual premiums are similarly disparate. In 2012, the average family premium in the South was $14,988, while the same coverage averaged $17,099 in the Northeast.
- Firms in the South were less likely to provide coverage for an employee’s domestic partner than other regions. In the South, 15 percent of firms reported providing benefits for same-sex partners (compared to 54 percent in the Northeast) and 14 percent reported offering benefits to opposite-sex domestic partners (compared to 53 percent in the Northeast).

**High Costs Drive Americans into Bankruptcy**

Universal coverage, in countries like the United Kingdom, Switzerland, Japan, and Germany makes the number of bankruptcies related to medical expenses negligible. Conversely, a 2013 survey found that about three out of five bankruptcy filings in the U.S. were linked to expenses from medical bills. Prior surveys found that in 92 percent of medical bankruptcy cases, high medical bills directly contributed to the bankruptcy. At illness onset, in 77.9 percent of these cases the bankrupt party had some form of insurance.

The following are the average medical expenses for the medically bankrupt:

- Out-of-pocket medical costs averaged $17,943 for all medically bankrupt families;
  - $26,971 for uninsured patients;
  - $17,749 for those with private insurance at the outset;
  - $14,633 for those with Medicaid;
  - $12,021 for those with Medicare;
  - $6,545 for those with VA/military coverage; and
  - $22,568 for patients who initially had private coverage but lost it.

For the medically bankrupt, hospital bills were the single largest out-of-pocket expense in
48 percent of cases, prescription drugs in 18.6 percent, doctors’ bills in 15.1 percent, and premiums in 4.1 percent. In 37.9 percent of families bankrupt for medical-related reasons, someone lost or quit a job because of the medical event.

Common Methods to Lower Health Care Costs

By taking an international perspective and looking to other advanced industrialized countries with nearly full coverage, much can be learned. While methods range widely, other OECD countries generally have more effective and equitable health care systems that control health care costs and protect vulnerable segments of the population from falling through the cracks. Among the OECD countries and other advanced industrialized countries, there are three main types of health insurance programs:

- **A national health service**, where medical services are delivered via government-salaried physicians, in hospitals and clinics that are publicly owned and operated—financed by the government through tax payments. There are some private doctors but they have specific regulations on their medical practice and collect their fees from the government. The U.K., Spain, and New Zealand employ such a system.

- **A national health insurance system**, or single-payer system, in which a single government entity acts as the administrator to collect all health care fees, and pay out all health care costs. Medical services are publicly financed but not publicly provided. Canada, Denmark, Taiwan, and Sweden have single-payer systems.

- **A multi-payer health insurance system**, or all-payer system, which provides universal health insurance via “sickness funds,” used to pay physicians and hospitals at uniform rates, thus eliminating the administrative costs for billing. This method is used in Germany, Japan, and France.

A universal mandate for health care coverage defines these systems. Such a mandate eliminates the issue of paying the higher costs of the uninsured, especially for emergency services due to lack of preventative care. Other methods for reducing costs may include:

- Funding health care costs in relation to income rather than risk or people’s medical history.

- In many countries insurers and health care providers must operate as non-profits. This is not the case in the U.S. where in 2008 for-profit hospitals consumed about 13 percent of health care premiums in profit.
• Negotiating the price of prescription drugs and bulk purchasing of prescription medications and durable medical equipment is a method used in other countries for lowering costs. This has been effectively used by the U.S. Department of Veterans Affairs, Medicaid, and Health Management Organizations in the U.S. Yet, it has been prohibited by law from traditional Medicare. Savings of up to five percent of total health care expenditures could result from the full adoption of these practices.55

An International Case Study: How Germany Pays for Health Care

Germany has one of the most successful health care systems in the world in terms of quality and cost. Some 240 insurance providers collectively make up its public option. Together, these non-profit “sickness funds” cover 90 percent of Germans, with the majority of the remaining 10 percent, generally higher income Germans, opting to pay for private health insurance. The average per-capita health care costs for this system are less than half of the cost in the U.S. The details of the system are instructive, as Germany does not rely on a centralized, Medicare-like health insurance plan, but rather relies on private, non-profit, or for-profit insurers that are tightly regulated to work toward socially desired ends—an option that might have more traction in the U.S. political environment.56

• The average insurance contributions to German sickness funds are based on an employee’s gross income, around 15.5 percent with an income cap at $62,781, and employers and employees each pay about half of the premium. Generally, an individual employee’s contribution is 8.2 percent and the employer pays the remaining 7.3 percent.57

• Premiums are not based on risk and are not affected by a person’s marital status, family size, or health. Germans have no deductibles and low co-pays.58

• Doctors are private entrepreneurs and get a fee from insurers for every visit and procedure they perform. However, they are tightly regulated. Groups of office-based physicians in every region negotiate with insurers to arrive at collective annual budgets. Doctors must remain in these budgets, as they do not receive additional funding if they go over. This helps keep health care costs in check and discourages unnecessarily expensive procedures. The average German doctor also makes about one-third less per year than in the U.S., around $123,000.59

• Government general revenues cover premiums for children, on the premise that the next generation should be the entire nation’s fiscal responsibility, instead of just the responsibility of the parents.60

• Germany reformed its coverage for prescription drugs in 2010 after costs for prescription
drugs continued to rise. Prior to reforms, drug companies set the price for new drugs and were not required to show that the new drug was an improvement over previously available prescription drugs. Pursuant to the reforms effective in 2011, manufacturers could set the price for the first 12 months a new drug is on the market. “As soon as the drug enters the market, a new process of benefit assessment begins.” Manufacturers must establish, through comparative effective research that the new drug has an “added benefit to the patient, compared to the previously existing standard treatment.” Drugs without added benefit will be reimbursed according to a government pricing list. New drugs without added benefits are available to patients, but the patient has to pay the price difference. For drugs with added benefit, a price will be negotiated between health insurers and the manufacturer.61

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

U.S. health care specialists are among the best in the world. However, treatment in the U.S. is inequitable, overspecialized, and neglects primary and preventative care.62 The end result of the U.S. approach to health care is poorer health in comparison to other advanced industrialized nations. According to the Commonwealth Fund Commission, in a 2010 comparison with Australia, Canada, Germany, Netherlands, New Zealand, and the U.K., the U.S. had the second lowest rank in quality of care. Overall, the U.S. ranked the lowest in this comparison, as it ranked last in all other aspects of health care: efficiency, equity, access, and length and productivity of citizens’ lives.63 Comparing other health care indicators in an international context underscores the dysfunction of the U.S. health care system.

- Despite the relatively high level of health expenditure, in the U.S. there are fewer physicians per capita than in most other OECD countries. In 2011, the U.S. had 2.4 practicing physicians per 1,000 people—below the OECD average of 3.1.64

- In the U.S., there are only about 1.2 primary care physicians per 1,000 people. Projections indicate that the U.S. will need 52,000 more primary care physicians by 2025 to meet demand.65 While population growth and aging make up a substantial proportion of this increased need, expanded access to insurance under the Affordable Care Act means more people will seek out treatment. Therefore, there are provisions in the legislation to increase the number of primary care physicians in the U.S.

- There is a significant spatial mismatch within the United States for physicians as well. While the U.S. averages 226 doctors active in patient care per 100,000 people in 2012, there is a wide variance across states; Massachusetts ranks highest with 324.1 active doctors per 100,000 people, while Mississippi has only 164.4.66

- In 2011, the U.S. infant mortality rate was 6.1 per 1,000 live births, while the OECD
median was 4.1.\textsuperscript{67}

- The obesity rate among adults in the U.S. was 36.5 percent in 2011, up from 33.8 percent in 2008. This is the highest rate among OECD countries. The average for the OECD countries was 17.6 percent in 2011.\textsuperscript{68}

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