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How does access to healthcare affect life expectancy?

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How Does Access to Healthcare Affect Life Expectancy?

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Abstract

Access to health care is a pressing issue in the United States, whether it be the cost of care or not having enough of it. To emphasize the importance of this topic, this paper assesses the impact of access to health services on life expectancy. A comparison is made between the universal health systems in France and Spain and the mixed system in the United States. Even though the United States spends the most on health care in the world, its statistics fall below those of other developed countries. After addressing other risk factors, it was found that individuals under a universal health care system live longer with lower mortality rates.

The text describes all three systems while highlighting the major advantages and disadvantages of each one. A key finding in the advantage of a national system includes guaranteed coverage, which enables individuals to not only receive care when they are ill but also preventive and early-interventional care. Additionally, establishing a universal system may decrease costs for the United States as a large portion of healthcare spending is due to the overflow in emergency departments, including avoidable visits that can be treated at an urgent care or a primary care practice. This paper also explores healthcare policy and reform's major impact on the accessibility of care. Although a completely universal system seems intangible for the United States, it is important for current health professionals and policymakers to advocate for change to expand overall coverage.

The final section discusses more reasons as to why the U.S. does not have universal health care, and what can be done to push for change in its current system in hopes of resulting in increased life expectancy and overall lower mortality rates.

Introduction

There are many factors affecting access to health care, including geographical location, laws, regulations, socioeconomic status, and government action. Additionally, these factors vary by country, or in some cases, by state or region in which the individual resides. This paper will draw a global comparison between the United States, France, and Spain. France and Spain both offer forms of universal health care whereas the United States does not have any type of universal coverage, but instead has a fragmented system. France and Spain report a higher life expectancy than the United States among their residents, and these two countries are among the ten countries with the highest life expectancy (OECD, 2017).

Even though the United States implemented programs to expand coverage such as Medicare, Medicaid, and CHIP (Children's Health Insurance Program), there still are millions of uninsured people. The uninsured population includes those who are ineligible or lack a connection with public insurance. The U.S. system had its lowest uninsured rate in 2014 with the enactment of the Patient Protection and Affordable Care Act (PPACA or ACA), however, the uninsured rate began to rise again with the Trump administration's efforts to "hobble" and repeal the ACA. In the U.S., those who do not have insurance do not have the guarantee of a reliable source for access to health care. The United States' system is quite convoluted, and the best way to describe it is as a hybrid system with both public and private financing. The issue at hand for the United States is not solely its shorter life expectancy but also its higher death rate among the population; even though the United States spends the most in the world on health care, data from the World Health Organization (WHO) shows the country having the highest mortality rate

among 16 other peer countries:

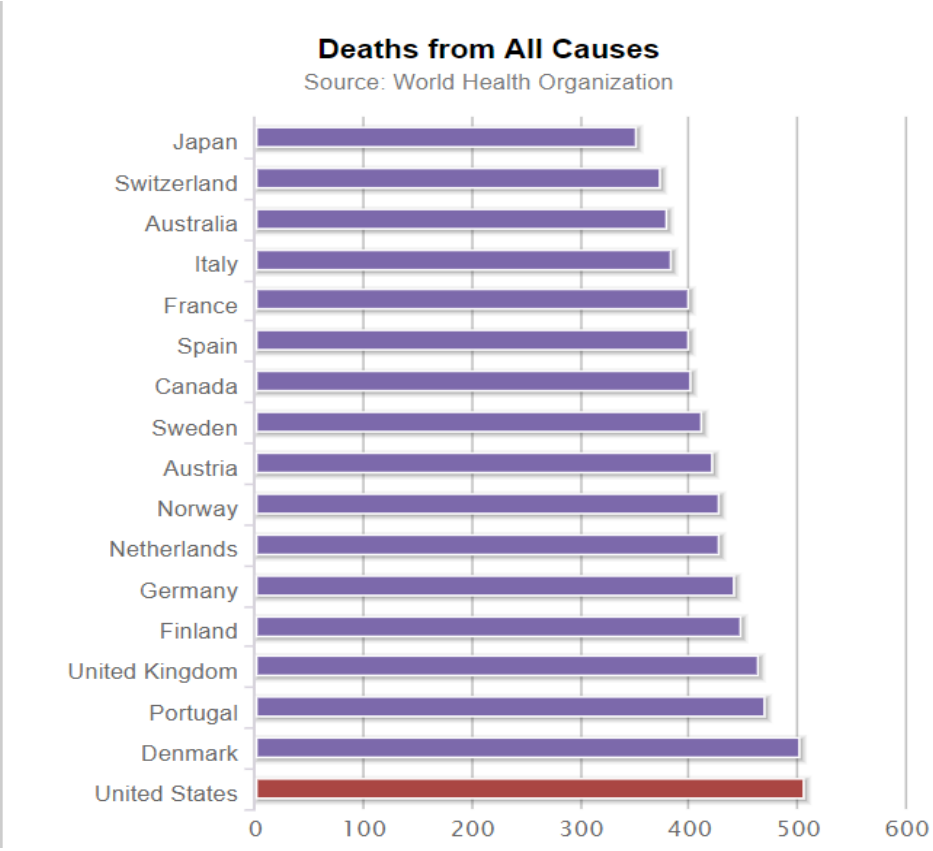

Figure 1. Graph of age-adjusted deaths per 100,000 from all causes according to the World Health Organization. From U.S. health in international perspective: shorter lives, poorer health by S. Woolf and L. Aron, 2013, Washington, District of Columbia: The National

The significance of researching this topic is to highlight the importance of ensuring access to health care is granted to each person, with health care recognized as a right, not a privilege. This research subsequently aims to scrupulously measure the effectiveness of France's and Spain's universal health care system so we can search for potential methods by which the

U.S. can improve its health system. Assessing the impact of access on life expectancy will further establish the essentiality of health care being a right, which is an extremely controversial notion in the United States. The U.S. must take into consideration several demographics and other determinants affecting life expectancy as well, since having access to health care is not the sole attributor to life expectancy rates. These other factors can include race, geographical location, education level, and income. Life expectancy also serves as one of the statistics with the ability to adequately tell us which country's health care system (or, what type of health care system) is the most beneficial to a population, and we can use this to identify obstacles to the United States' ability to adopt a more effective system. After adjusting for the other factors affecting life expectancy, having access to health care is important to distinguish as it provides a pathway to receiving preventive care measures and treating current illnesses.

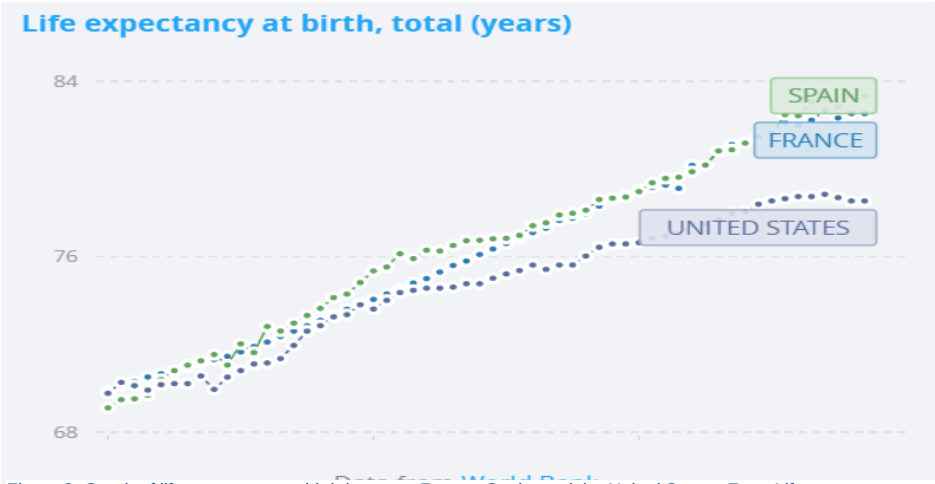

Figure 2. Graph of life expectancy at birth between France, Spain, and the United States. From Life expectancy at birth, total (years) - France, Spain, United States by the World Bank, 2017, retrieved from https://data.worldbank.org/indicator/SP.DYN.LE00

Spain: 83.329 France: 82.524 US: 78.539

Determinants of Health

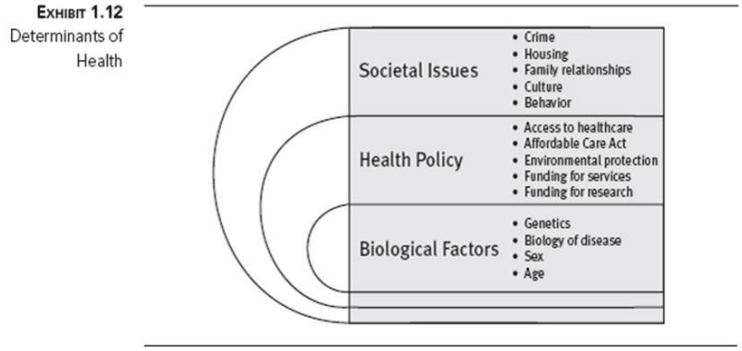

Figure 3. Table of determinants of health. From Fundamentals of medical practice management by S.L. Wagner, 2018, Chicago, IL: Health Administration Press.

Determinants of health include societal issues, health policy, and biological factors (Wagner, 2018). Understanding the various determinants of health is essential in understanding health care, including practice management, health policy writers, and health care administration as a whole. Biological factors include genetics, sex, age, and biology of the disease. Additionally, life expectancy may be affected by lifestyle behaviors such as diet and exercise, but after adjusting for these factors, there are many other determinants of health to consider. Individual behaviors such as living conditions, networks, broad cultural and environmental conditions, are controllable to a degree (Shi, 2014). If a person has poor habits regarding these behaviors thus resulting in complex or chronic conditions, having access to care could ameliorate these conditions.

Societal issues encompass crime, housing, culture, family relationships, and behavior. There are many social determinants with a direct effect on health and development, and these particular factors can vary from country to country. The term “social determinants” refers to broader social factors such as social exclusion or income inequality, which are two of the three

overarching factors of social determinants. The third factor is whether or not an individual has a sense of personal or collective efficacy, which is tied to their sense of control over their lives. A stronger sense of personal or collective efficacy is linked to prolonging life, maintaining a better health status, and participating more actively in society (Community Tool Box, 2018). A population-based survey conducted in Paris in 2010 found a great presence of socioeconomic inequalities for socioeconomic position indicators such as education, income, and perceived financial status. This study found a correlation between those with the most disadvantaged socioeconomic position and a higher risk for poor mental and general health, compared to the most advantaged (Jacquet et al., 2018). Furthermore, the education of most Parisian women influenced inequalities while income had the strongest influence on inequalities for Parisian men.

Meanwhile, the United States has had the highest poverty rate among children since the 1980s, according to the OECD's Family Database (OECD, 2019). The Kaiser Family Foundation (KFF) states that "declines in coverage for families would increase barriers to care and financial instability, negatively affecting the growth and healthy development of their children." (Atriga & Diaz, 2019). Despite some of these children being eligible for CHIP, other socioeconomic conditions, such as social mobility, have the country's population at a disadvantage as their ranking is again, below other countries' ranks. Many are aware of the United States spending the most on health care in the world, but how many citizens are aware of these disparities causing Americans to die younger and in higher numbers?

Health Policy

Public policy influences access to care and other health determinants. A positive change to seek includes promoting improvements to health policy to ensure equity of care. The Affordable

Care Act is a prominent example of improving health policy as it has one of the largest impacts on health care in the United States. The law has three primary goals:

(1) Make affordable health insurance available to more people. This includes providing consumers with subsidies that lower costs for households with incomes between 100% and 400% of the federal poverty level (FPL).

(2) Expand the Medicaid program to cover all adults with income below 138% of the FPL. In all states, Medicaid qualification is based on income, household size, disability, family status, and other factors (U.S. Centers for Medicare & Medicaid Services, 2019). Currently, 37 states and the District of Columbia have opted in to extend their Medicaid coverage to a larger range of people, i.e. their residents are able to qualify based on income alone.

(3) Support innovative medical delivery methods designed to lower the general costs of health care (HealthCare.gov, 2019).

The ACA has several other components, as well, including an attempt to eradicate denials of coverage due to pre-existing conditions, which means the insurance companies are not permitted to withhold coverage due to an individual having a health problem they already had before the start date of their new coverage. In addition to covering preventive services such as immunizations and screenings, the ACA requires health plans in the individual and small group markets to cover essential health benefits (EHB), shown in the figure below (Kraut, 2017):

Figure 4. Ten essential health benefits from the ACA. From Essential Health Benefits Under the AHCA (ACA Replacement) by R. Kraut, May 10 2017, retrieved from https://www.healthcarecounts.org/blog/2017/5/8/essential-health-benefits-under-the-ahca-aca-replacement.

Health policy can also hinder health depending on accessibility, policy, and potential restriction to care. The term "vulnerability" refers to the convergence of health risks occurring in three dimensions: physical, mental, and social. As an individual's overall health needs escalate with the mix of multiple risks along different dimensions. "Predisposing" characteristics include demographic characteristics, social structure variables, and health beliefs, while "enabling" characteristics include the resources available for use of services and attributes. Health policies may inhibit individuals from accessing a regular source of care (RSC) with the absence of health care coverage due to not fulfilling one or more health care dimensions. This is especially applicable to racial and ethnic minorities, as a larger portion of this population has a low family

income and has English as a second language, i.e. it is not the language primarily spoken or used at home. This prohibits individuals and families from understanding how to access care or their care directions if given treatment. There are federal, state, and local programs to combat disparities, however, this minority population is more likely to be dissatisfied with their care and is discriminatorily receiving lower quality care. The uninsured population also lacks RSC due to delays in medical care, not being likely to receive prescribed medications or dental care, and the overuse of emergency departments (Agency for Healthcare Research and Quality, 2011). A reduction in care quality due to identifying as a racial and ethnic minority is a pressing issue as it is projected for these groups to account for almost half of the U.S. population by 2050 (Agency for Healthcare Research and Quality, 2011).

Some of those who are uninsured also fall under other underserved categories such as the chronically ill, mentally ill, disabled, homeless, and those with HIV/AIDS. This poses a greater chance of these individuals being victims of marginalization which contributes to even higher mortality risk. Additionally, these populations are less likely to receive preventative care or recommended services and are more likely to have preventable hospitalizations. We do not see this particular dilemma occurring in other countries with universal coverage, like France or Spain, as their overall base policy is guaranteed health care. Furthermore, their policies are set in place to ameliorate other issues such as long wait times and access to specialty care. To prevent a further decrease in life expectancy in the U.S. and especially for this population, these disparities must be mitigated through health care reform, quality checks, and an expansion on coverage.

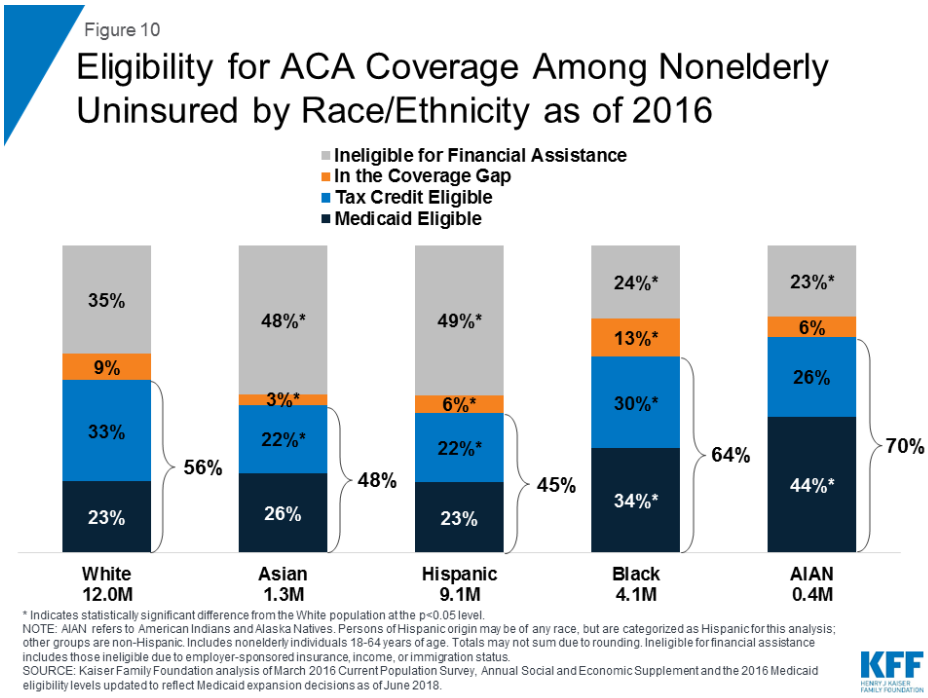

Figure 5. Bar graphs showing eligibility for coverage among uninsured by race and ethnicity as of 2016. Disparities in Health and Health Care: Five Key Questions and Answers by S. Artiga and K. Orgera, August 8 2018, retrieved from https://www.kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/.

The Kaiser Family Foundation (KFF) released an article discussing disparities in health and general health care. KFF identified the ACA coverage expansions as an aid in reducing the size of disparities in coverage, especially for minorities and low-income individuals (Artiga & Orgera, 2018). Current assistance programs are rather prescriptive; physicians, health care navigators, and patient advocates are often filling out checklists provided by insurance companies to determine if the patient qualifies for financial assistance in their health care. If an

individual does not meet every point on the list, they are denied care. Coverage gaps demonstrate the high level of fragmentation in the United States health care system.

France partakes in the management of their health system through public policies not only at the national level but at the regional level as well. This ensures the coordination of care, support, and disease prevention for each specific region by promoting the consistent management of resources to allow equal access in a continuous effort (Centre des Liaisons Européennes et Internationales de Sécurité Sociale, 2019). Once national policies are set in place, agencies adapt them to regional characteristics (demographic, epidemiological, and geographical) by establishing regional health programs. These programs are composed of prevention plans, organized schematics for city hospital care, and medical social organization for higher-need populations such as the elderly or disabled.

Spain has seen significant developments in public health policies, as well. Four challenging areas in its health system undergoing change include reducing the inappropriate use of antibiotics, investing more in the workforce, discouraging unhealthy behaviors, and improving overall access to services (OECD, 2017). These areas encourage Spain's government to advocate for policies to address and ameliorate the overall quality of care for its population in addition to guarantee of care their population already has.

What is “Access”? How is This Measured?

The Institute of Medicine defines “access” (in terms of health care) as “the timely use of personal health services to achieve the best health outcomes." (Institute of Medicine, 1993). Access entails three steps: gaining entry into the health care system (typically through insurance in the United States), geographic availability to access a location where health care services are provided, and finding a health care provider whom the patient trusts and can communicate with, even establishing a personal relationship with (Agency for Healthcare Research and Quality, 2015). In the United States, barriers to access include a lack of insurance coverage, limited availability of services, the high cost of health care, and the lack of culturally competent care (the provision of services that meet the cultural, social, and linguistic needs of patients). This includes language barriers and their ability to prohibit someone who is ill from getting health care or delay the process. Delays in receiving sufficient care, the inability to obtain preventive services, financial strains, and preventable hospitalizations all result in unmet health needs.

It is important to note that access to health care is not limited to relieving acute symptoms or preventing death in emergency situations; access includes maintenance of long-term functioning and relief from anxiety about the meaning of symptoms (Millman, 1994). This “relief” entails educating people about their care and what their symptoms and diagnosis(es) mean.

Five Dimensions of Access to Health Care

To help define access, below are the five dimensions of access to health care:

1. Affordability: How the provider’s charges relate to the client’s ability and willingness to pay for services

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Yara: I received notification that you posted a copy of your Honor's Capstone project. Could you send me a copy as an email attachment? How are you doing? Is this your final semester, or will you still be enrolled in the spring? I'm still tracking the efforts of the administration to stymie implementation of the ACA. As you noted, the number of uninsured Americans has begun to rise again. Would enjoy talking with you if you are still in H'burg. - David Cockley

a. Direct prices of services; opportunity costs related to loss of income; elasticity of demand for different types of health services (Shengelia, Murray, & Adams, 2003).
b. The desire for individuals to have the capacity to generate economic resources (income, savings, loans) to pay for health care services without "catastrophic expenditure" of resources required for basic necessities (e.g. sale of home)

2. Availability: Size or volume of the supply meets client's needs
    a. The existence of health resources with sufficient capacity to produce services
    b. Results from characteristics of facilities (density, concentration, distribution, building accessibility), of urban contexts (e.g. decentralization, urban spread, and transportation system) and of individuals (e.g. duration and flexibility of working hours). It also relates to characteristics of providers (e.g. presence of the health professional, qualification) and modes of provision of services (e.g. contact procedure and possibility of virtual consultations).
3. Accessibility: The location of supply (personnel and technology) aligns with the location of clients (those who need it) or demand
    a. How easily the client can physically reach the provider's location
    b. Congestion, coverage
    c. Restricted access occurs when these resources are unevenly distributed
    d. Entails client's knowledge about services that could help them out / transport them to providers
        i. People unable to miss work, handicapped, restricted mobility

4. Accommodation: How the provider's operation is organized in ways that meet the constraints and preferences of the client.
    a. Greatest concerns: hours of operation, how telephone communications are handled, client's ability to receive care without prior appointments, web services, cultural/language barriers
5. Acceptability: The extent of both the provider and clients' willingness to accept each other's characteristics, such as sex, age, social class, ethnicity, type of insurance (e.g. Medicare or Medicaid). These five dimensions function interdependently; if one or more dimensions are neglected, the others will be ineffectual as well. (McLaughlin & Wyszewianski, 2002)

Each dimension contributes to how researchers measure access. Furthermore, a true assessment of access requires the combination of all these measures to truly judge whether the characteristics of services, providers, and systems are aligned with people, households and communities' capabilities (Levesque, Harris, & Russell, 2013). As a result, an individual's life expectancy is affected if the health care system is not designed to ensure their personalized health care needs are taken care of. To research and evaluate these five dimensions, many authors use analysis methods such as consumer surveys, quality of care data, epidemiological surveys of utilization, organizational surveys, and outcomes. Likewise, various studies can be used to measure the prevalence of disease such as empirical studies, which are better for testing each dimension in different contexts/settings. Moreover, it is important to note that access to some services may be contingent on the use of other services, such as the use of primary care providers or case managers in order to access specialist or allied health professional care (Levesque et al., 2013).

High Cost of Healthcare in the U.S.

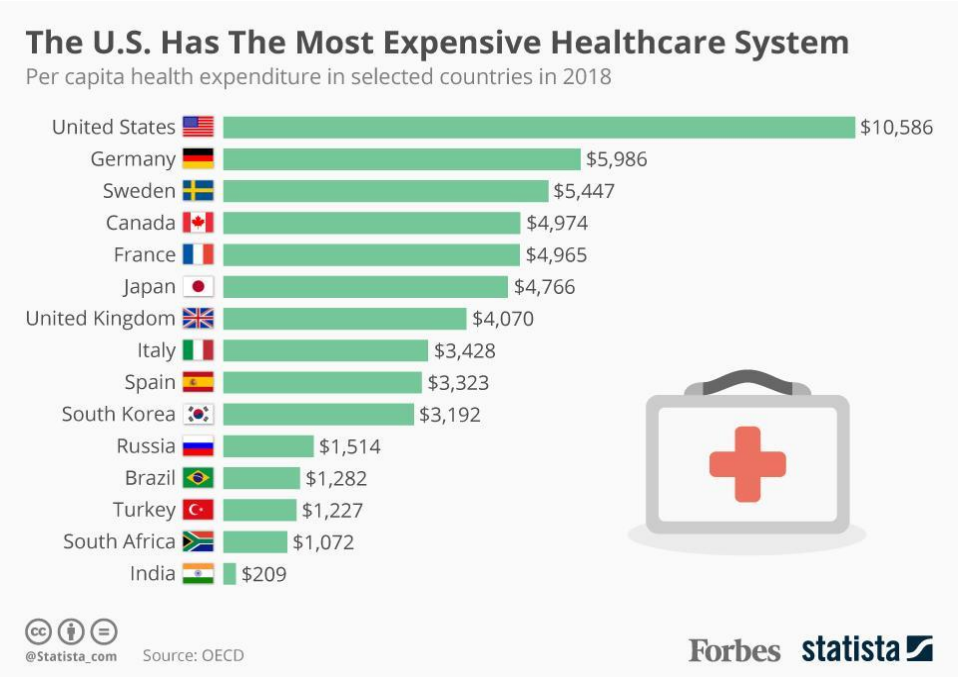

Figure 6. Chart displaying per capita health care expenditure as of 2018. From The U.S. has the most expensive health care system by the Organisation for Economic Cooperation and Development, 2019, retrieved from https://www.forbes.com/sites/niallmccarthy/2019/08/08/how-us-healthcare-spending-per-capita-compares-with-other-countries-infographic/#480d38ea575d

Due to the high cost of health insurance in the United States, many individuals with a lower income cannot afford to undergo the financial burden of large medical bills. Individuals who are uninsured are more likely to have an overall poor health status, die prematurely, have later or delayed diagnoses, and are less likely to receive medical care. These factors, especially premature death, contribute to decreasing the average life expectancy for Americans. Because health care is so expensive, many people will go to the emergency room (ER) for minor conditions because the ER is required to treat and stabilize them due to the Emergency Medical

Treatment and Labor Act (EMTALA). In some cases, individuals will not truly have anything medically wrong with them, but they go to the ER for temporary shelter since they know they cannot be turned away. This group of people is referred to as "frequent flyers".

Even though some of the uninsured population gets away with going to the emergency room for minor conditions or non-medical reasons, a large portion of this population is not able to do so. This is referring to the undocumented immigrants in the United States as many are reluctant to get medical assistance due to fear of being questioned about their immigration status, thus possibly getting deported. This fear is heightened due to the shift toward stricter immigration policies under the Trump administration, which is pursuing additional changes in public health programs which may result in a decrease in Medicaid and CHIP participation. We can further deduce that an impediment in healthy development can lead to premature death due to an increased likelihood of chronic illnesses. Worse health outcomes over the long-term may ultimately become more complex and expensive to treat (Garfield, Orgera, & Damico, 2019). Furthermore, according to the Kaiser Family Foundation, undocumented immigrants have limited access to coverage options in general. Certain eligibility criteria (i.e. individuals must be lawfully present) restrict them from participating in Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the ACA marketplaces (Atriga & Diaz 2019).

The United States spends approximately 20 percent of its gross domestic product (GDP) on health care. Graphed by the OECD, the United States spends more than double the amount per capita compared to France and over triple the amount per capita compared to Spain. When universal coverage is suggested, some are quick to assume this will increase the portion of GDP spending on health care, however, this is not necessarily true. According to the Centers for Disease Control and Prevention (CDC), chronic disease accounts for almost 75 percent of the

United States' aggregate healthcare spending, which equates to approximately $5,300 per person each year (National Association of Chronic Disease Directors). A lack of access can attribute to this large cost for a variety of reasons, such as the high number of avoidable emergency department (ED) visits:

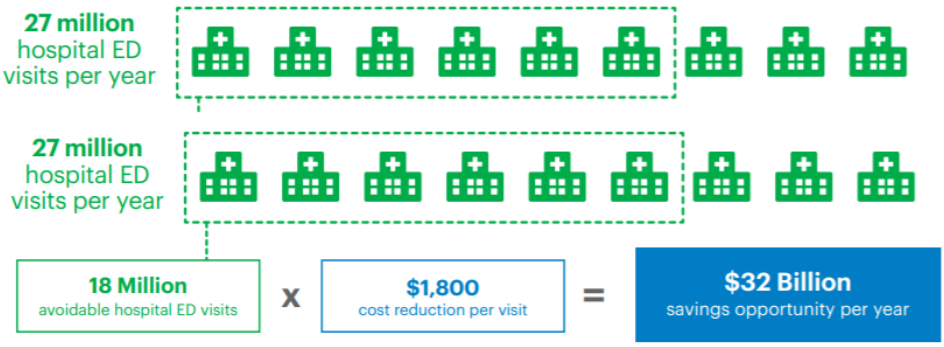

Figure 7. Cost of avoidable emergency department visits. From 18 Million Avoidable Hospital Emergency Department Visits Add $32 Billion in Costs to the Health Care System Each Year by UnitedHealth Group, 2019, retrieved from https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2019/UHG-Avoidable-ED-Visits.pdf

The overflow of patients in emergency rooms across the nation is extremely costly. Hospital care expenditures account for 33 percent of the spending share by type of service or product (Centers for Medicare and Medicaid Services, 2017). According to a data analysis by UnitedHealth Group, over two-thirds of emergency department visits are avoidable and unwarranted, as these visits can be "treated safely and effectively in high-quality, low-cost primary care settings" (UnitedHealth Group, 2019). Some of these primary care treatable conditions include the flu, headaches, strep throat, and headaches. The upcharge in the cost of an emergency department visit is attributed to the hospital's lab services and paying its staff. The delivery of primary care is not always accessible in the United States when people need treatment, especially if it is a dire need. The analysis also notes the staggering difference in cost

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between an emergency department visit and a primary care visit: the average hospital emergency department cost is 12 times higher than at a physician's office and 10 times higher than at an urgent care center. The average cost of treating 10 common primary care treatable conditions at a hospital emergency department is $2,032, which is $193 in urgent care and $167 in physician offices. If people in the United States had basic guaranteed coverage for at least primary care services, the usage of the emergency department for primary care treatable conditions would indubitably diminish, thus resulting in a decreased cost of care. UnitedHealth group estimates these potential savings to be approximately 32 billion dollars each year. The definition of basic health services should closely resemble the one stated under the Code of Virginia: "Basic health care services" means in and out-of-area emergency services, inpatient hospital and physician care, outpatient medical services, laboratory and radiologic services, mental health and substance use disorder benefits, and preventive health services." [VA. Code Ann. § 38.2-4300].

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Over 30 years ago, the Institute of Medicine identified three ways by which having health insurance improves health, which are still utilized today: getting care when needed, having a regular source of care, and continuity of coverage (Lurie et al., 1986). Without universal coverage even for basic care, the United States is unable to fulfill these three ways by which the health status of an individual can be maintained and improved. Using data from the Third National Health and Nutrition Examination Survey, an analysis was conducted using participants aged 17-64 years to establish a potential correlation between uninsurance and mortality rates. After adjusting for other strong determinants such as smoking, health status, body mass index, and exercise, a 40 percent (an estimated 45,000 deaths) higher mortality rate was found "attributable to a lack of health insurance" (Cohen, Crimmins, & Preston, 2011).

Health maintenance organizations play a big role in the American system. They construct contracts with health care providers and medical facilities to provide cost-reduced care to their members. This is all part of a private health insurance plan, and the amount of services covered depends on the rules and conditions of the plan. Evidently, when plans limit choices for where the enrollee receives care, they are less expensive. The majority of health care, even if financed by public funds, is provided through private networks. Private health insurance accounts for 34 percent of the spending share, while Medicare and Medicaid account for 20 and 17 percent respectively, with out-of-pocket spending accounting for 10 percent (Centers for Medicare and Medicaid Services, 2017). In total, the United States spends the most on health insurance in the world. Numerous aspects are contributing to the cost, such as chronic diseases, administrative costs, new drugs and technology, and employer-sponsored health benefits. With this being said, how can a country pay this much for health care without offering insurance to all its citizens?

A population-based cohort study compared patients with cystic fibrosis in Canada and the United States. Differences in survival persisted after adjusting for risk factors, with the exception of privately insured patients in the United States who were found to have a similar life expectancy to patients in Canada. Overall, this study found patients to live approximately ten years longer on average in Canada than in the United States, with this being strongly attributed to health care coverage (Stephenson, 2017). This emphasizes the chain reaction of how a lack of health care coverage can be correlated to lower overall life expectancies.

A lack of universal coverage is not the only overbearing issue in the United States. Oftentimes, poor care coordination, including miscommunication and confusion between clinicians and patients, is reported. According to the Commonwealth Fund, a foundation advocating for a higher-performing health system in the United States, patients in the United

States are more likely to report lapses in care quality and safety outside of hospitals. This was a conclusion drawn from multiple surveys given to patients in up to 11 countries (Woolf & Aron, 2013). Therefore, in addition to expanding access to health care, an improvement to the provision of these services is essential to the overall quality of the system in the United States.

France's Healthcare System

In France, universal coverage is provided for everyone who has lived in France for three months or more (Lopes, 2007). France adopted this type of system for industrial workers in 1928, which expanded to coverage for all employed individuals in 1974 (Rodwin, 2003). The shift from an employment-based health care system towards the universal coverage system was achieved with the 1999 Universal Health Coverage Act, which created a "residency-based" right to health care coverage (Brigham, Chevreul, Durand-Zaleski, & Hernández-Quevedo, 2015). Additionally, this created a reserve fund to provide coverage for uninsured individuals and those whose income falls below a certain point. Ranked the best health system in the world in 2000 by WHO, France remains in the top 20 today while continuing to advocate for optional health insurance plans to further alleviate and reduce chronic conditions.

The system is organized in four parts: the payer (social security), the decider (administration of health services), the effector (the overall health system), and the users (the patients). The French system is based on three main principles: solidarity, economic liberalism, and pluralism, i.e. social diversity. These three applied principles come with advantages to the French system. Solidarity is demonstrated throughout the French culture both in and out of the health care system; for example, France has a Day of Solidarity to represent the autonomy of the elderly and disabled population. In terms of health care, solidarity is demonstrated by granting even the poorest citizens health care coverage as a universal right in 1999. Moreover, under the previously mentioned Universal Health Coverage Act, undocumented residents are allowed care under state medical aid (Rodwin, 2003). Additionally, the French have autonomy in their choice of an insurance company if they seek private insurance, which demonstrates the country's economic liberalism. When patients have this choice, they are still likely to be reimbursed by the

government; moreover, physicians have a similar autonomy over their practices. This means they are able to choose more freely where they would like to practice. In summary, the accessibility of health services in France is the strong base supporting their entire system: access to preventive care contributes to patient satisfaction and the overall well-being of its citizens. France highly tolerates organizational diversity with its various types of care practices, whether they are competitive or not, which highlights the pluralistic feature of its system. (Rodwin, 2003). For example, physicians may practice in a private facility while also working under another public hospital system. Today, Americans are skeptical of this concept due to a general distrust of government involvement and being unsure about when involvement becomes "too much".

Commented [6]:

The emergency services sector in France is proven to be more cost-effective than most countries, including the United States. SAMU Social of Paris, where SAMU stands for Service d'Aide Médicale Urgente (Emergency Medical Aid Service), is part of APHP, the largest hospital system in Europe (Portail régional des SAMU/SMUR d'Ile de France, n.d.). Using this system, then the emergency health services line receives a phone call, the caller speaks with a doctor first to determine the severity of the situation and whether the full team needs to be sent to the caller's location. SAMU helps teams triage patients; if emergency care is not needed, the dispatch center may direct the patient to the proper care location such as primary clinics or a nearby hospital. Furthermore, these emergency teams consist of nurses and physicians who can directly diagnose patients and administer care when they arrive to the patient's location, which is faster than when paramedics transport the patient to the emergency room before any care takes place. On average, only 50 out of 1,000 calls actually require emergency care, and the rest of the calls can be handled without utilizing the entire team (Columbia Broadcasting System, 2006). Overall, this reduces the overuse of staff, medical supplies, and transportation.

For example, when someone visits their doctor, the national program pays approximately 70% of the charge associated with the visit; for someone with a chronic illness (diabetes, cancer, mental illnesses), the national program pays for 100% of the cost, including medications or operations. Conjointly with the treatment and prevention of illnesses, France concentrates on reducing the social disparities relating to the availability of care. France strives to eliminate this immense gap and ensure for those from any social class to have the same access to services. The United States ought to follow this model of equality; all health issues should be treated without financial obstacles/borders. Ethically speaking, each human life deserves the same care, regardless if they are homeless or rich. Equality, in this case, universal coverage, is essential because health complications can result in a question of life or death. The United States' perspective on the value of a life can easily be construed to feel like money is more important than a life due to a constant reference to a higher cost of care if it becomes guaranteed for everyone. There is additional backlash from the U.S. population about not wanting to pay for someone else's health care in taxes, but many do not realize this is already the case for those who buy health insurance. This is because buying health insurance is giving money to an organization to pay for those in need of health care; even if an individual is healthy, they are still paying their insurance each month even if their personal health services are not utilized. In summary, eliminating the need to purchase insurance and implementing an increase in taxes to fund health care are not much different, yet Americans tend to be reluctant to this method, as paying for others' health care is more explicitly stated if their taxes increase.

What Makes France's System Better for Higher Life Expectancy Rates?

The French health care system is more efficient and has an overall better rating than that of the United States. Many Americans tend to not visit their doctor enough, whereas the French

go to their doctor frequently simply because they can afford it (Columbia Broadcasting System, 2006). The French government virtually sets the price for everything, and many would be quick to label this as socialized medicine. This notion is refuted by many French health care professionals; their government intervention is viewed as managed care or “soins intégrés”, which is different from the insurance-term “managed care” in the United States. In this case, managed care refers to the assurance of overall health provision and comprehensive care. This highlights the ideology in France about health being more important than monetary concerns, especially in emergency situations. France clearly refers to health care for all as a right, not a privilege. The United States’ mentality is inadmissible as it is concentrated on money, power, and “uniqueness”. This mentality is shown when we look at how much the United States spends and its reluctance to change by adapting models from other countries, like France or Spain.

France’s healthcare system expresses an emphasis on the necessity for each resident to receive health care, which is the foundation for its entire system. The perfect system does not exist, and being the country with several statistics falling below the world’s average, the United States must begin to accept ideas and understand the need for change.

Spain's Healthcare System

Spain provides free public healthcare to all those who are in the country as an innate right, including undocumented immigrants. Dr. Jimenez of La Paz University Hospital in Madrid, Spain tells an NPR interviewer about what their healthcare system has to offer.

> "Patients have a choice of doctors they can see as often as they like, and there are no co-payments. Even undocumented immigrants are treated. For those Americans who are used to private doctors offering the latest technologies and tests, the Spanish system might seem a basic, but no one is turned away."
>
> -Dr. JIMENEZ, La Paz University Hospital (Socolovsky, 2009)

Jimenez highlights the amount of health care services available in Spain by saying he does not know of anyone who has had to go out of the country to receive a certain type of care. Jerome Socolovsky, a writer for NPR, comments on the astounding circumstances regarding out-of-pocket costs: the majority of out-of-pocket costs are on prescription drugs. This is very different from the United States where out-of-pocket costs are quite extensive, including copayments for doctor visits, deductibles, and coinsurance for covered services plus the full cost of services not covered.

Additionally, Spain has one of the highest physician densities in the European Union, i.e. one of the best ratios of doctors to people. Despite a longer wait for specialty services, those in Spain are always expected to receive the care they ultimately need without a worry for cost. In 2016, the OECD published health statistics showing the country with the highest life expectancy in Europe, which was Spain (OECD, 2014).

Spain has three guarantees when it comes to those under its healthcare system. The first is equity, which is access to benefits and the right to health protection under conditions of effective equality throughout the country and free movement of all citizens. The second guarantee is quality: in the evaluation of the benefit delivered by clinical actions, incorporating only those which contribute added value to the improvement of health, implicating the healthcare system. The third guarantee is participation: the public of citizens both in respect for the autonomy of their individual decisions as well as in the consideration of their expectations as users of the healthcare system (Ministry of Health, Social Services, and Equality, 2012).

What Makes Spain's System Better for Higher Life Expectancy Rates?

Today, Spain remains in the top ten percent of the world's best health care systems. Overall, health care is not solely a guaranteed right, but states are mandated to provide it. Patients have a choice of doctors they can see as often as they like with no co-payments or claims forms. Although the system is primarily funded by taxes, there are benefits outweighing the deduction in paychecks for health care coverage. In the United States, a majority of individuals receive health care coverage through their employer; this is not the case in Spain. This includes a sense of security in always having access to health care regardless of employment status.

Furthermore, Spain has a strong primary care division as primary doctors are the gatekeepers of their system. They do not have to arrange their care based on if their patients can afford it or if their patients qualify for government assistance; the doctor will recommend the best course of action for an individual without the hindrance and burden about how the care will be paid for. Even though long waits are reported, 35% of people in Spain are assisted the same day in primary care. Moreover, voluntary health insurance is available to accelerate wait times

for some services, which one fifth of the population has taken part of. Even if the Spanish system may seem a little “basic” as Americans may use private doctors with the most updated technology, the system still does not turn anyone away. Even without adopting the newest technological innovations, Spain offers care to everyone, which maintains a higher life expectancy and less deaths among its population.

Reasons Why the United States Does Not Have Universal Health Care

The United States is the only highly-developed countries without universal healthcare, as shown in the figure below:

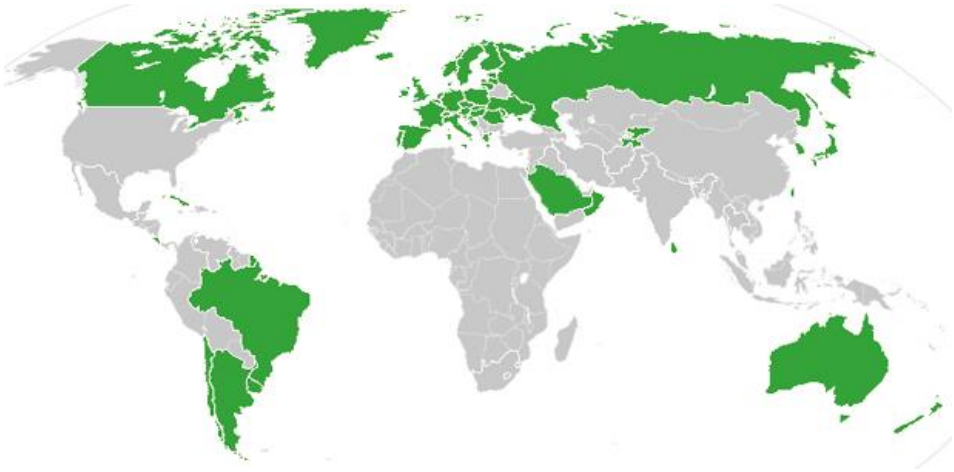

Figure 8. Map of developed countries with universal health care. From Here's a Map of the countries that provide universal health care (America's still not on it) by M. Fisher, June 28 2012, retrieved from https://www.theatlantic.com/international/archive/2012/06/heres-a-map-of-the-countries-that-provide-universal-health-care-americas-still-not-on-it/259153/.

One of the explanations for why the United States does not have universal coverage is because of its effort to conserve individualism, so a system where the government does not have too much power is carried out through many laws and policies in the United States. The debate about health insurance brings a lot of lobbying, which ensures the differences between citizens' interests are equally represented. Lobbyists encourage the federal government to make decisions for a specific issue while considering certain voices of the public to support the matter at hand. Moreover, lobbyists actually enjoy discussing insurance since it is a complex topic without consistency in the United States and is the cause of many disputes. For example, a lobbyist representing universal health care may raise a lot of money to fund a politician's campaign who

also advocates for this topic. For example, when lobbyists discuss the Affordable Care Act (put into effect by Barack Obama in 2010), they raise an estimated amount of 1.2 billion dollars (Eaton & Pell, 2017). Regarding monetary benefits, insurance companies make a great amount of money because the American system permits there to be various ways to have and pay for insurance.

These reasons are not sufficient in justifying the 28 million people under the American health care system without health insurance. Evidently, American politicians are keener on monetary benefits; if they could eliminate this mental barrier comprised of money and individualism when looking at health care, universal health care in the United States would be more feasible.

Bernie Sanders, a democratic American politician, strongly advocates for universal coverage. Even though his appeal was rejected, he does not stop to urge the federal government to institute more socialist strategies. In 2017, Sanders proposed a reform suggesting for the United States to expand Medicare, the guaranteed insurance program for citizens 65 years of age or older. Sanders proposed Medicare to be expanded to cover all citizens of the United States as a way to increase efficiency, rationality, and adaptability within our system. Additionally, Sanders suggested implementing a "Medicare card" for those under 18 years of age, and he advised to have a four-year program for integrating those who are not currently eligible for Medicare. Sanders also wants to eliminate financial coverage by employers and imagines a system similar to France's structure, which is a single-payer system with an increase in taxes to pay for it. Everything, from emergency surgery to prescription medications, from mental health to eye health, would be covered without copayments. Sanders' ideology does not completely eradicate the private sector; this sector would receive fewer clients, mostly because it would be

for those who want elective surgeries, such as cosmetic operations, as seen in Australia (Freed, Turbitt, & Allen, 2017).

Even if Sanders' position is seen as idealistic and intangible according to Congress, he believes all Americans (even doctors and the ill), if anything, should be willing to pay more taxes in exchange for a reduction in the frustration arising from dealing with private insurance companies. The costliness of a universal plan is widely recognized, but many other industrialized countries have found the means to implement it. Why does the United States tend to hold on so strongly to their power of independence and refuse to adopt ideas from other countries?

The United States population comprises of siloed political parties; oftentimes, Americans believe each redefined healthcare system proposal must be labeled as a Democratic or Republican idea. For example, to develop a sustainable healthcare product (sometimes labeled as "Medicare for All"), the United States would have to pose a significant increase in taxes. Once this idea was originally presented, the Republican Policy Committee (RPC) headlined their responding article as: "Medicare for All: higher taxes, fewer choices, longer lines". Its primary takeaways from Medicare for All were the emphasis on a 20 percent tax increase and an estimated cost of 32 trillion; the overall claim was "a single-payer health care system would eliminate all private insurance and place all medical care in the hands of the federal government" (Senate Republican Party Committee, 2018). Additionally, the article begins by immediately attributing this effort to the Democratic party, using terms such as "radical" and "decades-old" to describe the universal healthcare proposal. The underlying issue is tied to the notion of expecting one political party to take charge of the solution to increasing healthcare access; however, Americans and their government must realize there is not a need for a Republican or Democratic solution, but it is a necessity to implement the best one. This means an increase in access and

quality of care for the American population, which would include higher life expectancy rates in the future if a universal care solution is adopted.

Advantages of a National System

> "[Universal health coverage] has become the number one policy choice of governments all around the world and for very good reason, because universal health coverage can create avenues to fix broken health systems, it can help to save lives, it can avert death and disability, it can be a vehicle for achieving programmatic goals and most importantly, if it is delivered effectively, it could become the 21st century welfare contract between the state and the citizens, a state's promise to its people."
>
> -Sania Nishter, Chairperson, Benazir Income Support Programme 2019

The advantages of a national system outweigh the benefits of the current system in place for the United States. The biggest advantage is everyone having (at the very least) basic health insurance and would not worry about going to the hospital or visiting the doctor with bills too large to handle. If everyone had the opportunity (financially) to go to the doctor regularly, we can deduce a decrease in the number of mortalities from illnesses, primarily because physicians can catch diseases earlier on. Early detection may prevent the onset in the severity of a chronic disease which may cause further disabilities, other chronic conditions, or even death. This would result in a decreased prevalence of major illnesses; additionally, early detection of disease would not only help an individual and their surrounding population by herd immunity but may also help the economy.

In the workplace, if the general health status of all employees across the country is ameliorated, there will be a reduction in the employees who take many sick days off from work, which would result in an increase of productivity level. Furthermore, a system with universal coverage can stimulate growth for all businesses, especially those of smaller size. A business will not have the financial burden of finding adequate coverage for its employees if they already

receive sufficient/same coverage regardless. Without the worry of exorbitant costs for the provision of health insurance, these businesses may also open up more employment opportunities.

In France, individuals do not lose much of their autonomy, contrary to popular belief. Even with universal coverage, people have the power to choose their specialists (if need be). The option to have private insurance conjointly with universal coverage without paying an unreasonable cost is another advantage of this system. For example, S.O.S. Médecins is a 24/7 medical service in France that sends doctors to a patient's home instead of sending an ambulance. S.O.S. Médecins assists over two million people per year, and the majority of costs for visits are reimbursable (Columbia Broadcasting System 2006). When someone becomes sick in France, they do not worry about accumulating medical debt, which causes some bankruptcies in the United States.

Disadvantages of a National System

Universal health care coverage does not solely consist of advantages. This type of coverage always results in higher taxes. According to the Organisation for Economic Cooperation and Development (OECD) in 2017, taxes in France represent 46.2% of its GDP, the second-highest percentage in the world, while taxes in the United States represent 27.1% of its GDP, the 31st in the world. (OECD, 2017) Although, aside from having guaranteed coverage, French citizens also tolerate higher taxes because they receive many useful public services in return, such as transportation and education. As commonly anticipated, a national healthcare system demands a considerable amount of budgeting skills, which has the potential to reduce funding for services in other areas if costs are higher than forecasted (Regoli 2019).

According to the Canadian Institute for Health Information, longer wait times is a prevalent issue for some countries with universal health care, especially for specialty and surgical services. An international health policy survey from the Commonwealth Fund in 2016 showed the following: “In the United States, only 25% of patients had to wait at least four weeks to see a specialist compared to 59% in Canada, 56% in Norway, and 43% in the United Kingdom - all countries that have some form of a universal right to care” (Canada Institute for Health Information, 2016). France has a percentage of 36%, which is the average percentage of patients waiting four weeks or longer, however, this is still higher than the United States.

Even though wait times are higher in other countries, the exchange for lower payments outweighs a shorter wait time for a doctor visit resulting in hundreds or thousands of dollars in medical bills, which may lead to increased debt or even bankruptcy for some individuals. If longer wait times were a more pressing issue than cost, countries with universal coverage would

have higher death rates and shorter life expectancies; instead, this is the result of the United States.

With this national system, the competition between medical practices diminishes outside the private system. This means contracted physicians (i.e. not private; with the French social security) have salaries regulated by the federal government, so the competition to have more patients than someone else no longer exists. So, this system reduces the amount of money doctors can make, which also takes from the attraction of the profession. Moreover, there is already a national shortage of doctors in the United States, with a projected shortage of between 46,900 and 121,900 physicians by the year 2032, according to the Association of American Medical Colleges (2019). If the current system is changed to a national health system or a form of socialized medicine, there is a fear of the shortage worsening. However, there are many ways in which shortages in physicians can be mitigated, such as easing the process for international medical graduate students to practice in the U.S. They make up nearly a quarter of the current physician workforce in the U.S. and are more likely to work in underserved and low-income areas; however, the current licensure process is extremely complicated (Flier and Rhoads, 2018). Moreover, another potential solution is to hire more physician assistants (PAs), as it is more cost-effective because they are able to provide a certain level of care similar to physicians, even without supervision.

Conclusion

Which Characteristics from Other Countries' Systems Can the United States Adopt?

The United States can adopt some characteristics of other countries into its healthcare system to increase access and efficiency, thus potentially increasing life expectancy in the long-run. For example, this paper discusses France and its regional adoption of its overall national health policies. Although the United States is not primarily split into geographical regions, the country can use its state governments to model after France's regional agencies.

"Implementing Population Health In The US: Lessons From Spain", an article from *Health Affairs*, a leading journal of health policy thought and research, highlights particular strategies from the Spanish health care system for adoption in the United States. The necessity for overall strategic alignment between different political parties, programs, regions, and organizations is at the forefront of these lessons. Moreover, integrated efforts should be encouraged without concerns regarding party association and bias. A foundation of collaboration, trust, and accountability can help set common goals among health care, which is currently exhibited by integrated health organizations (IHOs) in Spain (Kellogg, Nuno-Solinis, Shortell, & Scheffler,2019). If greater emphasis is placed on population health, universal health care is perceived as more feasible.

Adopting a blanketed, socialized, universal health care system in the United States is far from feasible. The country's individualistic culture attributes to why citizens, especially of the healthier, wealthier population, refuse to accept this concept. Many individuals claim they do not want to pay for someone else's care, especially if it is through higher taxes. The United States' life expectancy is lower than most other developed and wealthy nations, and is the only country with substantial numbers of uninsured individuals (OECD, 2017). An analysis from the Global

Burden of Disease Study in 2015 concluded that a lower level of healthcare access to higher quality health care is correlated with an increased mortality rate from preventable causes or "amenable mortality" (OECD, 2017). As some Americans die sooner and in larger quantities for preventable reasons tied to a lack of access to care, the United States must increase the acknowledgment for a need in universal healthcare. Overall, an expansion of health care coverage in the United States enables an improvement in population health, which leads to people living longer. Healthcare policy and reform should push to implement our health system to cover the cost for every person to at least undergo health care screening or check-ups. This is one push in the direction to guarantee basic coverage to all, which may be intangible at this point.

Even though access in the United States is currently limited, American medical facilities must introduce self-management and self-care improvements among patients. This alleviates issues in lifestyle and behaviors which results in decreasing the disease burden; moreover, every practice and health care professional must continue to educate patients on healthier lifestyle practices. Advocating for these changes in current health care policies to expand care is the next step to implementing universal care methodologies, thus aiming for an increase in overall life expectancy among the population.

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