

# MEDICAL SOCIOLOGY

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**William C. Cockerham**

*University of Alabama at Birmingham*

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## Global Health Care



All nations of the world are faced with the pressure of public demands for quality health care and faced with rising costs of providing that care. Different approaches to these problems have led to renewed interest in comparative or transnational studies of health care systems in order to learn from the experiences of other countries (Gallagher, Stewart, and Stratton 2000; Kikuzawa, Olafsdottir, and Pescosolido 2008; Quadagno 2010; Stevens 2010). In this chapter, the focus is on socialized forms of health care common to Canada, Great Britain, and Sweden, followed by an examination of decentralized national health programs in Japan, Germany, and Mexico and former socialist systems in Russia and China.

The value of studying the health care delivery systems of different countries is the insight provided into the norms, values, culture, and national outlook of those societies, as well as the lessons learned from their experiences. Health care delivery systems worldwide are faced with the same problem of rising costs, aging populations, and the requirement to meet their nation's health needs (Kikuzawa *et al.* 2008). However, they differ in the variety of their approach. Such systems do not evolve in a vacuum but reflect the social and political philosophy of the country in which they exist. Therefore, social and political values underlie the choices made, the institutions formed, and the levels of funding provided. A nation's approach to health care is based upon its historical experience, culture, economy, political ideology, social organization, level of education and standard of living, economic resources, and attitudes toward welfare and the role of the state.

In Europe, the provision of health services became an important component of government policy in the last half of the nineteenth century. Behind this development was the desire of various European governments for a healthy population whose productivity could be translated into economic and military power. In

some countries, providing national health insurance was also a means to reduce political discontent and the threat of revolution from the working class. Compulsory health insurance was usually part of a larger program of social insurance intended to protect the income of workers when sick, disabled, unemployed, or elderly. Initially, protection was provided only to wage earners below a certain income level, but gradually benefits were extended to all or most of the population. Germany established the first national health insurance program in 1883, followed by Austria in 1888, and other European countries over the course of the twentieth century.

Entitlements based on citizenship are aimed at providing people with welfare and health benefits, regardless of their class position. The social welfare systems of Europe are more advanced in this direction than in the United States. Many Europeans receive comprehensive health insurance; protection of lost income due to illness, injury, or unemployment; and allowances to supplement family expenses for the maintenance of children, such as clothing and school lunches. These benefits are provided to all citizens, the affluent and the nonaffluent alike. The result is that European governments are typically responsible for the delivery of health care and most of its financing. For example, over 80 percent of all health costs in the European Union (EU) are financed from public sources, either through national health insurance or direct payments by the state.

It was not until 1965 and the passage of Medicare and Medicaid that the United States provided health care benefits for some Americans—the aged and the poor. When European governments were introducing social insurance programs, the U.S. government was not deeply involved in regulating either the economy or the health services. Although this is changing, Americans have historically been less committed to government welfare programs and more in favor of private enterprise in dealing with economic and social problems. However, except for the elderly, participation in the welfare system is still not considered normative in the United States, and those Americans under the age of 65 who do receive welfare benefits tend to be stigmatized and have low social status. In Europe, providing welfare and social security for the general population, not just the poor and elderly, is a normal feature of the state's role. This situation implies a fundamental difference in the social values of Americans and Europeans, with Americans stressing individualism and Europeans viewing government in a more paternalistic fashion.

The United States spends more on health than any other country in the world. Table 16-1 shows the total health expenditures as a percentage of gross domestic product (GDP) for selected countries from 1960 to 2006. In 1960, the United States was second only to Canada in health spending but forged into a tie for first place in 1970 and has been first ever since—except in 1980 when Sweden spent a higher percentage of its GDP. Table 16-1 shows that for 2006, the United States spent 15.3 percent of its GDP on health, followed by Switzerland at 11.3 percent, and Germany at 10.6 percent. The country with the lowest percentage of health expenditures among the countries shown in Table 16-1 is Mexico at 6.6 percent.

**TABLE 16-1** Total Health Expenditures as a Percentage of Gross Domestic Product: Selected Countries, Selected Years, 1960-2006.

| Country        | 1960 | 1970 | 1975 | 1980 | 1985 | 1990 | 1995 | 2000 | 2006 |
|----------------|------|------|------|------|------|------|------|------|------|
| Australia      | 4.3  | 5.4  | 5.7  | 7.0  | 7.5  | 7.9  | 8.2  | 8.8  | 8.7  |
| Austria        | 4.3  | 5.3  | 7.3  | 7.6  | 6.6  | 7.1  | 8.5  | 9.4  | 10.1 |
| Belgium        | 3.4  | 4.0  | 5.8  | 6.4  | 7.2  | 7.4  | 8.7  | 8.6  | 10.3 |
| Canada         | 5.4  | 7.0  | 7.3  | 7.1  | 8.3  | 9.0  | 9.3  | 8.9  | 9.9  |
| Czech Republic | —    | —    | —    | —    | 4.5  | 5.0  | 7.3  | 6.7  | 6.8  |
| Denmark        | 3.6  | 6.1  | 6.5  | 9.1  | 8.7  | 8.5  | 8.2  | 8.5  | 9.5  |
| Finland        | 3.9  | 5.6  | 6.3  | 6.4  | 7.2  | 7.9  | 7.5  | 6.7  | 8.2  |
| France         | 4.1  | 5.7  | 6.8  | 7.4  | 8.3  | 8.6  | 9.6  | 9.2  | 11.0 |
| Germany        | 4.7  | 6.3  | 7.8  | 8.8  | 9.3  | 8.7  | 10.2 | 10.3 | 10.6 |
| Greece         | 3.1  | 5.6  | —    | 6.5  | —    | —    | 8.9  | 9.9  | 9.1  |
| Hungary        | —    | —    | —    | —    | —    | —    | 7.5  | 7.1  | 8.3  |
| Iceland        | 3.3  | 4.9  | 5.9  | 6.1  | 7.2  | 7.9  | 8.2  | 9.2  | 9.1  |
| Ireland        | 3.6  | 5.1  | 7.7  | 8.4  | 7.6  | 6.7  | 7.3  | 6.3  | 7.5  |
| Italy          | 3.6  | 5.1  | 5.8  | 7.0  | 7.0  | 8.1  | 7.9  | 8.1  | 9.0  |
| Japan          | 3.0  | 4.6  | 5.5  | 6.5  | 6.7  | 6.1  | 7.2  | 7.6  | 8.1  |
| Mexico         | —    | —    | —    | —    | —    | 4.4  | 5.6  | 5.6  | 6.6  |
| Netherlands    | 3.9  | 6.0  | 7.7  | 8.0  | 7.8  | 8.5  | 8.9  | 7.9  | —    |
| New Zealand    | 4.3  | 5.2  | 6.4  | 6.0  | 5.3  | 7.0  | 7.3  | 7.7  | —    |
| Norway         | —    | —    | —    | —    | —    | 8.0  | 8.0  | 8.5  | 8.7  |
| Poland         | —    | —    | —    | —    | —    | 5.3  | 6.0  | 5.7  | 6.2  |
| Portugal       | —    | —    | 6.4  | 5.6  | 6.1  | 6.2  | 7.6  | 9.4  | 10.2 |
| Spain          | 1.5  | 3.6  | 5.1  | 5.4  | 5.4  | 6.6  | 7.0  | 7.2  | 8.4  |
| Sweden         | 4.5  | 6.9  | 8.0  | 9.1  | 8.7  | 8.5  | 8.1  | 8.4  | 9.2  |
| Switzerland    | 4.8  | 5.4  | 7.0  | 7.3  | 7.7  | 8.3  | 9.6  | 10.4 | 11.3 |
| United Kingdom | 3.9  | 4.5  | 5.5  | 5.6  | 5.9  | 6.0  | 6.9  | 7.3  | 8.4  |
| United States  | 5.1  | 7.0  | 8.4  | 8.8  | 10.1 | 12.0 | 13.4 | 13.3 | 15.3 |

Source: National Center for Health Statistics, 2009.

Another measure of health costs is per capita health expenditures. Table 16-2 indicates that the United States spent more per capita from 1960 to 2006 than any other country. For 2006, Table 16-2 shows the United States spent \$6,714 per capita on health. Mexico was last with expenditures of \$794. The United States clearly leads the world in health care spending.

The American health care delivery system is by far the most expensive in the world. Yet, on the two most common measures of a country's overall level of health—infant mortality and life expectancy—the United States does not rank especially high. As shown in Table 16-3, Japan and Singapore had the lowest infant mortality rate in the world at 2.6 per 1,000 live births in 2005. Finland was next with a rate of 2.8 infant deaths per 1,000 live births. The United States was twenty-eighth



TABLE 16-2 Per Capita Health Expenditures: Selected Countries, Selected Years, 1960-2006.

| Country        | 1960 | 1970  | 1975  | 1980  | 1985  | 1990    | 1995    | 2000    | 2006    |
|----------------|------|-------|-------|-------|-------|---------|---------|---------|---------|
| Australia      | \$89 | \$212 | \$443 | \$663 | \$998 | \$1,318 | \$1,792 | \$2,398 | \$3,141 |
| Austria        | 64   | 159   | 377   | 663   | 816   | 1,205   | 1,834   | 2,667   | 3,606   |
| Belgium        | 53   | 130   | 310   | 578   | 884   | 1,247   | 1,906   | 2,227   | —       |
| Canada         | 109  | 260   | 434   | 710   | 1,193 | 1,678   | 2,128   | 2,503   | 3,462   |
| Czech Republic | —    | —     | —     | —     | —     | 576     | 901     | 980     | 1,509   |
| Denmark        | —    | —     | —     | 819   | 1,177 | 1,453   | 1,882   | 2,380   | 3,362   |
| Finland        | 54   | 163   | 312   | 510   | 849   | 1,292   | 1,421   | 1,716   | 2,668   |
| France         | 72   | 206   | 393   | 701   | 1,082 | 1,520   | 1,991   | 2,450   | 3,449   |
| Germany        | 77   | 224   | 462   | 824   | 1,242 | 1,602   | 2,178   | 2,632   | 3,371   |
| Greece         | 21   | 100   | 104   | 345   | —     | 707     | 1,139   | 1,616   | 2,483   |
| Hungary        | —    | —     | —     | —     | —     | —       | 678     | 856     | 1,504   |
| Iceland        | 50   | 137   | 294   | 576   | 947   | 1,376   | 1,823   | 2,623   | 3,340   |
| Ireland        | 35   | 98    | 233   | 455   | 592   | 796     | 1,809   | 3,082   | —       |
| Italy          | 49   | 154   | 286   | 579   | 831   | 1,327   | 1,589   | 2,083   | 2,614   |
| Japan          | 26   | 130   | 260   | 523   | 818   | 1,082   | 1,632   | 1,967   | 2,578   |
| Mexico         | —    | —     | —     | —     | —     | 260     | 388     | 506     | 794     |
| Netherlands    | —    | 207   | 414   | 715   | 961   | 1,403   | 2,714   | 2,257   | —       |
| New Zealand    | 90   | —     | 359   | 456   | 587   | 937     | 1,244   | 1,605   | —       |
| Norway         | 46   | 131   | 311   | 632   | 915   | 1,363   | 1,864   | 3,080   | 4,520   |
| Poland         | —    | —     | —     | —     | —     | 258     | 420     | 590     | 910     |
| Portugal       | —    | 45    | 154   | 260   | 381   | 614     | 1,050   | 1,624   | 2,120   |
| Spain          | 14   | 82    | 190   | 325   | 454   | 815     | 1,068   | 1,520   | 2,458   |
| Sweden         | 89   | 270   | 477   | 850   | 1,172 | 1,492   | 1,622   | 2,271   | 3,202   |
| Switzerland    | 132  | 279   | 522   | 854   | 1,251 | 1,782   | 2,477   | 3,179   | 4,311   |
| United Kingdom | 74   | 144   | 277   | 444   | 669   | 968     | 1,301   | 1,858   | 2,760   |
| United States  | 141  | 341   | 582   | 1,052 | 1,735 | 2,688   | 3,637   | 3,637   | 6,714   |

Source: National Center for Health Statistics (2009).

among the thirty-six countries in Table 16-3, with an infant mortality in 2005 of 6.7 per 1,000 live births. Slovakia, Poland, Hungary, Cuba, and New Zealand all had lower rates of infant mortality than the United States.

As for life expectancy, perhaps the best overall single measure of a nation's health, Table 16-4 shows that Switzerland had the highest life expectancy for males at 78.7 years in 2005. Next are Japan, Israel, and Australia. The United States ranked twenty-fifth in male life expectancy at 75.2 years. Table 16-4 indicates that males in Costa Rica lived longer on average than their American counterparts. For females, Table 16-4 shows Japan with the highest life expectancy at 85.5 years for 2005. Switzerland was next at 84.0 years, followed by France and Spain. The United States is shown in Table 16-4 to have a female life expectancy of 80.4 years, which is ranked twenty-sixth highest, behind Denmark and just ahead of Cuba.

TABLE 16-3 Infant Mortality Rates: Selected Countries, 1990 and 2005.

| Country                             | <i>Infant Mortality Rate</i> |      |
|-------------------------------------|------------------------------|------|
|                                     | 1990                         | 2005 |
| Infant deaths per 1,000 live births |                              |      |
| Japan                               | 4.6                          | 2.6  |
| Singapore                           | 6.7                          | 2.6  |
| Finland                             | 5.6                          | 2.8  |
| Sweden                              | 6.0                          | 2.8  |
| Norway                              | 6.9                          | 3.2  |
| Czech Republic                      | 10.8                         | 3.3  |
| Portugal                            | 11.0                         | 3.6  |
| Austria                             | 6.5                          | 3.7  |
| Greece                              | 9.7                          | 3.7  |
| Ireland                             | 8.2                          | 3.8  |
| Denmark                             | 7.5                          | 3.8  |
| France                              | 7.3                          | 3.8  |
| Germany                             | 7.0                          | 3.8  |
| Spain                               | 7.6                          | 3.8  |
| Israel                              | 9.9                          | 4.3  |
| Netherlands                         | 7.1                          | 4.4  |
| Switzerland                         | 6.8                          | 4.4  |
| Scotland                            | 7.7                          | 4.5  |
| Australia                           | 8.2                          | 4.7  |
| England and Wales                   | 7.9                          | 5.0  |
| Northern Ireland                    | 7.5                          | 5.1  |
| New Zealand                         | 8.4                          | 5.2  |
| Cuba                                | 10.7                         | 5.3  |
| Canada                              | 6.8                          | 5.4  |
| Hungary                             | 14.8                         | 5.7  |
| Poland                              | 19.4                         | 6.0  |
| Slovakia                            | 12.0                         | 6.6  |
| United States                       | 9.2                          | 6.7  |
| Chile                               | 16.0                         | 7.6  |
| Costa Rica                          | 15.3                         | 9.6  |
| Russia                              | 26.9                         | 10.2 |
| Romania                             | 26.9                         | 13.9 |
| Belgium                             | 8.0                          | —    |
| Italy                               | 8.2                          | —    |
| Puerto Rico                         | 13.4                         | —    |
| Bulgaria                            | 14.8                         | —    |

Source: National Center for Health Statistics (2009).

TABLE 16-4 Life Expectancy at Birth, According to Sex: Selected Countries, 2005.

| <i>Males</i>      |                          | <i>Females</i>    |                          |
|-------------------|--------------------------|-------------------|--------------------------|
| Country           | Life Expectancy in Years | Country           | Life Expectancy in Years |
| Switzerland       | 78.7                     | Japan             | 85.5                     |
| Israel            | 78.6                     | Switzerland       | 84.0                     |
| Japan             | 78.6                     | France            | 83.7                     |
| Australia         | 78.5                     | Spain             | 83.7                     |
| Sweden            | 78.4                     | Australia         | 83.3                     |
| Canada            | 78.0                     | Sweden            | 82.8                     |
| New Zealand       | 77.9                     | Canada            | 82.7                     |
| Norway            | 77.8                     | Norway            | 82.7                     |
| Singapore         | 77.3                     | Finland           | 82.5                     |
| Ireland           | 77.2                     | Singapore         | 82.5                     |
| England and Wales | 77.2                     | Israel            | 82.4                     |
| Netherlands       | 77.2                     | Puerto Rico       | 82.4                     |
| Spain             | 76.8                     | Austria           | 82.2                     |
| Costa Rica        | 76.8                     | Germany           | 82.0                     |
| Greece            | 76.7                     | Belgium           | 81.9                     |
| Austria           | 76.7                     | New Zealand       | 81.9                     |
| France            | 76.7                     | Greece            | 81.7                     |
| Germany           | 76.6                     | Ireland           | 81.7                     |
| Scotland          | 76.2                     | Costa Rica        | 81.6                     |
| Belgium           | 76.2                     | Netherlands       | 81.6                     |
| Northern Ireland  | 76.0                     | England and Wales | 81.5                     |
| Denmark           | 75.9                     | Portugal          | 81.3                     |
| Cuba              | 75.6                     | Chile             | 81.2                     |
| Finland           | 75.6                     | Northern Ireland  | 81.0                     |
| United States     | 75.2                     | Denmark           | 80.5                     |
| Portugal          | 74.9                     | United States     | 80.4                     |
| Chile             | 74.8                     | Cuba              | 80.1                     |
| Puerto Rico       | 74.3                     | Scotland          | 79.5                     |
| Czech Republic    | 72.9                     | Poland            | 79.4                     |
| Poland            | 70.8                     | Czech Republic    | 79.2                     |
| Slovakia          | 70.1                     | Slovakia          | 77.9                     |
| Romania           | 68.8                     | Hungary           | 76.9                     |
| Hungary           | 68.6                     | Romania           | 75.8                     |
| Russia            | 59.0                     | Russia            | 72.4                     |
| Bulgaria          | —                        | Bulgaria          | —                        |
| Italy             | —                        | Italy             | —                        |

Source: National Center for Health Statistics (2009).

## SOCIALIZED MEDICINE: CANADA, GREAT BRITAIN, AND SWEDEN

A summary of the key features of fee-for-service, socialized medicine, decentralized national health, and socialist systems are shown in Table 16-5 (Field 1989). The fee-for-service model was examined in Chapter 15 on the United States. In this section, socialized medicine will be discussed. Socialized medicine refers to a system of health care delivery in which health care is provided in the form of a state-supported consumer service. That is, health care is purchased, but the buyer is the government, which makes the services available at little or no additional cost to the consumer. There are several different forms of socialized medicine, and the some differences between countries, what is common to all systems of socialized medicine, as shown in Table 16-5, is that the government (1) directly controls the financing and organization of health service in a capitalist economy; (2) directly pays providers; (3) owns most of the facilities (Canada is an exception); (4) guarantees equal access to the general population; and (5) allows some private care for patients willing to be responsible for their own expenses.

### Canada

The Canadian system of health care delivery is of particular interest to Americans, because it is the system most often discussed as a future model for the United States (Dickinson and Bolaria 2005). Like the United States, physicians in Canada are generally private, self-employed, fee-for-service practitioners. Unlike the United States, doctors' fees are paid by government-sponsored national health insurance, known as Medicare, according to a fee schedule negotiated between the provincial or territorial government and the medical association. Most hospitals also operate on a budget negotiated with government officials at the provincial or territorial level. Thus, Canada does not have a single health care delivery system, but instead ten provincial and three territorial ones. The federal government,

**TABLE 16-5** The Role of Government and Types of Health Care Delivery Systems.

| <i>Types of Systems</i> |                    |                     |                               |                    |
|-------------------------|--------------------|---------------------|-------------------------------|--------------------|
| Role of Government      | Fee-for-Service    | Socialized Medicine | Decentralized National Health | Socialist Medicine |
| Regulation              | Limited            | Direct              | Indirect                      | Direct             |
| Payments to providers   | Limited            | Direct              | Indirect                      | Direct             |
| Ownership of facilities | Private and public | Private and public  | Private and public            | Public             |
| Public access           | Not guaranteed     | Guaranteed          | Guaranteed                    | Guaranteed         |
| Private care            | Dominant           | Limited             | Limited                       | Unavailable        |

however, influences health policy and the delivery of care through fiscal and budgetary mechanisms, so the Canadian system is not as decentralized as that of Germany or France, where central governments exercise little direct control over health matters. Canada essentially has a private system of health care delivery paid for almost entirely by public money.

The publicly financed health care system is supported by taxes and premiums collected by the federal and provincial governments. Responsibility for providing health care rests with each province or territory, with federal government supplementary funds. Virtually every Canadian has comprehensive insurance coverage for hospital and doctor expenses. Dental care, prescription drugs for persons under age 65, ambulance service, private hospital rooms, and eyeglasses are not covered.

Canada was late in adopting its version of socialized medicine. Universal hospital insurance was not provided until 1961, and coverage for physician fees was not passed until 1971, over the opposition of doctors. Prior to this period, Canadians paid their medical and hospital bills in a variety of ways—direct payments by patients, private health insurance, and municipal government payments. The health profile of Canadians with respect to infant mortality and life expectancy is better than for Americans. Table 16-3 shows that, in 2005, Canadians had a lower rate of infant mortality than Americans (5.4 as compared to 6.7 deaths per 1,000 live births). Table 16-4 shows that Canadian males had a life expectancy of 78.0 years in 2005 compared to 75.2 years for American males. Canadian females had a life expectancy of 82.7 years compared to 80.4 years for American females. Like the United States and other countries, Canada has a social gradient in health and life expectancy, with Canadians at the bottom of the class structure being less healthy and living less longer than those at the top (Kostenuk and Dickinson 2003; McDonough, Walters, and Strohschein 2002).

The major problem facing Canada with respect to health care delivery is, as in most other major countries, one of rising costs. During the 1970s, Canada's expenditures for health remained constant at about 7 percent of GDP but rose to over 8 percent in the early 1980s. The federal government realized it had no control over spending and enacted Bill C-37 in 1977, which limited federal contributions to national health insurance and made them independent of provincial health spending. Federal income and corporate taxes were also reduced, thereby giving the provinces room to increase their taxes in order to balance spending without increasing the overall tax rate. Federal taxes went down, but provincial taxes went up, and taxation in general stayed at about the same level. Until 2004, the federal government paid about 24 percent of health care costs, the provinces/territories 44 percent, private spending 30 percent, local governments 1 percent, and workers' compensation 1 percent. At that time, these levels changed, with the federal government agreeing to send an additional \$14 billion in federal money over the next six years to the provinces and territories for health care, with guarantees of additional 6 percent annual increases through to 2015. This agreement to increase federal contributions should help equalize the budget allotments for all levels of government by bringing more federal money into the health care



system. In coming years, federal and provincial/territorial spending levels should be more similar. The new monies were necessary to offset the country's growing problems in the health sector, including an increasing shortage of doctors and nurses, lengthy waits for cancer care and surgery, and mounting costs for drugs for an aging population.

The private market for health is also growing in Canada, with the emergence of private clinics that accept both public and private health insurance. Canada's private health insurance, usually provided by employers, supplements public benefits with coverage for private or semiprivate hospital rooms, prescription drugs, dental and vision care, and other services. In 1984, the Canada Health Act was passed, reaffirming the principle of universal access to health care and imposed penalties on provinces that allowed physicians to charge patients fees above government limits. By 1987, all provinces had banned extra billing by doctors. However, while Canadian health care is essentially free at the point of service in that patients never see a bill, it is not free for the taxpayer. Canadians pay 15 to 20 percent more in income tax than Americans, with the result that some of the affluent pay over half of their income in tax. Quebec, for example, has the highest income tax, and persons in the highest tax bracket pay 51.7 percent of their income in taxes. Canadians also pay a sales tax (value added tax) of about 15 percent on their purchases.

Canadian physicians, like their American counterparts, are a profession whose power is in decline (Dickinson and Bolaria 2005). In 1986, doctors in Ontario conducted a major strike in protest to the federal government's decision to curtail the extra billing of patients. The issue was over whether or not doctors could set their own fees. The medical profession in Ontario contended that the Canada Health Act changed their status from that of private practitioners to "public employee," since the government determined how much physicians could charge for their services. Many physicians supported the strike, but others did not, and the protest collapsed, leaving the government's position unchanged. Since the mid-1980s, there has been little or no conflict between the government and the medical profession. Most Canadian physicians today appear to have accepted the government's payment system. Virtually all Canadian doctors participate in provincial health plans and have no other source of payment for most medical procedures.

Canadians appear to prefer their health care system—especially in contrast to the American model. Major reasons for the greater satisfaction of Canadians with their health care delivery system are its quality and lower cost. Canadian patients pay virtually nothing directly to doctors and hospitals. Rather, the provincial governments are the nation's purchaser of health services, paying a set fee to doctors for patient care and providing a set budget for operating costs to hospitals. Canadian hospitals, unlike American hospitals, cannot make more money by providing more services. The essential difference between the United States and Canada in health spending, as Robert Evans (1986) explained years ago, is that the Canadian system combines universal comprehensive coverage for the population combined with cost controls. "Universal coverage," as Evans (1986:597) points out, "is a necessary condition for government to engage in bilateral negotiations to exercise the leverage whereby cost

escalation can be controlled." Since the government buys essentially all the care provided, it has the leverage to control the costs of that care. The largest drawback to the Canadian system is long waits for some medical procedures, such as certain types of surgery, cancer radiation, and some diagnostic tests. It may take up to 16 weeks after diagnosis, for example, for cancer radiation treatment. When such delays are serious for individual patients, sometimes they cross the border into the United States on their own to obtain private care or the government allows them to do so at government expense (Brooke 2000).

The most significant recent change in Canada's public health care delivery system occurred when the Supreme Court ruled in 2005 that Quebec's ban on private health insurance was unconstitutional. The court held that the prohibition on banning private health insurance is not constitutional when the public system fails to deliver reasonable services. Quebec is allowing patients to be treated in private hospitals when they cannot be treated within six months in the public system, while Alberta, British Columbia, and other provinces are encouraging the expansion of private health facilities and insurance. Yet problems remain. Canada's population is aging, so fewer people will be working and paying taxes to support the health care system. At the same time, demands on the system will be increasing because older people need more care. Canada faces major challenges in maintaining the quality of its health care in the twenty-first century.

## Great Britain

Britain had inaugurated a national health insurance program between 1911 and 1913, but it provided limited benefits and covered only manual workers. In 1948 the British government went much further and formed the National Health Service (NHS) by nationalizing and taking over the responsibility for the country's health care. In such circumstances, the government becomes the employer for health workers, maintains facilities, and purchases supplies and new equipment through the use of funds collected largely by taxation. Health services are provided at no cost to those who use them. The NHS is Britain's largest employer with 1.7 million employees in 2009. It is also the largest publicly funded health service in the world.

Although Germany was the first country to enact national health insurance, Britain established the first health care system in any Western society to offer free medical care to the entire population. Prior to 1948, the quality of care one received in Britain clearly depended on one's financial resources, with the poor suffering from a decidedly adverse situation. The Labor Party, which was in power after World War II, wanted to ensure that everyone would receive medical treatment free of charge. To accomplish this purpose, the government had to take over privately owned medical facilities. The National Health Service Act of 1948 reorganized health care delivery in the United Kingdom under the single umbrella of the NHS. This organizational structure, as will be discussed, changed in 2000 with the political separation of the NHS into semi-autonomous services for England, Wales, Scotland, and Northern Ireland (Bury 2010; Hughes and Vincent-Jones 2008).

The first line of medical care in Great Britain remains that of the general practitioner (GP) who works from an office or clinic as part of either a solo or group practice. GPs are paid an annual capitation fee for each patient on their patient list, as part of a contractual arrangement with their NHS. The average number of patients on a GP's list is about 2,000. With special permission, a GP may have up to 3,500 patients on his or her list, if a solo practitioner. Group practices can have even larger patient lists, depending on the number of doctors involved. The GP is required to provide medical services free of charge. The patient (if over the age of 16) has the right to select his or her doctor, and the doctor is free to accept or reject anyone as a full-time patient. But if a potential patient is rejected from joining a doctor's list, the doctor must still provide treatment if the person is not on any other physician's list or if the person's physician is absent. A higher capitation fee is paid for patients who are 65 years of age or older, and additional sums are paid by the government to meet certain basic office expenses, to join a group practice, for additional training, for seniority, and for practicing medicine in areas that are underserved by physicians.

Except for emergencies, if treatment by a specialist (called "consultant" in the British system) or hospitalization is warranted, the GP must refer the patient to a specialist. Generally, specialists are the only physicians who treat patients in hospitals and are paid a salary by the government. About 11 percent of the total funds to support the NHS are derived from payroll deductions and employer's contributions, thus most of the revenue comes from general taxation. The average worker pays about 9 percent of his or her earnings for national health insurance, which is matched by employers. Because of strong opposition from physicians when the NHS was first organized, physicians are also allowed to treat private patients, and a certain number of hospital beds ("pay" beds) are reserved for this type of patient. Private patients are responsible for paying their own bills, and most of them have health insurance from private insurance companies. The advantage of being a private patient is less time spent in waiting rooms and obtaining appointments and, of course, more privacy. In addition to the medical care provided by the NHS, the British have a sickness benefit fund to supplement income while a person is sick or injured, death benefits paid to survivors, and maternity benefits.

The British Medical Association (BMA) had initially opposed both the enactment of national health insurance between 1911 and 1913 and the formation of the NHS after World War II. However, each became law as the government was determined to institute the programs, and enough inducements were offered to physicians to reduce the strength of their opposition. In the face of strong government determination and skillful politics by the prime ministers of that time (Lloyd George in 1912 and Aneurin Bevan in 1946), the BMA was rendered ineffective. Both prime ministers managed to divide the loyalties of the BMA. Bevan, for example, refused to be drawn into lengthy negotiations with the BMA but provided concessions to teaching hospitals and consultants (specialists) and permitted the treatment of private patients in state hospitals to gain the support of many in the medical establishment. It also became increasingly clear to the

medical profession that the government was going to turn the measure into law, either with or without the support of the BMA. In the end, the BMA became a partner with the government in instituting changes.

Initially, the NHS was marked by controversy and subjected to criticism. The mode of capitation payments to GPs meant that the more patients seen by a physician, the more money the physician was able to make. Hence, there was a serious concern and some evidence that medical care was being provided in quantity rather than quality. A measure was introduced to pay physicians less for treating more patients, but as the population has increased, the doctors have found it difficult to reduce their patient load. Also, the government and physicians have disputed the amount paid for capitation fees, with the physicians arguing that it is not enough. Disputes have likewise taken place between GPs and consultants (specialists). Consultants have higher prestige and draw higher incomes, and GPs have claimed that the NHS favors consultants, not only with regard to income but also to fringe benefits (vacations, retirement, and so on), while demanding that politicians and government administrators be more sensitive to their needs.

Consequently, conflict and problems concerning health care delivery in Britain are largely between health care providers and the government. There is little direct involvement by the general public. It is the state's role to act as the protector of patients' rights and interests, but only in the last few years have there been channels for the public to voice its concerns directly. The central problem faced by the NHS is its lack of financial resources. Although the UK has a relatively high standard of living, there are large pockets of poverty. Moreover, the NHS has worked hard to hold down medical costs, and only about 8.4 percent of Britain's GDP was spent on health care in 2006. This is less than the European average of 9 percent. Though relatively successful in combating rising expenses, this policy has had its drawbacks. British doctors and nurses, on average, are not paid high salaries. Occasionally they go on strike in order to bargain for more pay. Many doctors, especially consultants, do a considerable amount of private practice in order to increase their income. British patients became increasingly dissatisfied with waiting for long periods of time in doctors' offices and for appointments to see them. There were also long delays in obtaining elective surgery and criticism about low staffing levels in hospitals. In order to improve the situation, the British government, led by Prime Minister Margaret Thatcher, initiated reforms in the 1990s intended to create a competitive "internal market" within the nation's health care delivery system (Annandale and Field 2005).

The most important measure was enactment of the NHS and Community Care Act of 1990. The provisions of this act made the NHS more responsive to the needs of patients by delegating greater power and responsibility down to local health districts and hospitals. Hospitals can be self-governing as NHS hospital trusts can finance themselves by contracting directly for their services with district health authorities (DHAs). DHAs are responsible for paying for health care in their area, managing the provision of that care, and planning in accordance with regional and national guidelines. The DHAs are managed by, and receive their resources from, NHS executive regional offices, which are funded, in turn, by the



central government. Additionally, GPs in group practices, with at least 5,000 patients, can apply for a budget, as GP fund holders, to purchase services from hospitals for their patients. GPs are also given higher incomes from capitation fees and encouraged to compete for patients. Patients, in turn, are allowed to choose and change GPs more readily. And finally, the work of consultants is to be audited and reviewed regularly to determine satisfactory performance.

Furthermore, hospitals providing services to private patients are allowed to make a profit from those services instead of providing them at cost. Hospitals are also allowed to market their services to make them more attractive to private patients, and NHS patients can be admitted by their doctors to the best hospitals available—not just those in their district. These measures were intended by the government to improve efficiency, reduce delays in receiving treatment, and assist doctors and hospitals to increase their incomes by attracting more patients. Although these measures signified the application of free-market methods to a state-financed system, the principle of state-sponsored health care remained in place. In addition to reforming the health care marketplace, a *Patient's Charter* was provided that assured patients of ten basic rights, including the following: the right to receive care; be referred to a consultant, if necessary; be given a clear explanation of treatment; have access to health records, and have the confidentiality of those records maintained; receive detailed information on local health services; be guaranteed admission to treatment by a specific date; and have any complaints about the NHS investigated (Hughes and Griffiths 1999).

Despite these reforms, however, serious problems remained: Conditions in hospitals, many of them old and in need of renovation, worsened; waiting lists for surgery lengthened beyond a year; different regions of the country had different standards of care; and there was deepening dissatisfaction among doctors, nurses, and other health care workers over government budget cuts. Market reforms did not eliminate shortages caused by government underfunding. In 1997, the Labor Party came to power, and Prime Minister Tony Blair proposed to reorganize the health care system and abolish the internal market of the NHS established by the Conservatives. However, the internal market largely remained intact in England with its emphasis on primary care, contracts, and NHS trusts when the English NHS became partially independent in 2000 (Hughes and Vincent-Jones 2008). England was also the first to organize new foundation trusts for hospital care in 2004 that have the authority to issue legally binding contracts to corporate and other purchasers of their services. The other “home country” NHS services focused more on the public provision of health care while limiting internal market measures in their regions. There were some changes as primary care trusts, consisting of local networks of general practitioners and community health nurses, replaced the fundholding and non-fundholding general practices in purchasing care from hospitals and consultants. Most recently, the coalition government that took office in 2010 proposed abolishing the primary care trusts to save administrative costs and instead allocate funds directly to general practitioners for their use in paying hospitals and other health care providers for services provided to patients on their lists.

Although reforms have been found necessary, the NHS has accomplished what it set out to do—provide free comprehensive medical care to the residents of Great Britain. It has shown significant results. The general health profile of Britain is among the best in the world. Tables 16-3 and 16-4 show, for example, that the infant mortality rates for England and Wales are lower than in the United States, while life expectancy for males and females is higher. On balance, health care in Britain is of a high quality despite problems, and particular success has been achieved against heart disease. Yet significant inequalities in health remain between social classes (Bury 2010; Chandola 2000; Lahelma, Arber, Kivela, and Roos 2002; Lahelma, Arber, Rakkonen, and Silventoinen 2000; Marmot 2004; Marmot and Wilkinson 1999; Reid 1998). Poor health among the lower classes in Britain, however, is due more to the unhealthy lifestyles and living environment associated with poverty, rather than a lack of access to quality health care (Jarvis and Wardle 1999; Reid 1998; Shaw, Dorling, and Smith 1999).

## Sweden

Sweden, along with Great Britain, has demonstrated that a socialized system of health care delivery can be effective in a capitalist country through the formation of a national health service. The Swedish National Health Service is financed through taxation. Taxes in Sweden have been the highest in the world. Tax reform in 1991 reduced the highest income tax rate from 72 to 51 percent, but the top tax bracket was temporarily increased to 56 percent in 1995 and has remained in place. Sweden is one of the world's most egalitarian countries when it comes to the provision of welfare benefits to the general population, and inequities in living conditions have been reduced to a level that is more equal than in most other countries. Universal health insurance, old-age pensions, unemployment insurance, and job-retraining programs protect employed Swedes and their families from serious concern about being pushed into poverty by poor health, old age, and unemployment. There are social class differences in health in Sweden, with the lower class showing a less-positive health profile than more affluent Swedes, but the difference is less pronounced than in most other countries (Hemström 2005). Sweden, along with the other Nordic countries, has the lowest proportion of poor people in Europe. On virtually every measure, the Swedes must be considered one of the world's healthiest populations overall. As shown in Table 16-3, Sweden has the fourth lowest infant mortality rate in the world (2.8 deaths per 1,000 live births) in 2005. Table 16-4 shows that Sweden has the fifth highest life expectancy for males (78.4 years) and sixth highest for females (82.8 years). Sweden spent 9.2 percent of its GDP on health in 2006.

The Swedish National Health Service is the responsibility of the Ministry of Health and Social Affairs. Only particularly important health issues are decided by the ministry. Most decisions pertaining to health policy are made by the National Board of Health and Welfare. This board plans, supervises, and regulates the delivery of health services at the county level. Physicians are employed by county councils and are paid according to the number of hours worked rather than the number of patients treated. Physicians are obligated to work a fixed number of



hours per week, usually about 40 to 42. It is generally left up to the doctor to decide what percentage of his or her time is to be spent on treating patients, doing research, or teaching. Physicians' salaries are standardized by specialty, place and region of work, and seniority.

A major characteristic of the NHS in Sweden is that general hospitals are owned by county and municipal governments. These local governments are responsible for maintaining and providing services. The state pays the general hospitals a relatively small amount of money from a health insurance fund, leaving the balance to be paid from local tax revenues. Enrollment in the government-sponsored health insurance program is mandatory for the entire population. Most of the money to support the insurance program comes from the contributions of employers and payroll deductions of employees. This insurance, a form of national health insurance, is used primarily to pay the salaries of physicians and other health workers. There are also some general practitioners in private practice whose fees are paid by the insurance fund and token payments from patients. Fees for all physicians, however, are set by the government and paid according to their schedule.

The Swedish health care system has some additional benefits other than generally free medical treatment. Beginning in 2010, Swedes can choose whether they wish to be treated in either a public or private medical facility at state expense. They can almost be treated anywhere in the country they wish. Excessive travel expenses to visit physicians and hospitals are paid by the government, and there is a cash sickness fund designed to protect a person's standard of living against losses of income due to illness or injury. Under this program, people may receive up to 80 percent of the income they would be earning if they were able to work at their job. Drugs are either free or inexpensive, and financial supplements are paid to each woman giving birth to a child and to families with children under the age of 16, regardless of the family's income.

Thus, it would be somewhat misleading to consider the funding of Sweden's health care delivery system as an example of national health insurance, since most of the revenues come from county councils. The total health bill in Sweden is met by contributions of 71 percent from county taxes, 16 percent from the national government, 10 percent from the health insurance system and other sources, and 3 percent from patient fees. Pressure on government budgets had intensified during the early 1990s because of a slowdown in the economy, rising unemployment, and tax reform. As Bernard Jones (1996:104) explains, Sweden, for the first time in living memory, had to worry about finances, and the resources of the welfare state—previously provided on a generous scale—began to be rationed. The county councils, who allocate about 75 percent of their budgets to health care, reduced their expenditures. Patients spent less time in hospitals than in the past and are now treated more often as outpatients. In 1994, the county councils also introduced a new financial system of payments to hospitals based on the actual number of patients treated, instead of a traditional fixed annual budget, and competition between hospitals was allowed with the goal of improving quality and lowering costs. Consequently, Sweden, like Great Britain, has moved toward a purchaser-provider model within its own government-run health system and maintained this approach even when the economy improved in the late 1990s.

### BOX 16-1 National Health Insurance in Rwanda

The African country of Rwanda with a population of 9.7 million people is one of the poorest countries in the world, but it has national health insurance. The Rwandan health insurance program covers 92 percent of the population and costs \$2 a year. Since it was established in 1999, life expectancy has risen four years for the country as a whole from 48 years to 52 years, despite the AIDS epidemic. The plan provides basic coverage in a country where CT scans and kidney dialysis are usually unavailable, and there is only one neurosurgeon and three cardiologists (McNeil 2010). The two-dollar annual fee can't really cover the cost of care, even in Rwanda, but over half of the cost is paid by foreign donors, especially the United States. The poorest of the poor have their premiums paid by organizations such as the Global Fund to Fight AIDS since many people cannot afford to pay even \$2. A problem, however, is that some people do not like to pay in advance for something they may not use and want their \$2 refunded if they don't get sick.

Sweden remains committed to universal and equal access to health services paid by public funding. County councils have been directed by the national legislature to remain responsible for health care delivery but pass the responsibility for nursing homes to municipalities and transfer part of their budgets to local health districts. This measure will allow the districts to purchase services from different primary care centers and hospitals, a development intended to promote competition between providers and greater freedom of choice for patients. These changes in Sweden's health services are not extreme. Instead, they are intended to improve a highly successful system by introducing limited aspects of a free market.

### DECENTRALIZED NATIONAL HEALTH PROGRAMS: JAPAN, GERMANY, AND MEXICO

Decentralized national health programs differ from systems of socialized medicine, in that government control and management of health care delivery is more indirect. The government acts primarily to regulate the system, not operate it. Often the government functions in the role of a third party, mediating and coordinating health care delivery between providers and the organizations involved in the financing of services. In decentralized national health programs, the government indirectly controls the financing and organization of health services in a capitalist economy; (2) regulates payments to providers; (3) owns some of the facilities; (4) guarantees equal access to the general population; and (5) allows some private care for patients willing to be responsible for their own expenses. In this section, the decentralized national health care systems in Japan, Germany, and Mexico will be discussed.

## Japan

Japan spent 8.1 percent of its GDP on health care in 2006 (more than half of that of the United States), but the Japanese have achieved striking results over the last 50 years. For example, in 1955, the average life expectancy of a Japanese was more than four years less than that of an American. By 1967, Japan's life expectancy had passed that of the United States and, as shown in Table 16-4, is the second highest in the world for males (78.6 years) and highest for females (85.5 years) as of 2005. Japanese rates for infant mortality (Table 16-3) are the lowest in the world (2.6 per 1,000 live births in 2005).

Japan has a national health insurance plan, introduced in 1961, but its benefits are relatively low by Western standards. Japanese patients pay 30 percent of the cost of health services, with the national plan paying the remainder. However, patients are reimbursed by the plan for expenses over 60,000 yen (\$680) for medical care during any given month; low-income patients are reimbursed for amounts spent over 33,600 yen (\$381) monthly. People over 70 years of age have all of their costs covered. Patients are allowed to choose their own doctors and encouraged to visit them regularly, and these policies more than likely promote the longevity of the Japanese, since health problems can be diagnosed during early stages. Under a national law effective in 2008, companies and local governments are required to have the waistlines measured of persons under their jurisdiction between the ages of 40 and 74 years during their annual physical. Persons exceeding Japanese government limits of 33.5 inch waists for men and 35.4 inches for women are given guidance for dieting and time periods for weight loss. Companies and local governments that fail to meet weight reduction goals are required to pay fines to the national government.

About one-third of Japanese doctors are in private practice and are paid on a fee-for-service basis. All the rest are full-time, salaried employees of hospitals. Physicians not on a hospital staff cannot treat their patients once they are hospitalized. Physician fees for office visits and examinations are low because the government sets fees. Regardless of seniority or geographical area, all Japanese doctors in private practice are paid the same amount for the same procedures, according to the government's uniform fee schedule. Fee revisions are negotiated by the Central Social Medical Care Council in the Ministry of Health and Welfare, comprising eight providers (doctors, dentists, and a pharmacist); eight payers (four insurers, two from the government, and two from management and labor); and four who represent public interests (three economists and a lawyer). However, any changes in fees are ultimately decided by the Ministry of Finance because government subsidies must be kept within general budgetary limits. In effect, the government virtually determines fees for doctors and hospitals. Hospital costs tend to be low because the government refuses to pay high costs in that area as well.

The government fee schedule is the primary mechanism for cost containment. Providers are prohibited by law from charging more than the schedule allows. Japanese doctors do receive a substantial supplementary income from the drugs they prescribe (25 percent or more of the price of the drug). Also, the Japanese use

Prenatal Intensive Care Unit in Japan. The Japanese have the highest life expectancy in the world for both males and females.



more prescription drugs than patients anywhere (Ikegami and Campbell 1995; Powell and Anesaki 1990). Private practitioners in Japan earn significantly more (about four times as much) than hospital-based doctors.

The Japanese national health insurance plan does not cover all Japanese. Instead, the government encouraged private organizations to keep government involvement at a minimum by setting up their own welfare programs. Part of the normative structure of the Japanese business world is that companies are responsible for taking care of their own employees. In Japan, this responsibility includes providing retirement plans, helping retired employees find postretirement work, arranging vacations, offering low-cost loans for housing, and providing medical care. Consequently, there are separate programs of health services for employees of large companies, small and medium-sized companies, and public and quasi-public institutions. Some large companies employ doctors and own hospitals. There is also a program for citizens who are not covered under other plans. Consequently, the entire Japanese population is covered by some type of health insurance plan, and the average Japanese has a much greater measure of security concerning health care than the average American (Anesaki and Munakata 2005).

The concept of having a decentralized system of health care based largely on occupation is supported by Japanese businessmen, who generally provide more benefits than are required by law. Business leaders oppose a heavy welfare burden for the government, as they want to pay less in taxes and avoid the governmental



administrative overhead required for a large public welfare system. The tax burdens in welfare states such as Sweden and Great Britain are undesirable as is the income-based welfare system in the United States. Also important is the desire of Japanese businesses to provide security to their employees in exchange for employee loyalty and productivity. This policy gives large Japanese corporations an advantage in attracting workers because of the greater benefit packages they can offer. As a result, some Japanese have better health care benefits than others, although the overall provision of health benefits in Japan is highly equitable.

Japanese lifestyles and the country's high standard of living have undoubtedly contributed to the overall level of good health and longevity, while the provision of universal health insurance coverage without rationing care is a major achievement. While no health system can be perfect because demands can easily exceed resources, the Japanese have established one of the most efficient health care systems in the world: It is relatively low cost, effective, and equitable.

However, there are problems. Some 80 percent of all Japanese hospitals are privately owned by physicians, but many facilities are old and lack space. Because the Japanese government limits how much they can charge, Japanese hospitals are often required to admit more and more patients in order to meet their expenses. Overcrowding has therefore become common in most hospitals. The average length of hospitalization in Japan is also longer than in the West. Hospital administrators complain that it is difficult to finance updated facilities or hire additional personnel without increases in the amounts charged to patients.

There are typically long waits at doctors' offices and clinics as well, because Japanese physicians do not use an appointment system. Basically, it is a case of first come, first served, and some patients begin lining up outside the doctor's office before it opens. Furthermore, relationships between doctors and patients in Japan tend to be more impersonal than in the United States. Patients are told little about their diagnoses, the treatment prescribed, or types of drugs being administered. "Doctors," state Margaret Powell and Masahira Anesaki (1990:174), "tend to explain away the problem in soothing terms without necessarily providing precise information about what exactly the problem is." The doctor-patient relationship is based on trust and the traditional Japanese cultural value of deference to authority. A patient requesting information directly would be seen as questioning the physician's authority, judgment, and knowledge. Therefore, patients are to rely on what doctors tell them. The Japanese medical profession is highly self-regulated and adverse to public scrutiny.

There are also changes in disease patterns. Heart disease is on the rise and is now the second leading cause of death after cancer. Historically, Japan has had low mortality rates from heart disease in comparison to Western countries. This trend undoubtedly influences higher levels of life expectancy among the Japanese, especially among males. The traditional low-fat, low-protein, and high-carbohydrate Japanese diet of fish, rice, and green vegetables is a major factor in this situation (Cockerham, Hattori, and Yamori 2000; Powell and Anesaki 1990). Also, the stress-reducing aspects of Japanese culture, such as strong group solidarity and cooperation in dealing with problems and after-work socializing by males on a regular basis



with close friends in bars or noodle shops, may be important. These drinking places are often designed to encourage relaxation and allow a temporary escape from the tensions of modern living. After-work socializing with coworkers seems to have become a routine activity in the lifestyles of many men in industrial Japan.

Nevertheless, a more Westernized lifestyle and increase in the consumption of animal fats and proteins—associated with Western diets—have promoted more heart disease, along with the stresses of living in a dynamic, hardworking, and densely populated society (Anesaki and Munakata 2005). Research examining socioeconomic differences in risk behavior for coronary heart disease in urban Japanese civil servants shows that persons with less education and lower status jobs smoke significantly more than those with a university education and higher status positions (Nishi, Makino, Fukuda, and Tatarra 2004). Alcohol consumption, however, was widespread at both the top and bottom of the social scale. The shift toward higher fat in Japanese diets has also contributed to a rise in colon and pancreatic cancers, and heavy smoking among Japanese males has led to an increase in mortality rates from lung cancer. The Japanese also have the highest rates of stomach cancer in the world. Increases in death rates from cancer and heart disease, as well as the highest mortality rates from stroke of any advanced country, suggest that increases in life expectancy for the Japanese may be slowing down and perhaps reaching a limit.

These changes, combined with the rapid growth of Japan's elderly population, are likely to place tremendous pressure on Japan's health care delivery system in the future. The proportion of people living to old age is increasing in Japanese society faster than in any other country in the world, and this situation is going to require a significant response from Japan's system of health care delivery.

## Germany

The structure of health care delivery in the Federal Republic of Germany has not changed significantly since 1883 and the reforms instituted by Bismarck's administration in imperial Germany. The program established at that time was based on three principal components: (1) compulsory insurance; (2) free health services; and (3) sick benefits. Employees, self-employed, unemployed, old-age pensioners, and certain categories of domestic workers providing infant and child care, home help, and so on are all required to be insured by one of Germany's public health insurance organizations. There are about 1,300 public health insurance groups, and membership in a particular health plan was once determined by occupation or place of employment. Today, anyone can join any plan who can now advertise for members. Germany's largest public health insurance organization is the Allgemeine Ortskrankenkassen (AOK), which insures about half the population. The AOK originally insured only blue-collar workers but broadened its membership base to include the general population. Bismarck's welfare measures in the late nineteenth century were both a response to democratization and an attempt to suppress it. That is, Bismarck wanted to defuse the demands for political rights from an increasingly well-organized and leftist-oriented working class by providing them with social rights that linked workers to the state, rather than to labor unions or socialist political parties.

Included in Bismarck's plan was the first national health insurance program ever. Regardless of his political motives, Bismarck's health insurance scheme proved to be durable and effective.

Following Germany's defeat in World War II and the incorporation of its eastern lands into a separate communist state, West Germany became a multiparty republic in 1949. The Federal Republic's constitution, the Basic Law, guarantees the social welfare of its citizens, continues the comprehensive social welfare system developed by Bismarck, and now includes the East Germans after reunification in 1990. The program that currently exists includes health insurance, old-age pensions, sickness benefits for income lost to illness or injury, unemployment insurance, and family assistance in the form of allowances for children, rent (especially for the elderly), and public funds for the construction of low-income housing.

Approximately 90 percent of all Germans participate, involuntarily or voluntarily, in the nation's public health insurance program. The remainder consists mainly of civil servants, who have their own insurance, and high-income earners who can take out private insurance or pay for state-sponsored insurance. In the state plan, health care is free to the individual except for small copayments and covers medical and dental treatment, drugs and medicines, and hospital care as needed. In the event of illness, the employer must continue to pay the employee's full wages for six weeks, and then the health insurance fund provides the individual with his or her approximate take-home pay for up to 78 weeks. If the illness is more protracted, benefits are continued under a welfare plan unless the person is permanently incapacitated and is entitled to a disability pension. About 13.2 percent of a worker's monthly gross earnings goes to pay for health insurance, with half paid by the employee and half by the employer.

Public health insurance plans are coordinated by the National Federation of Health Insurance. The insurance plan issues a medical certificate to members and their dependents periodically. This certificate is presented to a physician when services are rendered. The physician then submits the certificate to his or her association of registered doctors, which all physicians are required to join. Payment is made to the physician through the doctors' association, according to a fee schedule agreed upon by the association and the public health insurance plans. Hospital fees and payments are handled in the same manner.

As the preceding discussion indicates, the German government does not play a major role in the financing of health services. The government's primary function is one of administration. The Federal Ministry of Labor and Social Affairs exercises general supervision of the health care delivery system through state ministries and local health boards. According to Donald Light (Light and Schuller 1986), this form of health service organization is one of corporatism and represents a unique contribution by Germany to the provision of health care. Corporatism in the German context consists of: (1) compulsory membership on the part of the population in a national health plan and (2) a set of institutions situated between the government and its citizens with the authority to manage health care under government auspices. Approximately 50 percent of Germany's physicians are general practitioners, which is a high percentage compared to the United States. Most German doctors

practice medicine in private offices or clinics on a solo basis. Few work in a group practice, but that may change as outpatient medical centers are being established throughout the country. German physicians are well paid, earning somewhat more, on average, than American doctors. The Health Care Reform Act of 1989 helped limit costs by increasing the amounts paid by persons insured voluntarily in the public health plan, adding a small copayment for prescription drugs, establishing price ceilings for most drugs, and other measures. The Health Structure Act of 1993 mandated price cuts for drugs, lower incomes for doctors and dentists (along with compulsory retirement at age 68), increased copayments for patients, and limits on hospital budgets. Germans have been able to choose their own public health insurance plan since 1997. The 2007 Strengthening of Competition in Legal Health Insurance Law made having health insurance mandatory for all Germans and extended insurance options.

Since 1995, approximately 10 percent of the GDP has been spent on all health, and cost containment remains a major policy objective for the government. The German population is also aging, which signals higher expenses in the future. Some 25 percent (or one in four) of the German people were age 60 and over in 2006. This situation is complicated by the fact that Germany has the lowest birthrate in Europe at 8.2 births per 1,000 persons in 2006. German death rates have exceeded birthrates since 1972 and, as a consequence, its population is shrinking, having declined by 130,000 people in 2006 alone and now stands at 82.4 million inhabitants despite immigration. Fewer younger adults of working age in relation to the number of elderly persons means fewer potential tax revenues to support health care and the social welfare system. In order to generate more income without raising taxes, health ordinances have increased copayments by patients for prescription drugs, hospitalization, physical therapy, and other services. Future changes in health policy are inevitable as Germany continues to provide generous benefits to its citizens and permanent residents.

The general level of health of the German population, however, is good. Table 16-3 shows that in 2005 Germany had a lower infant mortality rate than the United States. The U.S. infant mortality rate was 6.7 per 1,000 compared to 3.8 for Germany. Table 16-4 indicates that both German men and women had a higher life expectancy than Americans. For men, the Germans showed a life expectancy of 76.6 years in 2005 and American men were listed at 75.2 years. For women, the German figures were 82.0 years versus 80.4 years for Americans. Almost half of all deaths are due to diseases of the heart and circulatory system. The prevalence of heart disease in eastern Germany is higher than in the western lands, with eastern men showing higher levels of cigarette smoking, hypertension, cholesterol, and obesity (Knesebeck and Siegist 2005; Nolte, Scholz, Shkolnikov, and McKee 2002). However, evidence shows that the change in the health care delivery and improved living conditions in eastern Germany is improving life expectancy (Nolte *et al.* 2002).

## Mexico

Mexico has a decentralized national health system covering most of the general population through a variety of programs that fall into one of three broad categories. First, there are the public social security organizations that provide both health insurance

and old-age benefits for specific groups of private and government employees. Second is the health care provided through the government's Secretariat of Health and Welfare or Secretaría de Salud (SSA), which is the primary source of care for the majority of persons not covered by a social security organization—especially the urban poor. And third, there is the private health care system, which consists of various private practitioners, hospitals and clinics, and charitable organizations.

The largest health plan in Mexico covers workers in the private sector and is administered by the Mexican Social Insurance Institute or Instituto Mexicano de Seguro Social (IMSS). The IMSS was established in 1943 as a compulsory government-sponsored social security program for salaried workers in Mexico City and surrounding areas, financed by contributions from workers, employers, and the state. The program was extended to other metropolitan areas during 1943–1945. Salaried agricultural workers were added in 1954; and, in 1973, legislation was enacted that provided for the extension of IMSS social insurance to everyone with jobs in the private sector, including those who could not afford to contribute financially. Known as the IMSS Social Solidarity Program, health services are provided free of charge to low-income workers and their families in return for approximately ten days of work in public projects. The level of benefits available for low-income members, however, is not comprehensive and is limited to general medical and maternity care. Further, despite efforts to expand the IMSS program to rural areas, more than 90 percent of the IMSS membership is urban.

Another health plan, which provides the most extensive and generous benefits of any social security program, was established in 1960 for government workers and is administered by the Social Insurance Institute of State Employees or Instituto de Seguridad y Servicios Sociales Para los Trabajadores del Estado (ISSSTE). The IMSS and ISSSTE programs are by far the largest health insurance plans in Mexico. Other social security programs with health insurance are available to members of the armed forces (ISSSFA) and the state-run oil industry (PEMEX). Approximately 45 percent of Mexico's population is covered by these various social security plans.

The Secretariat of Health and Welfare (SSA), created in 1943, is responsible for Mexico's overall health policy and provides health care directly to the urban poor through its own hospitals and clinics. Nearly 20 percent of the population is dependent on the SSA to meet their health needs. Another 15 percent of the population utilizes the private sector.

In theory, Mexico has a national health system; yet in reality, not everyone has access to it (Castro 2005). Only 50 percent of the population has health insurance (Barraza, Bertozz, Gonzalez-Pier, and Gutierrez 2002). While exact figures are unknown, health care facilities are not readily available for some 15 to 20 percent of the population. Most of these persons live in rural areas, including highly isolated sections of the country. When physicians and clinics are not available locally, people turn to a variety of sources, such as nuns or folk healers, or they rely on self-treatment (Nigenda, Lockett, Manca, and Mora 2001).

Mexico also has a serious problem of maldistribution of services. More than 35 percent of all doctors are located in the Mexico City area, which has 20 percent of the population. Consequently, Mexico City has a surplus of physicians, while other parts of the country have a shortage. Even though health clinics are established



throughout the country, rural areas are likely to be served by a nurse. For the country as a whole, there are approximately 80 physicians per 100,000 people, and about 75 percent of all doctors are employed in some type of government-sponsored health program—although some have both a public and private practice. The remaining 25 percent are private fee-for-service practitioners. In border areas near the United States, affluent Mexicans and others covered by some type of U.S. health insurance visit American doctors. Some Americans, in turn, seek the services of less expensive Mexican physicians and buy drugs at cheaper prices in Mexican pharmacies. Many drugs in the United States requiring prescriptions, including some antibiotics and painkillers, are sold over the counter in Mexico. Crossing the U.S.–Mexico border from one side or the other to obtain health services is common for some people. The overall health of the Mexican population is improving. Life expectancy in 2005 was 73 years for males and 77.9 years for females. Infant mortality was 27 deaths per 1,000 births in 2005 compared with 80 per 1,000 in 1965. Some 6.6 percent of Mexico's GDP was spent on health in 2006. Health care delivery in major urban centers in Mexico is often of high quality, especially in the national medical institutes in Mexico City. In rural areas, however, access to modern medicine is limited and difficult to obtain. Overall, Mexico has established a generally effective national system of health care delivery, despite being a developing nation and having an often-troubled economy that has affected public spending on health care.

But significant problems remain. Mexican health care is oriented toward curative rather than preventive medicine. Hence, there has not been a large-scale effort to

Only half of Mexico's population is covered by health insurance.



prevent illness through public health programs intended to improve nutrition, water, sewage systems, and training in hygiene. In addition, the various social health insurance plans differ in the levels of benefits provided, and the decentralized system of health care delivery promotes a lack of coordination, planning, and fiscal control in a country that lacks great national wealth. And, most importantly, as noted, a significant segment of the population in rural areas lacks access to modern health services.

However, health care coverage has at least been extended to large segments of the working population, including both blue- and white-collar workers. Mexico's health policy emphasizes continued improvement in the health of the general population, with a particular focus on meeting the basic health needs of the underprivileged and extending health insurance coverage. Health care for the urban poor seems to be Mexico's highest priority at this point in the development of its health care delivery system. According to Mexican medical sociologist Roberto Castro (2005), health conditions in Mexico changed significantly in the last century, but this change was not the same for all social classes and regions in the country.

## SOCIALIST MEDICINE: ALTERATIONS IN RUSSIA AND CHINA

The socialist model of health care delivery features central government ownership of all facilities, employment of workers, and free universal care paid out of the national budget. It has largely disappeared since 1989–1991, when communism ended in Eastern Europe and the former Soviet Union. Of the four remaining communist countries, socialist health care persists only in Cuba and North Korea, while China and Vietnam have replaced the former socialist system with health insurance programs. In this section, we will review the alteration of the socialist form of health care in Russia and China.

### Russia

Following the collapse of the old Soviet Union in 1991, the new Russian Federation passed legislation establishing a system of health insurance, consisting of compulsory and voluntary plans (Twigg 2000, 2002). The compulsory social health insurance plan is financed by central government subsidies for pensioners and the unemployed, along with contributions (3.1 percent of payrolls) from employers to cover workers. Health insurance is mandatory for all employees, provides the same basic benefits without choice, and is administered by 89 regional government health insurance funds that make payments to participating private insurance companies. Individuals or employers have a choice of insurance companies, and competition between these companies is expected to control costs and ensure quality services. There is also a voluntary plan of private insurance that anyone can purchase out of his or her own pocket that provides supplemental benefits. The intent is to move away from the former Soviet method of paying for health care directly out of the central government's budget and to replace it with a universal

system of health insurance, providing basic benefits for all citizens in the form of payments to providers. One of the most important changes was to shift funding from the federal to the local level, so the financing of health care (about 60 percent) comes mainly from local budgets (which are based on both federal and local allocations) and the remainder from health insurance. This development marks a major change in financing health care delivery for the Russian people.

Prior to the collapse of communism, the health care delivery systems in the former Soviet Union and Eastern Europe were philosophically guided by Marxist-Leninism programs for reshaping capitalism into socialism. The ultimate goal was the establishment of a classless society, featuring an end to class exploitation, private property, worker alienation, and economic scarcity. However, Marxist-Leninist ideology pertaining to health was never developed in depth. The Soviet state established in the aftermath of the 1917 revolution nevertheless faced serious health problems, including large-scale epidemics and famine. More out of practical than theoretical necessity, the Soviet government mandated that health care would be (1) the responsibility of the state; (2) provided without direct cost to the user; (3) controlled by a central authority; and (4) allocated priority for care to workers; with (5) an emphasis on preventive care (Cassileth, Vlassov, and Chapman 1995). Because of the critical need for doctors and a shortage of manpower resulting from industrial and military demands, large numbers of women, especially nurses with working-class backgrounds, were sent to medical schools where they were given cram courses and certified as physicians. William Knaus (1981:83) explains:

Many had no ambitions beyond a weekly paycheck. The Soviet government responded in kind with a low wage scale and a social status for medicine that treated the new physician with no more respect given a factory worker. Professionalism was not rewarded nor even encouraged. Medicine became a job and women were the ones chosen to do it.

Russia has more doctors per capita than any major nation (about 4.7 physicians for every 1,000 people), and some three-fourths are women. However, men hold the majority of academic positions in medicine and medical posts in the Ministry of Health. In 1987, four years before the collapse of the Soviet regime, the average salary for health care providers was about 30 percent less than the national average for all salaries. Doctors were paid about the same as high school teachers. Prominent physicians, however, had special privileges with respect to housing, vacations, schools for their children, access to restricted stores, and other benefits. The general public did not have a choice of physicians, as assignment to a medical practitioner was made on the basis of residence. In order to receive more personal attention from their doctors and better care, patients typically provided gifts or bribes, which evolved into a second economy within the overall health care system. Mark Field (1993:167) referred to the bribery system as the "commercialization of Soviet medicine" and noted that it was paradoxical that payments by patients were reintroduced in a system designed to remove financial incentives from the patient-physician relationship. Russian doctors now have a payment structure based on income from insurance and patients for services rendered.

The former Soviet health care system is now part of history, as the Russian Federation's new insurance-based structure has come into existence. Nevertheless, serious problems remain, including low financing of health care services and declining life expectancy. In the Russian Federation in the mid-1990s, less than 2 percent of the GDP was spent on health (Field 1995), and the figure was only 5.3 percent of the GDP in 2006. This is a low percentage in comparison to other industrialized countries and less than one would expect, given the magnitude of health problems in the country.

From the end of World War II until the mid-1960s, health progress in the former Soviet Union was rapid and consistent. For example, Table 16-6 shows that in Russia (the former Russian Soviet Federated Socialist Republic in the old Soviet Union) life expectancy for males was 40.4 years in 1938 but reached 64.0 years in 1965; for females, life expectancy increased from 46.7 years to 72.1 over the same period. However, in the mid-1960s, ironically just as the former Soviet Union reached its highest point of economic development in relation to the West, life expectancy began a downward trend, largely brought on by rising mortality from heart disease among middle-age working-class males. With the collapse of the Soviet Union in 1991 and decline of Russia's standard of living in the 1990s, the decrease in life expectancy for both men and women accelerated.

This situation is depicted in Table 16-6, showing life expectancy in Russia for selected years between 1896 and 2008. Table 16-6 shows that male life expectancy in Russia fell from 64.0 in 1965 to 61.4 in 1980, but improved to 64.9 in 1987. Russian demographers credit this brief rise in male longevity to Gorbachev's anti-alcohol campaign in the mid-1980s, which significantly curtailed both the production and consumption of vodka. For example, Vladimir Shkolnikov and Alexander Nemtsov (1994) calculated the difference between observed and expected deaths by sex and age and found that longevity increased 3.2 years for males and 1.3 years for females during the campaign's duration, with the greatest advances occurring in 1986. Shkolnikov and Nemtsov (1994:1) concluded that "the rapid mortality decrease in the years 1984 to 1987 can be assumed to reflect a pure effect of reduced alcohol abuse on mortality, because there were no other significant changes in conditions of public health in that short period." But the campaign was discontinued in late 1987 because of its widespread unpopularity, and both alcohol consumption and male mortality correspondingly increased. As shown in Table 16-6, the average life expectancy for Soviet men had declined to 64.2 years by 1989.

Following the 1991 collapse of the former Soviet Union, Table 16-6 shows that life expectancy for Russian males dropped from 63.5 years to a low of 57.6 in 1994. For females, Table 16-6 shows a relatively slow but consistent upward trend between 1965 and 1989 from 72.1 years to 74.5 years. In 1991, in the new Russian Federation, females lived 74.3 years on average, but by 1994 life expectancy for women had fallen to 71.2 years. Consequently, both Russian men and women had a lower life expectancy in 1994 than their counterparts in 1965. Between 1995 and 1998, however, there was a slight increase in life expectancy for both Russian men and women, due to a reduction in alcohol-related deaths (Shkolnikov, McKee, and



TABLE 16-6 Life Expectancy at Birth in Russia, 1896-2008.

| Year | Males | Females |
|------|-------|---------|
| 1896 | 30.9  | 33.0    |
| 1910 | —     | —       |
| 1926 | 39.3  | 44.8    |
| 1938 | 40.4  | 46.7    |
| 1958 | 61.9  | 69.2    |
| 1965 | 64.0  | 72.1    |
| 1970 | 63.0  | 73.4    |
| 1980 | 61.4  | 73.0    |
| 1984 | 61.7  | 73.0    |
| 1985 | 62.7  | 73.3    |
| 1986 | 64.8  | 74.3    |
| 1987 | 64.9  | 74.3    |
| 1988 | 64.8  | 74.4    |
| 1989 | 64.2  | 74.5    |
| 1990 | 63.8  | 74.3    |
| 1991 | 63.5  | 74.3    |
| 1992 | 62.0  | 73.8    |
| 1993 | 58.9  | 71.9    |
| 1994 | 57.6  | 71.2    |
| 1995 | 58.3  | 71.7    |
| 1996 | 59.8  | 72.5    |
| 1997 | 60.8  | 72.9    |
| 1998 | 61.8  | 72.8    |
| 1999 | 59.9  | 72.0    |
| 2000 | 59.0  | 72.3    |
| 2001 | 58.9  | 72.2    |
| 2002 | 58.7  | 71.9    |
| 2003 | 58.6  | 71.8    |
| 2004 | 58.9  | 72.3    |
| 2005 | 58.9  | 72.4    |
| 2006 | 60.3  | 73.2    |
| 2007 | 61.4  | 73.9    |
| 2008 | 61.8  | 74.2    |

Source: Goskomstat (2009).

Leon 2001). The most vulnerable people had died, and their premature deaths had less effect on life expectancy as a result. This was not a genuine improvement in longevity, as Table 16-6 shows life expectancy figures resumed their downward movement from 61.8 years for males in 1998 to 58.9 years in 2005, only to recover back to 61.8 years in 2008. Nevertheless, males averaged 2.2 fewer years of life

expectancy in 2008 compared to 1965. Longevity for females rose only 2.1 years during the same period. The gender gap in life expectancy in 2008 continued to be the largest in the world, as the average Russian woman lived 12.4 years longer than the male (Pietila and Rytikönen 2008; Van Gundy, Shleman, Kelley, and Rebellion 2005). With rising death rates and falling birthrates, it is not surprising that Russia's population has declined from 147 million persons in 1989 to 141.9 million in 2009. The decline of life expectancy in Russia and elsewhere in the old Soviet bloc countries was one of the most significant developments in world health in the late twentieth century. It continues today in Russia and a few other former Soviet republics (Belarus, Ukraine, and Kazakhstan). This situation is without precedent in modern history. Nowhere else has health worsened so seriously and for so long in peacetime among industrialized nations. Ironically, the former socialist countries espoused an ideology of social equality that theoretically should have promoted health for all. However, the reverse occurred, and life expectancy turned downward in the region in the mid-1960s without recovering in some parts of the former Soviet Union. This is a surprising development, as such a prolonged decline in public health was completely unexpected.

The rise in mortality was greatest in Russia and came very late to East Germany, but virtually all former Soviet bloc countries were affected to varying degrees. The deaths largely stemmed from higher rates of heart disease and to a lesser extent from alcohol abuse and alcohol-related accidents. An unhealthy lifestyle appears to be the primary cause of the increase in heart disease and other health problems leading to the downturn in life expectancy (Cockerham 1997b, 1999, 2000c, 2006b, 2007b; Cockerham, Sneed, and DeWaal 2002; Medvedev 2000; Van Gundy *et al.* 2005). This lifestyle was characterized by extremely heavy alcohol and cigarette consumption, high-fat diets, and little or no leisure-time exercise, and was noted to be particularly common among middle-aged working-class males who were the principal victims of the rise in premature deaths. Thus, gender (male), age (middle age), and class (working class) were the key sociological variables in this health crisis. Medical treatment could not compensate for the damage to the circulatory system caused by unhealthy lifestyle practices, and the pathological effects they engendered overshadowed the contributions of infectious diseases, environmental pollution, and medically avoidable deaths to the increase in mortality. A health policy that failed to cope with the rise in heart disease and stress was also an important causal factor. The Soviet system lacked the flexibility, both administratively and structurally, to adjust to chronic health problems that could not be handled by the mass measures successful in controlling infectious ailments (Field 2000). Ultimately, the unhealthy lifestyle of a particular segment of the population appears to be the major social determinant of the downturn in life expectancy.

For example, the amount of taxed alcohol consumed in Russia annually is about 7 liters of pure alcohol per capita, but the real figure appears to be at least 13 to 15 liters when the consumption of unregistered imports and home-distilled beverages are taken into account (Nemtsov 2002). This is the highest per capita consumption of alcohol in the world. When it is noted that adult males consume 90 percent of the alcohol, yet comprise 25 percent of the population, it is apparent that the drinking

practices of males far exceed per capita consumption and reflect a tremendous concentration of drinking. Not only is per capita consumption extraordinarily high, but also the type of alcohol typically consumed (vodka) and the drinking style (oriented toward drunkenness and binge drinking) are considerably more harmful than the moderate drinking of wine. Cigarette consumption is also higher in Russia than in the West, and male deaths from lung cancer are extremely high by international standards (Oglobin and Brock 2003). About 53 percent of all Russian men and 20 percent of women smoke. As for nutrition, the Russian diet has changed considerably since the 1960s, moving away from the consumption of cereals and potatoes toward much greater consumption of sugar and red meat. By 1990, over 36 percent of Russian food provided energy from fat, making it one of the fattiest diets in the world (Popkin *et al.* 1997). Furthermore, men consume about 50 percent more fat than women (Shapiro 1995). There are few data on healthy exercise, but what there are show exercise to be minimal (Palosuo 2000). As Russian medical sociologist Elena Dmitrieva (2005) concludes that Russia lacks a self-protective health culture.

## China

The People's Republic of China remains a socialist country politically, but its economic transition from socialism to a market-driven economy has been accompanied by dramatic changes in its health care delivery system. China no longer has a socialist system of health care in which the state controls, organizes, finances, and allocates health care directly to all citizens free of charge. The Chinese health care system is now financed largely by fees paid by patients, employers, and health insurance companies (Chen 2005).

Prior to the 1949 revolution that brought the communists to power, there were few Western-trained physicians in China, and these doctors generally lived in major cities, where they commanded high fees for their work. Except for a few missionary doctors in the countryside, the bulk of the Chinese population received medical care from folk practitioners. There was a heavy death toll from disease, poor sanitation, and widespread ignorance about health matters. In 1949, the average life expectancy of a Chinese was only 35 years.

Improvement in health became one of the major goals of the Communist Chinese government after it came to power following the civil war with nationalist forces. One of the first public health measures was the "Patriotic Health Movement," in which millions of Chinese killed flies, removed trash, and worked to improve sanitation. Two other measures were also important. First, traditional Chinese medicine was revived, featuring the use of herbal medicines and techniques such as acupuncture, in which pain is controlled by the insertion of needles into certain designated points in the body. Even though its therapeutic value is not fully understood, traditional Chinese medicine is still used today throughout China, with considerable effectiveness for many health problems. China is the only country that consistently treats traditional and scientific medicine equally, making both of them legally available and requiring Western-style physicians to learn traditional methods.

Second, the so-called barefoot doctors movement was initiated, in which 1.8 million paramedical personnel were eventually trained in rudimentary medicine and sent to rural areas to provide basic medical treatment and assist in efforts at preventive medicine and public health. Through this movement, the majority of the population was able to have at least some routine access to basic health care.

China's attempts at improving its health care system suffered a serious setback during the Cultural Revolution of 1966 to 1970. The Cultural Revolution was intended by China's leaders to be a mass movement of the people that would expose corruption and rid the government of unnecessary bureaucracy. Many influential people were subjected to severe public criticism and even persecuted by revolutionary groups such as the Red Guards, whose membership included thousands of young students. Schools and universities were closed as young people abandoned their studies to participate in revolutionary activities. Factions developed within the movement itself, and this period of Chinese history is marked with chaos as power struggles were waged within the hierarchy of the government and the Communist party. There was a widespread disruption of work and education. For nearly four years, there was virtually no medical research or training of medical students. Thousands of doctors were forced to leave their positions and were sent into the countryside to work with peasants in agricultural communes. When medical education was resumed in 1970, the time for training was cut from eight years after high school to three years, with emphasis on practical and applied medicine. Almost anyone could gain admission to medical school, and few or no examinations were given during training. The quality of Chinese doctors declined accordingly, and the old system was returned, but many valuable years were lost in regard to both medical education and research.

Today, an extensive network of health care facilities exists in China. Neighborhood clinics are available in cities, and people with serious illnesses or injuries are referred to local and regional hospitals. Many factories have their own clinics and hospitals. Medical care for factory workers is paid of by insurance that is state-owned, and some collectively owned factories have established with money obtained from the sale of goods. Employees for privately owned firms and the government also have health insurance. However, in rural areas, China's transition from a communal (collective farm) agricultural system in the 1980s to a household-centered approach (on state-owned land) led to the collapse of the collective farm health care system (Chen 2005). Without collective farming income, farm health clinics were dissolved, and many barefoot doctors left health care altogether or went into private practice. The financial burden in rural areas was shifted to individual households who have to pay for health care out of their pockets. Those who cannot afford to pay may go without care—as the Chinese government struggles to find an equitable and efficient way to deliver health services to rural areas (Bloom and Tang 1999). A health reform plan has been introduced to provide universal insurance coverage with comprehensive benefits in the cities and later in the countryside, with financing by contributions from employers, employees, and local governments. At present, the central government provides less than 1 percent of all health expenditures. The responsibility for health services was delegated to provincial and



county governments. But the amount of money available covers only minimum wages for health care workers and capital investments for the construction of new facilities. The remaining expenses are to be covered by patient fees. Basic levels of health care tend to be provided below cost, but profits can be made from the sale of drugs and use of technology. Hospitals and health centers have to generate their own incomes from the services they provide to patients, but they control the allocation of profits. The result is the end of China's system of universal access to free health care and its replacement by a fee-for-service model. Although incomes have risen throughout China in recent decades, the urban and especially the rural poor are the most disadvantaged in obtaining health care (Liu, Hsiao, and Eggleston 1999). Some 60 percent of urban residents have health insurance compared to 20 percent of rural dwellers (Liu, Zhao, Cai, Yamada, and Yamada 2002).

Social change has also influenced health in other ways. Feinian Chen, Yang Yang, and Guangya Liu (2010) examined the effects of China's rapid modernization on socioeconomic disparities in health and found a pattern opposite to that of the United States. Chen and her colleagues determined that while disadvantaged circumstances over the life course of several Chinese age cohorts culminated in greater inequalities in health at older ages as in the United States, the pattern was strikingly different with respect to education and income within recent cohorts. Well-educated and higher-income Chinese tended to have *worse* health in these cohorts than less-educated and low-income persons. The difference is attributed to unhealthy lifestyle choices. Whereas higher SES groups in the United States have healthier lifestyles with respect to diet, smoking, alcohol use, and exercise, Chen *et al.* (2010:144) observed that in developing countries experiencing rapid economic development such as China, higher SES groups are more likely to have diets with high fat and sugar content and to be more sedentary, causing them to be more obese, and also to smoke and drink more. "With their rising purchasing power," states Chen and her associates (2010:144), "the socioeconomically advantaged adopt these unhealthy behaviors because they view these choices as privileges." Consequently, in China, as in Russia, the lifestyles of certain segments of the class structure promote unhealthy outcomes.

In 2005, the average life expectancy in China for males was 71.0 years and for females 74.0 years. The infant mortality rate was 27.0 infant deaths per 1,000 live births in 2005. Acute infectious diseases were largely under control or eliminated, but the global SARS epidemic started in China and caused considerable problems in Hong Kong and Beijing. Heart disease and cancer, however, are the major afflictions in most parts of the country. An increasingly important health problem now and in the future is lung cancer. China has an estimated 350 million smokers who account for 30 percent of the world's tobacco consumption. Some 70 percent of China's adult male population smokes, and the proportion of adult female smokers is about 7 percent. Lung cancer rates are increasing 4.5 percent a year, and smoking-related deaths are expected to reach around three million annually by 2025 or about 30 percent of the world's deaths from cigarettes. Already some 1.2 million Chinese die annually from smoking-related causes. The government has initiated a nationwide campaign against smoking, but this effort is counter to the interests of the vast state-owned tobacco monopoly, which is the world's largest

producer of cigarettes. Tax revenues from tobacco sales are the government's single largest source of income. Consequently, the Chinese government is faced with an important dilemma: If smoking declines, a primary source of income will be reduced.

## CONCLUSION

This review of the organization and social policy of health care in selected countries suggests that no nation has an ideal system of dealing with health problems. All nations are faced with rising demands for quality health care in the face of limited resources, and the high cost of care has presented special problems in achieving desired outcomes. Exact comparisons between nations in terms of the effectiveness of their respective health care delivery systems are difficult because of varying political structures, degree of technological advancement, social commitment to national health care, diet, and cultures, which have an impact on the overall health profile of a particular country.

Sweden and Japan, for example, appear to have especially effective approaches to the provision of health care when levels of life expectancy and infant mortality are considered. Yet, these countries have smaller and more homogeneous populations than large countries like the United States and have fewer social class differences. It is much easier for the Swedes to focus on health care and mobilize their financial resources to cope with it. Japan has been particularly successful with its health care system, which is both low cost and readily accessible to the general public. The Japanese have the highest life expectancy for both men and women in the world. Economic conditions in Japan and Japanese lifestyles may be the primary factors in this development, but health care delivery has undoubtedly made a major contribution. Yet, the Japanese situation is one that other capitalist countries may not necessarily want, since large business corporations have the expense of providing their own health benefits, people under 70 years of age in the national plan are responsible for up to 30 percent of the cost of their care monthly, and the use of prescription drugs is the highest in the world.

It is clear from the discussion in this chapter that the governments worldwide are under increasingly greater pressure to contain health care costs and yet maintain high-quality coverage for the entire population. One approach in Western Europe, influenced by the "internal market" measure introduced by Britain, has been to allow limited competition between providers within government-run health care systems to contract their services to purchasers, such as a regional health agency. These agencies, in turn, allocate the care to the people in their areas. Efforts at reform are likely to continue in the twenty-first century as the numbers of elderly increase and place greater demands on health care systems, with fewer workers in the economy paying taxes to support those systems.

For the present, several general trends are appearing in developed societies, which are likely to have an effect on health care policy in the future. These trends are the following: (1) Considerable attention is being paid to the cost of health care, and controls over such costs are an important aspect of health policy. (2) Preventive

medical services are receiving increasing emphasis in developed countries, as more attempts are being made to keep well people healthy. (3) Efforts are being made to design a more effective administration of large health care systems. (4) There is more demand and increased responsiveness on the parts of governments and policymakers to provide a health care system that meets national needs. While different countries are taking different approaches to solve health problems, all countries appear to be moving toward a system that will reduce inequities and control costs.

## SUGGESTED READING

COCKERHAM, WILLIAM C. (ed.) (2005) *The Blackwell companion to medical sociology*. Oxford, UK: Blackwell.

A reader containing chapters on health care in countries around the world.

## HEALTH CARE IN OTHER COUNTRIES INTERNET SITES

### Canada

1. Canadian Institute for Health Information.  
<http://www.cihi.ca>
2. Health Canada—Canadian Ministry of Health.  
<http://www.hc-sc.gc.ca>

### Great Britain

1. The British Medical Association.  
<http://www.bma.org.uk>
2. Health in the United Kingdom.  
<http://www.who.int/countries/gbr/en/>

### Sweden

1. The Swedish Government, Ministry of Health and Social Affairs.  
<http://sweden.gov.se/sb/d/2061>

### Japan

1. Japanese Ministry of Health, Labour, and Welfare.  
<http://www.mhlw.go.jp/english/>

### Germany

1. The German Federal Ministry of Health and Social Security.  
<http://www.bmg.bund.de/EN/>
2. Health in Germany.  
<http://www.who.int/countries/deu/en/>

**Mexico**

1. Ministry of Health (in Spanish).  
<http://www.salud.gob.mx/>

**Russia**

1. State Committee of the Russian Federation on Statistics (Goskomstat).  
<http://www.fsgs.ru/wps/portal/english>

**China**

1. Chinese Medical Association.  
<http://www.chinamed.com.cn/chinamedorg>