AN ANALYSIS OF THE UNITED STATES AND UNITED KINGDOM HEALTH CARE SYSTEMS

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UNITED KINGDOM HEALTH CARE SYSTEMS

by

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ABSTRACT

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Caitlin Schenkel

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The health care experience of two individuals, one from the United States and one from the United Kingdom with similar medical conditions, provided an interesting vantage point for this focused comparative analysis of two different models of health care delivery. The impact of the health care system’s unique financial, payment, organization, regulation and behavior profile on the individual reduces abstraction and drives home the profound impact health care policy choices have on its citizens. It was my intent to present the pros and cons of each health care system model in the hopes that public policy makers from both countries might learn from each other.

KEYWORDS: MEDICAL care – United States, GREAT Britain, MEDICAL care, Type 2 diabetes, Affordable Care Act, National Health Service
# TABLE OF CONTENTS

Chapter

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>List of Figures</td>
<td>v</td>
</tr>
<tr>
<td></td>
<td>List of Tables</td>
<td>vi</td>
</tr>
<tr>
<td>1</td>
<td>Vignette</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Introduction</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>Diabetes Focus</td>
<td>7</td>
</tr>
<tr>
<td>4</td>
<td>Five Control Knobs for Health Sector Reform</td>
<td>11</td>
</tr>
<tr>
<td>5</td>
<td>Financing</td>
<td>15</td>
</tr>
<tr>
<td>6</td>
<td>Payment</td>
<td>20</td>
</tr>
<tr>
<td>7</td>
<td>Organization</td>
<td>25</td>
</tr>
<tr>
<td>8</td>
<td>Regulation</td>
<td>30</td>
</tr>
<tr>
<td>9</td>
<td>Health Behavior</td>
<td>34</td>
</tr>
<tr>
<td>10</td>
<td>Patient Outcomes</td>
<td>39</td>
</tr>
<tr>
<td>11</td>
<td>Conclusion</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>References</td>
<td>44</td>
</tr>
</tbody>
</table>
List of Figures

Figure 1: Control Knobs for Health Sector Reform 13
Figure 2: International Comparison of Spending on Health, 1980-2008 17
Figure 3: Health Care Expenditure per Capita by Source of Funding, 2008 18
Figure 4: United States Physical Activity in 2008 37
List of Tables

Table 1: Health Spending in Select OECD Countries, 2008  17

Table 2: Supply and Utilization of Doctors and Hospitals in Select OECD Countries, 2008  27

Table 3: Hospital Admissions for Chronic Diseases and Diabetes Amputations in Select OECD Countries, 2008  36

Table 4: Summary Table of United States and United Kingdom Health Care  44
CHAPTER ONE

Vignette

Background on US patient: “David”

David, an overweight 45 year old male from Warner, SD has been feeling strange since he got to work this morning. He has only been at work for two hours but he has already had at least ten glasses of water and has also made several trips to the bathroom. Not only has David’s unquenchable thirst and numerous bathroom trips been bothering him, but he has also been dealing with blurry vision and has felt groggy all morning. David quickly dismisses his increased thirst and bathroom trips thinking that maybe he is just a little dehydrated. He assures himself that his fatigue is due to the dogs next door barking all night and his vision is only blurry because he did not get enough sleep. David does the best that he can to continue with his work day, but instead of feeling better as he had anticipated, he finds that he is only feeling worse as the day progresses. Eventually David decides he should go home.

Once David arrives at home he calls his wife and leaves a message saying that he came home sick from work and he might go in to see the doctor later if he does not feel better soon. After waking up from a nap and finding that this has helped nothing, David decides that he needs to go and see his doctor but no longer feels well enough to drive. When David’s wife gets home from work, she drives him to the nearest Urgent Care clinic in Aberdeen, SD fifteen miles away from their home. David explains to the nurse and physician at the clinic how he has felt all day and says that he thinks he “has a bug or something.” After drawing labs on, the physician informs David that his blood glucose is
649, a dangerously high level and therefore diagnoses him with hyperglycemic hyperosmolar syndrome. The physician also informs David that he will need to go to the hospital immediately to get this corrected.

After treating David’s condition, David and his wife were informed that he has been diagnosed with Type 2 Diabetes. During recent years David’s doctor had warned him about his poor diet choices, weight gain, and lack of exercise, but David had never thought that he would develop Type 2 Diabetes. While in the hospital, David is taught how to check his blood sugar and how to determine how much insulin he will need to administer accordingly. He is also taught to follow a diet that helps prevent his blood sugar from becoming elevated but David does not see the point in following a diet when he can just give himself more insulin to treat his high blood sugar levels. He is warned about all of the potential complications that can take place if his blood sugar levels are not controlled and he is told the importance of taking special care of his feet. By the time David is discharged four and a half days later (Centers for Disease Control and Prevention, 2013), he is feeling extremely overwhelmed by all the information presented to him.

After being discharged from the hospital, David and his wife purchase a device called a glucometer which will read his blood sugar levels, test strips, finger lancets, syringes, and insulin. He is astonished by the cost (Afonso & Priscilla, 2008) of all of the equipment that he needs. Even with the health insurance he has through his employer, David’s bill for all of his new equipment comes to $200 (Health Action International, 2010). Yet this is nothing compared to the hospital bill that David and his wife receive a few weeks after being discharged; a staggering $5,248.60 (The Henry J. Kaiser Family
David’s wife insists that they also stop by the grocery store to pick up some food that will adhere to David’s new diet. David has a follow-up appointment scheduled with his primary care physician.

**Background on UK patient: “Thomas”**

Meanwhile in the United Kingdom, Thomas, an overweight 45 year old from Lyddington, has also been feeling strange all day. He too has been drinking large amounts of water and been making numerous bathroom visits. Thomas has also been feeling weak and tired all day but attributes this to staying up late recently to work on that big project he’s been trying to finish for his job. He has noticed that over the past week or so his vision has been getting worse but he planned to make an eye appointment at the end of the week once his project at work was finished. Throughout the course of the morning, Thomas notices that he is feeling worse and worse and makes the decision to go home even though he knows it will set him back on his project.

As his day continues, Thomas is still feeling sick and exhausted despite several naps and drinking copious amounts of water. Once Thomas’s wife gets home he too decides to go to the doctor at the nearest clinic in Oakham, fifteen miles away from his home. Upon arrival at the clinic, Thomas explains his symptoms to the nurse and doctor. Thomas vehemently tells his doctor that he only has a bug of some sort and that he only wants an antibiotic so that he can get back to work as soon as possible. However, suspecting that this is something more serious than a cold or the flu the physician orders labs in order to check Thomas’s blood glucose level. The results show that Thomas has a blood glucose of 632. The physician informs Thomas that his blood glucose levels are dangerously high and that he will need to be hospitalized in order to fix this problem.
Thomas is admitted to the hospital with a diagnosis of hyperglycemic hyperosmolar syndrome.

Once Thomas’s blood sugar levels approach a normal level, he and his wife are informed that he has Type 2 Diabetes. Thomas is irate about his diagnosis and tells his wife that he does not have time for all of this. Despite Thomas’s protests, he remains in the hospital for five days while his blood sugar is brought under control. Before his discharge, Thomas is taught how to check his blood sugars before each meal and bedtime, how to administer insulin, and what kind of foods he should and should not be eating. Thomas and his wife are also given several packets of information on the complications of diabetes and how to prevent them. Along with the brochure, Thomas has several follow up appointments scheduled in a diabetes clinic. Thomas is frustrated with the amount of time that his new diagnosis will consume, but reluctantly agrees to go to all of his appointments after he is told just how important they are.

Thomas and his wife stop at a pharmacy on the way home to pick up all of the new supplies that he will need. Since his family pays a yearly stipend for prescriptions, Thomas and his wife merely have to pick up his needed supplies without paying anything (National Health Service, 2012). Thomas never receives a bill for his hospital stay thanks to the income taxes that he pays.
CHAPTER TWO

Introduction

David and Thomas’s stories highlight the successes and short comings of the United States’ and United Kingdom’s health care systems. With the recent focus on healthcare reform in the United States, it could be argued that the United States would be able to learn something by looking to similar developed countries. By examining problems experienced in other countries, the United States might learn from their experience – avoiding policy mistakes and adopting promising new ideas for the American health care system. According to Roberts, Hsiao, Reich and Berman, “Findings from cross-national comparisons of health care systems can inform public policy, highlight areas where nations could improve, and yield benchmarks of high performance” (2008). Eben Harrel also gives a broad overview of how each country can learn from each other.

Like most developed countries, Britain ranks above the U.S. in most health measurements. Its citizens have a longer life expectancy and lower infant mortality, and the country has more acute-care hospital beds per capita and fewer deaths related to surgical or medical mishaps. Britain achieves these results while spending proportionally less on health care than the U.S. – about $2,500 per person in Britain, compared with $6,000 in the U.S. for these reasons, the World Health Organization (WHO) ranked Britain 18th in a global league table of health-care systems (the U.S. was ranked 37th). However, there are measures by which the U.S. outperforms Britain: for instance, the U.S. has lower cancer mortality rates” (Harrell, 2009).

As can be seen, the United States and the United Kingdom could both learn more about how to more effectively run their healthcare systems in terms of outcomes, cost per patient, prevention, and overall quality of care. Both countries have been in discussions with each other on how to improve their medical systems which will be fully addressed
later. Each of the United States’ and United Kingdom’s successes and short comings pertaining to their healthcare will be addressed by discussing the following aspects of their healthcare systems; financing, payment, organization, regulation, and behavior.

Both the United States and United Kingdom have been reluctant to change their healthcare system. Currently, healthcare is a hot topic in the United States. With many differing opinions on how various aspects of the reform should be handled, healthcare has become a battle ground for the political realm. The original intent of the Affordable Care Act was to ensure that all Americans have some form of health insurance. However, due to concessions made to pass the bill and a recent Supreme Court decision, there will still be Americans not be covered by a health insurance plan. With Conservatives and Liberals arguing for and against the new legislation, there seems to be a substantial group of United States citizens who do not agree with the new healthcare reform. In May of 2013, roughly 43% of the American population did not approve of the new Affordable Care Act (The Henry J. Kaiser Family Foundation, 2013). The United Kingdom went through a similar upheaval surrounding their National Health Service during the 1940s where many citizens were against its implementation. Ultimately, the United Kingdom Conservatives and Liberals decided that all citizens would be covered by a tax funded, government run healthcare system called the National Health Service (NHS). Now most citizens in the United Kingdom are fully supportive of their National Health Service and vehemently oppose any attempts to lessen government control of this particular aspect of their lives (National Health Service, 2013). Seeing how the popular opinion on substantial government involvement in healthcare has changed in the United Kingdom there is potential that this would also be possible in the United States.
CHAPTER THREE

Diabetes Focus

The topic of healthcare is a broad topic, therefore this analysis will the focus on healthcare surrounding the diagnosis of Type 2 Diabetes. With its prevalence, cost for care, its preventable nature, and number of complications that can occur, diabetes provides an optimal exemplar for comparison of the United States and United Kingdom healthcare systems. It will be used to analyze the inherent strengths and weaknesses of both systems and how key differences influence a patient’s healthcare experience.

There are two kinds of diabetes, Type 1 and Type 2 diabetes. Type 1 diabetes generally occurs in children and is caused by the body’s immune system attacking the cells in the pancreas that produce insulin causing a deficit of insulin in the body. Type 1 diabetes is not preventable and is considered an autoimmune disease. Individuals with this form of diabetes will have to use supplemental insulin for the rest of their lives.

Type 2 diabetes is a largely preventable form of the disease. Type 2 diabetes occurs when the cells of the body become resistant to the insulin or when the body no longer produces adequate amounts of insulin. In some cases genetic factors can contribute to the onset of Type 2 diabetes as well. This form of diabetes generally occurs in people who are overweight, inactive, and or make poor food choices. Unlike Type 1 diabetes, Type 2 diabetes can usually be controlled through lifestyle changes such as becoming more active and watching dietary intake. For the purpose of this analysis, the focus will be placed on Type 2 diabetes as this is considered a preventable disease (Ignatavicius & Workman, 2013).
Diabetes is one of the more prevalent diseases in both the United States and the United Kingdom. In the United States in 2011, there were 25.8 million children and adults that had diabetes, accounting for roughly 8.3% of the total population. Of these, 1.9 million were newly diagnosed (American Diabetes Association, 2013). In comparison, there are 2.9 million people in the United Kingdom who have been diagnosed with diabetes which accounts for roughly 4.45% of their total population (Diabetes UK, 2012). With such a substantial portion of the population diagnosed with diabetes, how each country handles this particular disease could be translated into how they handle other similar diseases as well.

Along with being one of the more prevalent diseases in both the United States and the United Kingdom, diabetes is also an expensive illness. With the cost of insulin, antidiabetic medication, syringes, and blood glucose testing supplies, the amount of money that a patient has to spend in order to manage their diabetes can be substantial. Patients with diabetes will also have more visits to their primary care provider. These visits are intended to help diabetic patients better manage and control their disease by running lab tests and doing regular assessments and monitoring for the emergence of complications. In the United Kingdom, an individual with Type 2 Diabetes paid $1,308 a year on average in order to manage their disease (Department of Health, 2001). While in the US, an individual with Type 2 Diabetes can anticipate to pay $7,900 annually in order to control their illness (American Diabetes Association, 2013). Complications from diabetes are also a huge source of expenditure. These complications can lead to hospitalizations, more medications, surgeries, and the need for additional medical equipment. Even with insurance, the cost of these supplies, doctor visits, and
complications can have a large impact on the patient. However, it is not just the patient that is affected monetarily by this disease. Both the United States and the United Kingdom spend billions of dollars managing patients with diabetes. As of March 6, 2013, the direct medical cost of diabetes in the United States was $176 billion. The United States also saw $69 billion in lost productivity due to diabetes (American Diabetes Association, 2013). The United Kingdom’s National Health Service spends $16.2 billion on diabetes which accounts for 10% of their National Health Services budget (Diabetes UK, 2012).

In order to adequately control a Type 2 Diabetes, a patient must play an active role in their treatment plan. After diagnosis, patients are taught how to best control their diabetes and how to monitor their disease. For most patients, this means checking their blood glucose levels at least four times a day, once before breakfast, lunch and dinner and once before going to bed. Depending on this reading, the patient may need to self-administer insulin. The disease also has a large impact on a person’s diet. Those who control their diabetes effectively must count the number of carbohydrates that they are eating at each meal to ensure that they are not eating too few or too many. Another thing that most diabetic patients are encouraged to do is exercise on a regular basis. If a patient does not take these measures to control their diabetes, they could quickly develop life-threatening complications from the disease (Ignatavicius & Workman, 2013).

For the patients that do not control their type two diabetes, there numerous complications that can occur. These include heart disease, stroke, hypertension (high blood pressure), blindness, kidney disease, nervous system damage in the form of neuropathy, and amputations (Ignatavicius & Workman, 2013). As previously stated,
these complications lead to an increase in the cost of diabetes due to hospitalizations, increased use of medications, surgeries, and the need for medical equipment. Along with the increased cost, complications also lead to a decrease in the quality of life for the patient. All of these complications are avoidable though if the patient can keep their diabetes under control (Ignatavicius & Workman, 2013).

Not only can patients avoid complications, but a patient can sometimes completely avoid the diagnosis of Type 2 Diabetes altogether since it is an almost entirely preventable disease. Through exercise, good eating habits, smoking cessation, physical exams by primary providers, and management of heart disease a person could successfully prevent a Type 2 diabetes diagnosis (Ignatavicius & Workman, 2013). The fact that the disease is generally preventable makes it an interesting disease to examine in terms of how both the United States and the United Kingdom approach it. How each country deals with prevention of type 2 diabetes will be discussed in full detail later on.
CHAPTER FOUR

“The Five Control Knobs for Health Sector Reform”

Figure 1. Control Knobs for Health Sector Reform

Figure 1. Predictive assessment models are used to analyze the direct relationship and the degree of the correlation between an intervention or an event and its impact on individuals, communities and populations.

According to Roberts et al., the authors of Getting Health Reform Right: a Guide to Improving Performance and Equity there are five ways or policy “knobs” that can change in order to manipulate the ways health care systems work. These include financing, payment, organization, regulation, and behavior. By introducing policy change in one or more these different sections, a country can make needed adjustments or completely change its healthcare system. Figure 1 gives a visual representation of how these policy areas can impact the outcomes of a healthcare system. How a country currently has these various aspects set will affect efficiency, quality, and access which
will in turn determine the level of a country’s health status, healthcare satisfaction, and risk protection from diseases (Roberts et al., 2008).

Financing, according to *Getting Health Reform Right*, consists of all the different ways in which a country raises money to pay for their healthcare system. There are several ways that a country can do this; imposing taxes, insurance premiums, and direct payments by patients. Insurance companies and in some cases, the government plays a large role in how this aspect functions (Roberts et al., 2008).

Closely related to financing, is the topic of payment. *Getting Health Reform Right* states that payment is the means by which a country “transfers money to health-care providers.” Those who receive these funds include doctors, hospitals, and public health care personnel. The main ways that these funds are distributed are through fees, capitation, and budgets. The authors argue that this particular aspect provides incentives for healthcare providers and therefore can greatly influence how they behave within their system (Roberts et al., 2008).

How a country organizes their healthcare also plays an important role in how the system functions. Organization includes not only the logistics of how the system works, but it also includes determining the quantity and type of various healthcare providers, definitions of their various roles, and how those providers interact with one another professionally.

These mechanisms typically include measures affecting competition, decentralization, and direct control of providers making up government service delivery. It includes who does what and who competes with whom, as well as the managerial aspects of how providers work internally, such as how managers are chosen and how employees are rewarded.
Organization, therefore mostly deals with how the system is set up to function overall (Roberts et al., 2008).

Regulation refers to the way in which a healthcare system controls financing, payment, organization, and behavior. However, just because a regulation has been put into place in a country, does not mean that it is necessarily enforced or fully implemented. With that in mind, this can influence how easy or difficult it is for healthcare to make changes to (Roberts et al., 2008).

Behavior refers to how a system, group, and/or individual acts to affect health and healthcare. Things that would fall under this particular aspect include the role of the media, individual patients, medical societies, and healthcare workers. How these different groups impact views on health and healthcare can have a very large impact on how a healthcare system works. For instance, if the media places an emphasis on the failures of a hospital to control hospital acquired infections, public outrage could lead the hospital to make changes on how they handle infection prevention in their facility. Healthcare workers are also able to influence the behaviors of their patients by teaching them about the diseases and illnesses that patients are at risk for. If a physician tells his patient who is at risk for developing diabetes if he does not change his diet and lose weight, the physician has the potential of changing his patient’s behavior (Roberts et al., 2008).

The unique blend of a country’s policies and regulations determines how well their healthcare system works. Getting these “settings” right can be the tricky part. A country that places too much emphasis on one particular aspect may find that the other areas are severely lacking. For example, if a country puts too much emphasis on
financing and payment they may find that their healthcare system does not function properly because there is a lack of organization and regulation. The country might also find that their population has a higher incidence of hospitalizations because behavior is not being streamlined or positively influenced. Countries must therefore be careful and conscientious of which aspects they want to focus on with their healthcare.
CHAPTER FIVE

Financing

Table 1

Health Spending in Select OECD Countries, 2008

<table>
<thead>
<tr>
<th>Country</th>
<th>Per capita</th>
<th>Percent GDP</th>
<th>Average annual real growth rate per capita: 1990–2006</th>
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<tr>
<td>Australia</td>
<td>$3.353*</td>
<td>8.6%*</td>
<td>3.6%*</td>
</tr>
<tr>
<td>Canada</td>
<td>$4.079*</td>
<td>10.4%*</td>
<td>3.4%*</td>
</tr>
<tr>
<td>Denmark</td>
<td>$3.540*</td>
<td>9.7%*</td>
<td>3.5%*</td>
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<td>France</td>
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<td>11.2%</td>
<td>2.3%</td>
</tr>
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<td>Germany</td>
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<td>Netherlands</td>
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<td>9.9%*</td>
<td>4.1%*</td>
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<td>New Zealand</td>
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<td>4.4%</td>
</tr>
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<td>Norway</td>
<td>$6,003*</td>
<td>8.5%*</td>
<td>0.8%*</td>
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<td>Switzerland</td>
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<td>10.7%*</td>
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<td>United Kingdom</td>
<td>$3,129</td>
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<td>United States</td>
<td>$7,538</td>
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<td>3.4%</td>
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<tr>
<td>OECD median</td>
<td>$2,995</td>
<td>8.7%</td>
<td>3.0%</td>
</tr>
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</table>

*2007
*Adjusted for differences in cost of living
*Estimate

Source: OECD Health Data 2010 (Oct. 2010).

Figure 2. International Comparison of Spending on Health, 1980–2008

Figure 2. Average spending on health per capita and the total expenditures on health as percent of GDP in twelve developed nations.
Figure 3. Average health care expenditure per capita by source of funding in twelve developed nations adjusted for differences in cost of living.

United States

Historically, in the United States, healthcare was largely financed through employer sponsored insurance premiums and direct payments from patients (Khan Academy, 2011). In the past, whether the money came from premiums or direct payments depended on what the insurance covered and if the patient had health insurance. Figure 3 gives a summary of where money for healthcare came from (public, private, and out of pocket) in 2008 and how much of this money is used to finance the healthcare systems in the United States and other developed nations. With the recent passage of the Affordable Care Act, each state has the right to choose to expand Medicaid and those individuals who do not qualify for Medicaid or Medicare are required to find some form of insurance. Americans that would qualify for these programs but live in states that have chosen not to expand Medicaid and Medicare, are not required to buy
health insurance. Prices of healthcare (hospital stays, doctors’ fees, medication and procedural costs) and health insurance policies vary markedly from one area to another. In 2011, Americans paid an average of $183 a month for insurance premiums or $2196 a year (eHealthInsurance, 2011). In the United States, Americans must pay a certain amount of money out of pocket before their health insurance will start covering some or all of the cost of their healthcare. These deductibles vary depending on the kind of health insurance the individual or family has. The average deductible for individual Americans in 2012 was $1,097 (Rae, Panchal, & Claxton, 2012).

There are certain aspects of the healthcare system that the United States government funds. These areas include Medicare, Medicaid, State Children’s Health Insurance Program (SCHIP), Indian Health Service (IHS), TRICARE, and the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). Each of these programs is partially funded through the government and the patient. All working Americans contribute to these funds through taxes.

The State Children’s Health Insurance Program, or SCHIP, is a healthcare insurance program that applies to children of low income families who do not qualify for Medicaid. This program covers eligible children until the age of nineteen. SCHIP provides coverage for most preventative services, physician services, inpatient, and outpatient services. Funds for this program come from both the federal and individual state governments. Each state decides how much money will be allocated to the program for the year. The federal government then matches this amount (Valerius et al., 2005).

Indian Health Service is also a part of the United States healthcare system that is funded through the government. Each year, IHS proposes a budget which is reviewed
and approved by the United States Congress (Indian Health Service, n.d.). This particular program is a division of the Department of Health and Human Services and is funded by the federal government. Those who are covered by this service are American Indians and Alaska Natives who are members of a federally recognized tribe (Indian Health Service, n.d.).

TRICARE is the name of the health insurance plan for those who are in the United States military and their family members. This particular part of healthcare is partially funded through the United States government. Money is raised for this program through taxes to pay for certain aspects of military personnel’s healthcare. Patients who use this insurance plan still pay deductibles, copays, and a percentage of their inpatient and outpatient healthcare similar to individuals who have private insurance. All other expenses are paid by the government in acknowledgment of the patient’s service to the United States (Valerius, Bayes & Newby, 2005).

CHAMPVA patients are similar to TRICARE patients in that it is military based. However, in order for the patient to qualify for CHAMPVA, the military personnel must either be “totally and permanently disabled due to a service-connected injury” or be the remaining family members of a serviceman who died in the line of duty (Valerius et al., 2005). Like TRICARE, these patients pay deductibles and a certain percentage of their healthcare charges. While both TRICARE and CHAMPVA patients do receive government help with their healthcare, they by no means get free healthcare. Instead, the healthcare that they receive is at a reduced rate.

Medicare and Medicaid are also two very large areas of healthcare that both are both financed through the government. Medicare is solely funded through the federal
government while Medicaid is funded by both the federal and individual state
government (Valerius et al., 2005). Americans who are eligible for Medicare are over the
age of 65, disabled adults, spouses of those who are eligible, retired federal employees,
and individuals who are in end-stage renal disease (Valerius et al., 2005). Americans
who are eligible for Medicaid include those with “low income and few resources.”
Unlike Medicare, the exact Medicaid eligibility requirements vary from state to state so
while in one state a patient may not be eligible, they might be eligible in another
(Valerius et al., 2005). This particular area of healthcare is funded by taxes on the
general public. However, this does not mean that patients who are on Medicare or
Medicaid receive free health care. Instead, like some insurance policies, they only cover
certain doctors, clinics, tests, and procedures (Medicare.gov, 2013). Patients who are on
Medicare are also still expected to pay copayments, premiums, and parts of the cost of
their prescriptions. Medicaid patients, however, are not expected to pay premiums for
their healthcare (Valerius et al., 2005). In other words, these programs help the patient
pay for certain areas of their healthcare (Medicare.gov, 2013).

Financing in the United Kingdom

The UK has two insurance systems that are funded differently. The National
Health Service is government operated and funded, while the private sector is funded by
those who use its services. The United Kingdom’s gross domestic product in 2010 was
reported as 2.26 trillion dollars (Chang, Peysakhovich, Wang & Zhu, 2008). Of this,
9.3% was spent on healthcare which would account for roughly 210 billion
dollars (The World Bank, 2011). This is substantially less than the United States who
spent 17.6 percent of their gross domestic product on healthcare (Kane, 2012). Figure 2
and Table 1 also give summaries of how much gross domestic product is spent on health care in twelve different developed nations including the United States and United Kingdom.

The National Health Service in the United Kingdom finances their healthcare system through direct taxation of their citizens. All citizens are required to pay these taxes which account for four and a half percent of their income. When looking at the total taxes that a citizen pays, roughly eighteen percent of a United Kingdom citizen’s income tax goes to fund healthcare. Consequently, citizens can access their healthcare free at the point of care (Chang et al., 2008). However, citizens can opt to use private healthcare rather than public.

The private sector of healthcare insurance in the United Kingdom is funded through insurance premiums and fees for service. These premiums are determined by numerous factors including: age, preexisting conditions, scope of coverage, gender, occupational status, and smoking status. A higher risk patient pays higher premiums for their private healthcare. In many cases, this means that younger individuals in good health pay less than those who are older and have numerous chronic diseases (Foubister, Thomson, Mossialos & McGuire, 2006). Once premiums are determined, patients who have private medical insurance are charged based on what healthcare services they utilize.
United States

Payment in the United States is a fairly complex process. For the most part, healthcare in the United States is paid for on a fee-for-service basis. This means that patients and their insurance company receive an itemized bill for all services and supplies that they needed while receiving care. Hospitals, clinics, health care providers then receive payments based upon services they provided for their patients. These payments are generally paid through insurance companies, patients, Medicare, or Medicaid or some combination thereof.

How hospitals get paid is determined by numerous factors. One way in which hospitals get paid is through Medicare. Hospitals get paid for each Medicare patient they treat. How much the hospital gets paid is determined by many factors surrounding the patient such as diagnosis, days in the hospital, and complications that occurred during the hospital stay. The total a hospital is paid by Medicare depends on which diagnosis-related group the condition for which the patient is treated falls within.

Medicaid also makes payments to hospitals (Reinhardt, 2009). Payments to providers and hospitals are made with the understanding that the patient will only have to pay a copay, a very low deductible, and coinsurance (Valerius, Bayes & Newby, 2005). These payments can be based on one of three methods; case-based payments, a set amount of money for each day that the patient is in the hospital, or fee-for-service. (Reinhardt, 2009)
Even though hospitals get paid by Medicare and Medicaid, many United States hospitals lose money by taking care of these patients. The cost of taking care of Medicare and Medicaid generally far exceeds how much the hospital is reimbursed by these programs. According to the American Hospital Association, “They are losing money on Medicare patients, to the tune of nearly $24 billion a year” (Luhby, 2013). Medicaid pays hospitals even less for the care of their patients, further adding to the financial gap that healthcare facilities face. Whether or not a hospital is fully reimbursed for a procedure or visit for a Medicare of Medicaid patient depends on what the procedure or visit is for. Some procedures and primary care visits are fully reimbursed which means the hospitals neither make nor lose money on these patients. Other procedures and visits are only partially compensated which is where most hospitals lose their money. In order to compensate for this loss of money, hospitals charge their non-Medicare and Medicaid more for the same care. This difference in cost of care is referred to as “cost-shifting” (Landers, 2013). Therefore, most hospitals make most of their money from patients who have private health insurance.

Patients with private health insurance pay for their healthcare on a fee-for-service basis. 64% of the American population currently finds themselves in this category (Smith & Stark, 2012). The fees that these patients pay usually exceed the cost that it takes to actually treat them. (Reinhardt, 2009). Extra money that the hospitals make from patients who have private health insurance then covers the losses that these facilities face from treating the Medicare and Medicaid patients whose procedures and visits are not fully reimbursed. In fact, the money made from patients with private health insurance
allows hospitals to make a profit which can then be invested into technology, research, raises for healthcare workers, and the purchase of new pieces of healthcare equipment.

Physicians bill their patients separately from hospitals for their services which means that they get paid in a slightly different manner. Primary care providers in the United States get paid based on three categories; fee-for-service, how many patients they treat, and a salary. These payments can come from a hospital or insurance company. Typically, physicians who specialize in a particular area of medicine make more money than those who are in general practice (Khan Academy, 2011). For this reason, the United States is facing a deficit of general practitioners in rural areas.

**United Kingdom**

In the United Kingdom, Parliament has control over where tax payers’ money is spent. Parliament then decides which departments get how much money and for what reasons. The Department of Health is in charge of the National Health Service in the United Kingdom. Parliament therefore gives money to the Department of Health who in turn give a portion of this money to sectors such as the NHS hospital trust, NHS mental health trust, NHS ambulance services trust, and community health NHS trust (National Health Service, 2012).

The hospitals that operate under the National Health Service are then paid through the funds that are determined and allocated on a yearly basis. Hospitals determine the amount of money that they will need for the upcoming fiscal year and then report it to a Trust board. These trusts are a public sector corporation that consists of both executives and non-executives who are recruited via public advertisement. The estimates that the
hospitals report are then reviewed to determine how much money the hospitals will actually receive (University Hospital Southampton, 2010).

The Trust compiles an annual Financial Plan which is approved by the Trust Board. The Plan demonstrates how the Trust will generate sufficient surplus to meet its capital expenditure and loan repayment needs, whilst undertaking activity at the levels required to meet demand, deliver clinical contracts and achieve Government waiting targets. The Plan also contains an analysis of the risks faced by the organization in the coming year. From information contained within the Plan, annual budgets are compiled for all departments in the Trust. The Trust exercises tight financial control through a system of monthly monitoring of expenditure and investigation into variances from budget. The Trust board reviews the financial performance of the Trust on a monthly basis (University Hospital Southampton, 2010).

Hospitals can then use this money to pay their staff, buy new medical equipment, and invest in technology for their facility. Hospitals in the United Kingdom also receive incentive payments for favorable outcomes for their patients. The number of positive outcomes that a hospital has determines the hospitals’ quality rating that is used to give incentive bonuses to hospitals (Bingham, 2012). Physicians who work in these hospitals and other facilities run by the National Health Service are paid a salary and are expected to work a forty hour work week (National Health Service, 2012).

Many physicians who work the National Health Service also work for the private sector. All physicians who work for the National Health Service are required to work at least forty hours a week for the government run healthcare. After those forty hours, physicians are free to work wherever else they wish, an option that most physicians fully utilize. The main reason that these physicians decide to work in the private sector is due to the better pay. Overall, physicians are paid more for their work with the private sector than under the National Health Service. Yet, there is sentimentality in the UK among
physicians that there is almost a humanitarian duty to work for the National Health
Service (Wachter, 2012).

Healthcare facilities that are not run by the National Health Service are paid in a somewhat similar manner as are the United States hospitals. Privately run healthcare facilities are paid on a fee-for-service basis, much like patients in the United States who have private health insurance. Money comes from both the patients and their private insurance companies (Wachter, 2012).
Chapter Seven

Organization

Table 2

Supply and Utilization of Doctors and Hospitals in Select OECD Countries, 2008

<table>
<thead>
<tr>
<th></th>
<th>Physician Supply and Use</th>
<th>Hospital Supply, Use, and Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Practicing physicians per 1,000 pop.</td>
<td>Doctor consultations per capita</td>
</tr>
<tr>
<td>Australia</td>
<td>2.07&lt;sup&gt;a&lt;/sup&gt;</td>
<td>6.4</td>
</tr>
<tr>
<td>Canada</td>
<td>—&lt;sup&gt;f&lt;/sup&gt;</td>
<td>5.7&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Denmark</td>
<td>3.42&lt;sup&gt;a&lt;/sup&gt;</td>
<td>8.9</td>
</tr>
<tr>
<td>France</td>
<td>—&lt;sup&gt;f&lt;/sup&gt;</td>
<td>6.9</td>
</tr>
<tr>
<td>Germany</td>
<td>3.56&lt;sup&gt;a&lt;/sup&gt;</td>
<td>7.8</td>
</tr>
<tr>
<td>Netherlands</td>
<td>—&lt;sup&gt;f&lt;/sup&gt;</td>
<td>5.9</td>
</tr>
<tr>
<td>New Zealand</td>
<td>2.46&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4.3&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Norway</td>
<td>4.01&lt;sup&gt;a&lt;/sup&gt;</td>
<td>—&lt;sup&gt;f&lt;/sup&gt;</td>
</tr>
<tr>
<td>Sweden</td>
<td>3.56&lt;sup&gt;b&lt;/sup&gt;</td>
<td>2.9</td>
</tr>
<tr>
<td>Switzerland</td>
<td>3.02&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4.0&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>2.61&lt;sup&gt;a&lt;/sup&gt;</td>
<td>5.9</td>
</tr>
<tr>
<td>United States</td>
<td>2.43&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4.0&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>OECD median</td>
<td>3.00&lt;sup&gt;a&lt;/sup&gt;</td>
<td>8.4</td>
</tr>
</tbody>
</table>

<sup>a</sup>2007
<sup>b</sup>2005
<sup>f</sup>Data not available

Source: OECD Health Data 2010 (Dec 2010).

United States

Within the United States, insurance companies and the government, to some extent, pay providers for their services, as previously discussed. Insurance companies can either receive payments from employers or patients depending on what kind of plan or coverage they have. Healthcare providers include all those who provide some sort of healthcare service to a patient. This includes nurses, physicians, hospitals, pharmacies, physical therapy, physician assistants, and clinics. Providers, then care for those who seek their services (Khan Academy, 2011).

Healthcare provided in the United States is variable depending on who the patient sees, what the physician prefers for treatment, what the patient can afford, what the
insurance will cover, and other numerous factors. Take David, who lives in South Dakota, for example. While David would have the same overall goal and general plan of care for his diabetic crisis, his healthcare team may provide his care in a different manner than those elsewhere in the country. For instance, his doctor may prefer one treatment for the crisis over another. David’s insurance might cover one medication but not another. There are several different factors that come into play when dealing with how a patient will be treated while in the hospital.

Another way in which one can look at healthcare organization in the United States is by looking at the various levels of health care providers. The one area in which the U.S. shines when compared to other countries is in the presence of midlevel practitioners. According to WHO, “Mid-level practitioners are front-line health workers in the community who are not doctors, but who have been trained to diagnose and treat common health problems, to manage emergencies, to refer appropriately, and to transfer the seriously ill or injured for further care” (Lehmann, 2008). Within the United States, mid-level practitioners include both Certified Nurse Practitioners and Physician Assistants. According to the Agency for Healthcare Research and Quality, there were 106,073 CNPs and 70,383 PAs practicing primary care in the U.S. in 2010 (Agency for Healthcare Research and Quality, 2011). When looking at the number of physicians in 2010 there were 209,000 who were licensed and practicing primary care in the United States (Agency for Healthcare Research and Quality, 2011). Table 2 also shows the prevalence of physicians within the United States and other developed countries, such as the United Kingdom. As this shows, mid-level providers play a substantial role within the United States when it comes to primary care of patients.
United Kingdom

The basic premise for how healthcare is organized in the United Kingdom is like a reversed version of the United States healthcare system. In the United Kingdom, the government pays for all healthcare costs for citizens under the National Health Service while private insurance companies pay for those who choose to opt out of the National Health Service or for those who choose to supplement the care they already receive through the National Health Service. Where the United States has mostly private insurance paying for healthcare needs, the United Kingdom has their government paying for most healthcare demands.

In terms of insurance, the United Kingdom has two different systems, the National Health Service and the Private Sector. All citizens have access to the National Health Service. In this health system, all citizens are offered the same healthcare and care follows predetermined pathways called National Institute for Health and Care Excellence (NICE) pathways (National Health Service, 2013). Within this system, all citizens have access to basic healthcare which includes a primary health care provider and emergency care. Depending on a patient’s age, they may even be eligible for free prescriptions as well. If a British citizen does not fall under specific age categories, prescriptions can be attained at a minimal price by paying for a yearlong voucher. For $165, a patient can attain however many prescriptions they need throughout the year. There is no limit on how many doctor visits a patient can make each year (National Health Service, 2012).

Healthcare provided through the National Health Service is very structured and regimented. All care follows NICE pathways and medical maps. These pathways lay out
the prevention plans, treatment plans, and teaching that happen with all major diseases. Primary care providers are expected to use these steps while treating their patients. All of these pathways are online so that patients have access to them so that they can know exactly what to expect when they go in to see their health care provider or the emergency department.

The National Health Service has recently found itself facing a shortage of healthcare personnel. The main groups of workers that the NHS is facing a shortage include nurses and physicians which has had an effect on the already long wait time that some patients are already facing. One way to remedy this situation is by further expanding Nurse Practitioner and Physician Assistant roles and encouraging the expansion of the training programs related to these fields. Currently, these midlevel provider roles are severely lacking in the United Kingdom. For the mid-levels that do exist in the United Kingdom, there is a certain level of mistrust on the part of their patients and the general public. The mistrust seems to stem from the fact that even though these healthcare providers have gone to school, they are not certified or accredited (Stewart & Catanzaro, 2005).

The Private Sector is something that citizens can choose to opt into. This healthcare is viewed as a supplement to the National Health Service and the medical care that it provides. It does not entirely replace the National Health Service health care that all citizens are eligible for. Instead, if a patient decides that they would like to see a certain specialist or that they would like a certain treatment, they can choose to buy private health insurance that will cover these visits or treatments while still using the National Health Service to cover other areas of their healthcare. The main reasons that
patients choose to buy private health insurance are faster access to treatment, a more comfortable care environment, and a wider choice of specialists, treatment facilities and timing of treatment. Those who buy this healthcare tend to be businesses and wealthier British citizens (Foubister, Thomson, Mossialos & McGuire, 2006).
Chapter Eight

Regulation

United States

Within the United States there are several regulatory bodies in place that pertain to healthcare. Regulatory entities in the United States include: Centers for Disease Control and Prevention, Food and Drug Administration, Centers for Medicare and Medicaid Services, and Agency for Healthcare Research and Quality. All of these regulatory bodies fall under the jurisdiction of the United States Department of Health and Human Services (U.S. Department of Health & Human Services, 2013).

The Centers for Disease Control and Prevention monitors and attempts to regulate diseases that are present or that threaten the American population. Their mission, according to their website is,

CDC works 24/7 to protect America from health, safety and security threats, both foreign and in the U.S. Whether diseases start at home or abroad, are chronic or acute, curable or preventable, human error or deliberate attack, CDC fights disease and supports communities and citizens to do the same. CDC increases the health security of our nation. As the nation’s health protection agency, CDC saves lives and protects people from health threats. To accomplish our mission, CDC conducts critical science and provides health information that protects our nation against expensive and dangerous health threats, and responds when these arise (Centers for Disease Control and Prevention, 2013).

The main goal of the CDC is to protect the American people from disease processes.

With that in mind, one of the main regulations that the CDC has in place is the reporting of certain diseases such as anthrax, West Nile, Cholera, and tuberculosis that are highly dangerous (Centers for Disease Control and Prevention, 2011). The CDC then tracks
these diseases and ensures that everything is done to treat patients and to stop the spread of diseases.

The Food and Drug Administration handles a wide variety of areas. In terms of healthcare, they make regulations on medications, foods, medical devices, vaccines, and any products that emit radiation. Basically, the FDA deals with anything that could somehow gain access to a patient’s body and could thus have an adverse effect on the patient (U.S. Food and Drug Administration, 2013). For instance, all new medications must be approved by the FDA before the drug can be marketed within the United States. In order for a new medication to be approved, its benefits must outweigh the risks involved with the medication (U.S. Food and Drug Administration, 2010). The FDA also monitors medications that are already on the market to ensure that all information pertaining to the medication is accurate and to ensure that the medications itself is safe for patient use (U.S. Food and Drug Administration, 2010).

The Centers for Medicare and Medicaid Services handles all of the rules and regulations that pertain to operating Medicare and Medicaid. Regulations affect who can and cannot receive the benefits of these programs, what services these programs will cover, how much the programs will pay providers, and what providers must do in order to treat patients who belong to these programs (Centers for Medicare and Medicaid Services, 2013).

The Agency for Healthcare Research and Quality deals with helping the American public make informed decisions about their healthcare.

The Agency for Healthcare Research and Quality's (AHRQ) mission is to improve the quality, safety, efficiency, and effectiveness of healthcare for all Americans. As 1 of 12 agencies within the Department of Health and Human Services, AHRQ supports research that helps people make more informed decisions and improves
the quality of health care services (Agency for Healthcare Research and Quality, 2013).

The agency supports their mission by helping to fund research on quality improvement and by sharing statistical data that research produces. The research that they fund and the initiatives that they develop are all aimed at improving quality of care for American patients. One key regulation that the AHRQ was behind was the Patient Safety and Quality Improvement Act of 2005 which outlined the requirements that patient care facilities must meet for patient safety (Agency for Healthcare Research and Quality, 2005).

United Kingdom

There are two main regulatory bodies in the United Kingdom in terms of healthcare, the Care Quality Commission and the Department of Health. Both groups play large roles in how the United Kingdom healthcare system is run. Both groups reports directly to Parliament on issues, regulations, and financial means. Each group can be further broken down into subgroups that handle more specific areas of the overall jurisdiction (The King's Fund, 2013).

The Department of Health’s main focus is the regulation of the market in health care services. The Department of Health deals mostly with how the United Kingdom’s healthcare system actually runs. The department also focuses on which hospitals get paid what and how to ensure the healthcare market is still competitive even though it is free at the point of care for patients. The Department of Health not only regulates the National Health Service, but also the private sector as well, making them a very powerful department within the United Kingdom (The King's Fund, 2013).
The Care Quality Commission’s focus is the regulation of the quality and safety of care that is offered in the United Kingdom. The Commission has the capability to make new regulations regarding patient safety and quality of care with the United Kingdom. It also has the capability to assess the safety and quality performance of healthcare facilities in the country. This group is not as tied into the government as the Department of Health and can therefore act more independently. One subgroup under the Care Quality Commission is the Medicines and Healthcare Products Regulatory Agency (The King’s Fund, 2013).

The Medicines and Healthcare Products Regulatory Agency in the United Kingdom could be compared to the FDA in the United States. The main focus of this body is regulating medical products and medications. The agency decides which products are safe for use on British citizens through research and investigation (The Medicines and Healthcare products Regulatory Agency, 2011). If a product is not deemed safe, then it is not allowed to be marketed in the United Kingdom. The agency also makes drug recalls if necessary.
# Chapter Nine

## Health Behavior

### Table 3

*Hospital Admissions for Chronic Diseases and Diabetes Amputations in Select OECD Countries, 2007*

<table>
<thead>
<tr>
<th>Country</th>
<th>Asthma</th>
<th>Chronic obstructive pulmonary disease</th>
<th>Congestive heart failure</th>
<th>Hypertension</th>
<th>Diabetes acute complications</th>
<th>Diabetes lower extremity amputations per 100,000 population, age 15 and older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada</td>
<td>18</td>
<td>190</td>
<td>146</td>
<td>15</td>
<td>23</td>
<td>11</td>
</tr>
<tr>
<td>Denmark</td>
<td>43</td>
<td>320</td>
<td>185</td>
<td>85</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>France</td>
<td>43</td>
<td>79</td>
<td>276</td>
<td>_e^</td>
<td>_e^</td>
<td>13</td>
</tr>
<tr>
<td>Germany</td>
<td>21</td>
<td>184</td>
<td>352</td>
<td>213</td>
<td>14</td>
<td>_e^</td>
</tr>
<tr>
<td>Netherlands</td>
<td>20</td>
<td>154</td>
<td>171</td>
<td>19</td>
<td>3^b</td>
<td>11</td>
</tr>
<tr>
<td>New Zealand</td>
<td>73</td>
<td>308</td>
<td>206</td>
<td>16</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Norway</td>
<td>42</td>
<td>243</td>
<td>188</td>
<td>70</td>
<td>20</td>
<td>11</td>
</tr>
<tr>
<td>Sweden</td>
<td>25</td>
<td>192</td>
<td>299</td>
<td>61</td>
<td>19</td>
<td>12</td>
</tr>
<tr>
<td>Switzerland</td>
<td>32</td>
<td>100</td>
<td>155</td>
<td>55</td>
<td>12^a</td>
<td>16^a</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>76</td>
<td>236</td>
<td>117</td>
<td>11</td>
<td>32</td>
<td>9</td>
</tr>
<tr>
<td>United States</td>
<td>120</td>
<td>203</td>
<td>441</td>
<td>49</td>
<td>57^a,c</td>
<td>36^a,c</td>
</tr>
<tr>
<td><strong>Median (countries shown)</strong></td>
<td><strong>42</strong></td>
<td><strong>192</strong></td>
<td><strong>155</strong></td>
<td><strong>52</strong></td>
<td><strong>19.9</strong></td>
<td><strong>12</strong></td>
</tr>
</tbody>
</table>

^Agesex standardized rates. Data not available for Australia.
^2005.
^2003.
^U.S. does not fully exclude dry cases.
^Netherlands includes admissions for additional diagnosis codes, which marginally elevates rates.
^Data not available.

Source: OECD Health Care Quality Indicators Data 2009.
In the United States, behavior plays a large role in the country’s health status. Generally, the United States does a relatively poor job at preventing diseases and complications of these chronic diseases. This can be seen by looking at Table 3. The United States out ranks numerous countries’ on their number of hospitalizations (Squires, 2011). While there are various groups and organizations in the United States who focus on prevention of Type 2 diabetes, Table 3 shows that these groups are not entirely effective in their efforts to avoid the complications of Type 2 diabetes. Instead the country has mainly focused on treatment of these diseases and has therefore excelled at this particular aspect. By looking at the average length of stay of five and a half days for
a patient in the United States (Squires, 2011) it can be seen that while the United States may have more hospitalizations, their patients do not stay in the hospital as long as other countries.

Lately, there has been a push to control the belt lines of Americans. These initiatives can be seen by going to a nearby McDonalds. Take a look at the menu and one would notice that all food items now post the number of calories for each item. Soon, McDonald’s will not be the only restaurant with this information readily posted on their menu. Thanks to the Affordable Care Act, the FDA has been given the task to come up with laws that would apply to all chain restaurants, convenience stores, supermarkets, and vending machines that sell prepared food. The hope is that Americans will make healthier food choices once they see how many calories are in the food that they are ordering. American’s diets are not the only thing that is under scrutiny (Fox News, 2013).

Americans tend to lead a sedentary lifestyle. Half of the populace does not meet the criteria for being physically active (Schoenborn CA, Adams PF, Peregoy JA., 2013). According to the Centers for Disease Control and Prevention, being physically active as an adult means that an individual spends two hours and thirty minutes a week partaking in moderate intensity aerobic activity along with doing muscle strengthening activities at least two or more days a week. According to Figure 4, most Americans do not meet the criteria suggested by the Centers for Disease Control and Prevention (Centers for Disease Control and Prevention, 2011). Poor diet choices combined with being less active has created a deadly mixture for many Americans. Many businesses in the United States have started requiring that their employees take part in healthier lifestyle choices. One
way in which this has been carried out is by requiring all employees to get an annual physical from their primary care provider (Mobile Health, 2013).

Healthcare providers in the United States have just recently started to notice the importance of prevention of diseases. As previously stated, the US has for the most part been reactive rather than proactive about diseases. While this has led to the development of better treatment options, it has become apparent that a different approach is needed if the country wishes to avoid having their citizens develop chronic disease. Many primary care providers now focus on how to prevent their patients from developing one of the many chronic diseases that has become so prevalent in the United States.

United Kingdom

In the United Kingdom, there is a huge emphasis placed on prevention of diabetes. The main focus of this prevention is maintaining a healthy weight. By controlling weight, not only would the country be reducing the prevalence of diabetes, but numerous other diseases and illnesses. There are four main areas that the UK has focused on in order to promote overall wellbeing of their citizens which include media, restaurants, food labels, and work places.

Restaurants and food labels are one of the main targets for the United Kingdom’s healthy lifestyle campaign. By promoting and encouraging all restaurants to display the amount of calories in dishes on their menus, it is hoped that customers will choose healthy options. The Department of Health in the UK also encourages restaurants to limit portion sizes. Restaurants are not the only groups that have been targeted for healthy eating though. The Department of Health also requires a comprehensive food labels on
all processed foods and strongly encourages food packaging companies to limit the amount of harmful preservatives and unhealthy ingredients in their products.

The Department of Health in the United Kingdom has put together an activity promotion campaign. By promoting their citizens to get up and move, the NHS hopes to decrease the number of people who are diagnosed with Type 2 Diabetes along with other diseases. One of the ways that this has been done is by incentivizing businesses to implement Physical Activity Policies in the workplace. While these programs are meant for all United Kingdom citizens, they are especially tailored to those who are considered more at risk for the development of Type 2 diabetes (National Institute for Health and Care Excellence, 2013).

The National Health Service has implemented several programs that focus on the promotion of healthy lifestyles. One such program is Change4Life. Geared towards both children and adults, the program has both an interactive website and mobile application. Both the website and mobile application list alternatives for healthy eating, local physical activities taking place, ideas for how to keep the entire family active at home, and an alcohol intake tracker which lists calories and cost of adult beverages. Change4Life has also partnered with a popular children’s TV show called LazyTown. LazyTown has a super hero who focuses helping citizens make healthy lifestyle choices. Overall, the National Health Service appears to be doing its best to use the media to encourage United Kingdom citizens to become healthier overall.

British citizens have also been shown to use their primary healthcare more often and more readily than other countries. Since their healthcare is free at the point of use, it makes sense that British citizens would utilize their healthcare more frequently.
However, this overuse of healthcare has made it so that waits for elective procedures and exams can be quite lengthy in the National Health Service (Williams, 2013). A long wait time also applies for specialists. This is one of the main reasons why British citizens elect to have private health insurance along with the health insurance that the National Health Service provides (Williams, 2013).
Chapter Ten

Patient Outcomes

David’s Outcome

David has been struggling with his diagnosis of Type 2 Diabetes for the past year. Two months after his diagnosis, David’s primary care physician left to join a practice in Minneapolis, Minnesota which paid a higher salary. Finding a new doctor to take his case was somewhat of a challenge for David. After finding a new physician, the transition was less than smooth since David had to explain years of past medical history. David’s new doctor has been pushing for David to adhere to his diabetic diet, but David refuses to change his diet.

Consequently, David’s diabetes has been poorly controlled. David refuses to follow his prescribed diet saying that, “it’s just a pain” whenever his physician asks why he will not follow it. David also says that he has no time for exercise. Between his refusal to control his diet and his lack of exercise, David has failed to lose any weight or control his diabetic condition. Since his diagnosis, David has been hospitalized a second time due to poor management of his disease. Once again, David’s blood sugar was too high. David has also started to notice that his sight has gotten worse over the past year.

Not only has David been having issues with his health, but he has also been having issues with his finances due to his condition. Every time David purchased more supplies or insulin for his diabetes, his insurance company has billed him either too much or refused to pay anything at all. All of this has meant countless hours on the phone
debating with the insurance company representatives about what is and is not in his plan. David’s second hospitalization also added onto this financial burden.

**Thomas’s Outcome**

Thankfully, Thomas managed to finish his big project at work following his diagnosis. While work has not slowed down over the past year, Thomas has managed to make it to all of his follow-up appointments with his diabetic specialist team that he was assigned to. Throughout these appointments, Thomas has been walked through all of the prevention, potential complications, new diet, and treatment that are associated with Type 2 diabetes. While Thomas received all of this information at his initial hospitalization, he did not fully understand what this meant until he started going to his appointments.

Despite his hectic schedule, Thomas and his wife dedicated themselves to a healthier lifestyle. Thomas’s wife now only cooks food that adheres to the diabetic diet that Thomas has to follow. Along with following his diet, Thomas and his wife have also started going on walks every morning before work to get some exercise. Thanks to all of the education that Thomas has received and all of the hard work that he and his wife have put in to his health, Thomas has managed to control his diabetes.
### Table 4

**Summary of Healthcare in the United States and United Kingdom as Related to Patients**

<table>
<thead>
<tr>
<th>Control Knobs for Health Sector Reform</th>
<th>United States (David)</th>
<th>United Kingdom (Thomas)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Financing</strong></td>
<td>• Employer sponsored insurance premiums</td>
<td>• Income tax</td>
</tr>
<tr>
<td></td>
<td>• Direct payments from David</td>
<td></td>
</tr>
<tr>
<td><strong>Payment</strong></td>
<td>• David: fee-for-service</td>
<td>• Thomas: Free at point of care</td>
</tr>
<tr>
<td></td>
<td>• Hospitals: fee-for-service</td>
<td>• Hospitals: receive annual payment based on previous year’s spending</td>
</tr>
<tr>
<td><strong>Organization</strong></td>
<td>• Dependent on resources, primary care providers, and patient</td>
<td>• National Health Service</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Private Health Insurance</td>
</tr>
<tr>
<td><strong>Regulation</strong></td>
<td>• Food and Drug Administration: control over diabetic medications and insulin</td>
<td>• Care Quality Commission: quality and safety of care related to diabetic patients</td>
</tr>
<tr>
<td></td>
<td>• Centers for Disease Control and Prevention: report the instances of diabetes and ways to prevent its development</td>
<td>• Department of Health: maintaining a functional healthcare system for Thomas and other UK citizens</td>
</tr>
<tr>
<td></td>
<td>• Agency for Healthcare Research and Quality: researching new aspects of healthcare that could benefit diabetic patients</td>
<td>• Medicines and Healthcare Products Regulatory Agency: control over diabetic medications and insulin</td>
</tr>
<tr>
<td></td>
<td>• Centers for Medicare and Medicaid Services: controls rules and regulations related to Medicare and Medicaid patients</td>
<td></td>
</tr>
<tr>
<td><strong>Behavior</strong></td>
<td>• High prevalence of chronic diseases and complications</td>
<td>• Emphasis on prevention of diabetes</td>
</tr>
<tr>
<td></td>
<td>• David: doesn’t meet criteria for being physically active</td>
<td>• Limited portion sizes</td>
</tr>
<tr>
<td></td>
<td>• Calories on menus</td>
<td>• Calories on menus</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• More usage of healthcare</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Promotion of healthier lifestyles</td>
</tr>
</tbody>
</table>
Chapter Eleven

Conclusion

The United States healthcare system has much that it can learn from the United Kingdom. Table 4 summarizes differences and similarities between the United States and United Kingdom health care systems. Prevention and management of chronic diseases is one area that the U.S. could learn from the U.K. While the United States has excelled at treating patients requiring advanced technology and specialty services, the country does a poor job at preventing and managing these diseases so that complications do not occur. The cost of healthcare is another thing that United States could take advice from the United Kingdom on. The drastic disparity between the costs of care can be seen through David and Thomas’s stories.

The United Kingdom could also learn some things from the United States. The use of mid-level healthcare providers is one area that the United Kingdom could use in their country. With the shortage that the country is facing with primary care providers, the United Kingdom healthcare system could potentially use this group of healthcare providers to fill that void, much like the United States. Another area in which the United Kingdom could learn from the United States is through the use of technology. While this probably has something to do with how the healthcare systems are funded and financed, the United States has drastically outpaced the United Kingdom with the use of technology in the medical setting. This technology could potentially lead to more advanced research, better screening techniques, and more efficient communication between healthcare professionals.
Both the United States and United Kingdom could learn from each other's healthcare systems. Each country has strong points and weak points within their healthcare systems. The ways in which these lessons could be implemented within each country is a topic that would merit further investigation. With discussions currently taking place within the United States, it would be worth looking to other similar countries to see what does and does not work, the United Kingdom being one such country.
REFERENCES


