

Stuart Hurst

US and Norwegian Healthcare Systems

Introduction

Earlier this year, I woke up in the middle of the night with intense stomach pain. After a couple of hours, I realized I needed to go to the hospital. I woke my parents up, and we drove to Piedmont Hospital, a private hospital in Atlanta, Georgia. It was seven in the morning when we arrived, and within twenty minutes I was in a room being seen by a physician. She ran some tests and gave me medication for the pain. After getting the results of the tests and poking around some more, she called for a surgeon; I had appendicitis. I was on the operating table by eleven and sent to a private room for recovery. The attentive staff provided everything I needed, and I was discharged the next morning. I could not have imagined a better healthcare experience. But I have health insurance. If I did not, this story would sound much different.

Healthcare is a subject of profound importance and fierce debate in the United States. It is clear that the system is far from perfect. The United States spends a higher percentage of its GDP on healthcare than any other country at 16%, yet there are 45 million uninsured in the country (National Center for Health Statistics, 30). These uninsured are treated with substandard care, or no care at all, unless they are able to fully cover the cost of healthcare out-of-pocket. Despite Medicaid and Medicare, it is apparent that specific subgroups in the US are not receiving the same care as others. Almost every other developed nation in the world has some form of universal coverage which reduces this disparity in care. However, many of these systems are purportedly ridden with their

own issues such as high cost and long waiting times. By comparing the US system with a universal system, I can investigate the effectiveness of each in terms of the quality of care provided and the equality of distribution of that care.

Norway is a particularly interesting choice for several reasons. Norway has total coverage of its citizens, but at 10.3% of its GDP, it spends proportionately less money on healthcare than the US. The Norwegian system is also a significantly more regulated form of healthcare, yet it is more decentralized than many of the universal systems, like Canada and the UK. After an overview of both US and Norwegian policy, I will evaluate the statistics and compare the quality and the equality of healthcare in each system.

The US Healthcare System

Coverage in the US healthcare system falls into three main categories: the privately insured, the government insured, and the uninsured. As of 2003, 68.6% of Americans were privately insured, with 88% of this coverage being provided by employment based plans. The remaining private insurance comes through direct-purchase. Twenty-six percent of Americans have some form of government insurance, including 13.7% on Medicaid, 12.4% on Medicare, and 3.5% on some form of military healthcare. Fifteen-point-six percent of Americans are uninsured (DeNavas-Walt, 16). While the different forms of coverage lead to distinctly different health outcomes for each group, the uninsured are subject to the worst health outcomes; thus the number 15.6% bears further investigation.

The first issue to address in discerning who comprises the 15.6% is how that number is derived. The Census Bureau's Current Population Survey (CPS) considers one

insured if he has any form of health insurance in the previous twelve months. One is uninsured if he has no health insurance for this period (DeNavas-Walt, 14). The Center for Disease Control's (CDC) National Health Survey takes another angle. It measures the percent uninsured under the age of 65, since any citizen over the age of 65 is eligible for Medicare. Using this standard, the percent of Americans under 65 without health insurance at some point in the year is 20.1%. While the CPS has an advantage in that its percentages are out of the entire population, the CDC's survey provides data on the percent uninsured both for the entire year and for any portion of the year. Table 1 contains a breakdown of the uninsured by age, income level and race/ethnicity as calculated by the CDC.

Characteristic	Length of time uninsured prior to interview					
	Total uninsured prior to interview		More than 12 months		Any period up to 12 months	
	Percent	SE	Percent	SE	Percent	SE
Age						
Under 65 years	20.1	0.3	11.4	0.2	7.6	0.2
Under 18 years	12.5	0.3	5.4	0.2	6.3	0.2
18–24 years	36.1	0.7	19.9	0.6	14.8	0.5
25–34 years	31.1	0.6	18.1	0.4	11.7	0.4
35–44 years	20.9	0.4	13.0	0.4	6.7	0.2
45–54 years	16.2	0.4	10.1	0.3	5.0	0.2
55–64 years	13.4	0.4	8.7	0.3	3.7	0.2
Percent of poverty level						
Below 100%	35.8	0.7	23.2	0.7	11.4	0.5
100%–less than 150%	36.3	0.8	23.2	0.8	11.8	0.6
150%–less than 200%	32.7	1.1	19.9	0.9	11.7	0.6
200% or more	13.1	0.3	6.3	0.2	5.8	0.2
Race and Hispanic origin						
Black or African American only, not Hispanic or Latino	21.3	0.6	11.1	0.4	8.8	0.4
Asian only	18.7	1.3	11.4	1.0	5.7	0.7
White only, not Hispanic or Latino	15.6	0.3	7.6	0.2	7.1	0.2
Hispanic or Latino (total)	38.2	0.7	28.4	0.6	8.9	0.3
Mexican	41.2	0.8	31.5	0.8	8.9	0.4
Cuban	24.9	2.1	18.3	2.0	6.3	1.2
Puerto Rican	24.2	1.8	14.2	1.5	9.2	1.2

SE is standard error.

NOTES: Data are for the civilian noninstitutionalized population. Total uninsured prior to interview includes 1.1% of people with unknown length of time uninsured. Persons of Hispanic origin may be of any race. Total for Hispanic includes groups not shown separately. Asian only race includes persons of Hispanic and non-Hispanic origin. Uninsured persons are not covered by private insurance, Medicaid, State Children's Health Insurance Program (SCHIP), state-sponsored or other government-sponsored health plans, Medicare, or military plans. Persons with Indian Health Service only are considered uninsured. Percent of poverty level is based on family income and family size and composition using U.S. Census Bureau poverty thresholds. Missing family income data were imputed for 32% of persons under 65 years of age in 2004. See [Appendix II, Family income; Health insurance coverage, length of time uninsured; Hispanic origin; Poverty; Race](#).

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

Table 1: Health Insurance Status Among People Under 65. (National Center for Health Statistics, 96).

When sorted by age, children under eighteen are the least likely to be uninsured; this is due to programs like State Children's Health Insurance Program (SCHIP) which target children. Excluding minors, there is a trend of increasing percent uninsured with decreasing age. There are a number of potential reasons for this trend. It may be that older individuals tend to hold higher-paying positions, and they can therefore afford health insurance. It could also be that older individuals put a higher priority on health insurance due to the increased likelihood of their becoming ill.

The relationship between income level and health insurance is one of the most crucial points to analyze in the US healthcare system. Over thirty-five percent of those under the poverty threshold (as defined by the Census Bureau) are uninsured, despite the fact that Medicaid attempts to provide for this group. The percentage increases to 36.3% for those earning 100-150% of the threshold, which is likely attributable to fewer from this group qualifying for Medicaid. There is a slight drop to 32.7% in the 150-200% group followed by a dramatic decrease to 13.1% for those earning more than 200% of the poverty threshold. This enormous drop is one of the most telling statistics on inequality in the US healthcare system.

There is clear disparity in the makeup of uninsured Americans when one delineates based on race and ethnicity. As seen in table 1, minorities have a higher percent uninsured than whites, with Hispanics having significantly greater percentages than any other group. Sorting the population in this manner can be misleading, however. The question of whether race is actually a factor in one's ability to obtain healthcare is

not totally answered by these data. One must consider the percent in poverty of these groups: 8.2% of Whites, 24.4% of Blacks, 11.8% of Asians, and 22.5% of Hispanics are below the poverty line (DeNavas-Walt, 12). The fact that a higher percentage of blacks are uninsured is more likely a reflection of the higher percentage of blacks in poverty. For Hispanics, the substantially worse rate of insurance is due to both this higher level of poverty and the non-resident status of a large portion of the Hispanic population. PRWORA, enacted in 1996, excludes most legal immigrants, so they are unable to take advantage of its guaranteed medical coverage (U.S. Department of Health and Human Services, 1). That is not to suggest that race does not play a role in healthcare coverage, but that the role it plays is probably indirect. The percent uninsured is directly correlated to income level, and the more of a group in a lower income level, the higher the percent uninsured will be. One can then ask the question of why there is a disparity in income based on race, but in terms of healthcare, income is probably the governing factor in inequality of coverage.

The uninsured are an enormous cost to the healthcare system, despite the fact that no public funding explicitly is directed to provide coverage for them. When the uninsured are treated in an emergency room, for example, it still costs the hospital money to treat them. Hospitals, clinics, health programs spend over 30 billion on the uninsured.⁵ The government must often compensate hospitals for these expenditures to avoid their bankruptcy. In addition to the cost for the system, the uninsured themselves incur full responsibility for the cost of their medical care. As the poor are disproportionately likely to be uninsured, the people who can least afford unexpected expenditures like medical care are the people who must fully pay for it.

A distinguishing factor in the US healthcare system is that most of the private insurance is provided through an employer. In fact, as previously stated, 88% of private insurance plans are employment-based (DeNavas-Walt, 16). With such a close connection between employment and health insurance, one would imagine that the uninsured would largely consist of the unemployed and part-time workers for whom employers are not obligated to provide health insurance. However, a study profiling patients in an emergency room found that 36% of the uninsured patients were employed full time (Jackson, 65). This percentage is in sharp contrast to the idea that the employed have their health insurance taken care of by their employers.

Health Outcomes for the Uninsured

It is clear that the uninsured are subject to worse health outcomes than the insured. The Institute of Medicine's (IOM) 2002 report on the consequences of being uninsured showed numerous negative effects on health outcomes due to lack of insurance. The uninsured are less likely to receive preventative care and screenings. Among other issues, this leads to a higher incidence of late-stage cancer, since the cancer is not caught in a preventative screen and progress until other symptoms arise. The IOM reported a 64% greater mortality rate for colorectal cancer in the uninsured than in the privately insured (IOM, 55). The uninsured also have a higher mortality rate for cardiovascular disease. A study of acute myocardial infarctions (MI) found that the mortality rate for the uninsured was 30% higher than for the privately insured. Interestingly, Medicaid patients were found to have the same mortality rate as the uninsured (IOM, 58). By comparing only patients presenting with MI and adjusting for

history and demographics, the study is not evaluating the incidence of MI among the insured and the uninsured, but the care that these groups receive. Incidence of MI could be influenced by a number of variables outside of the healthcare system; the uninsured, who are largely low-income individuals, might have a more unhealthy lifestyle and specifically a more unhealthy diet than the insured. Thus, a higher incidence is not necessarily reflective of shortcomings in the healthcare system. But the higher mortality rate found in this study is particularly worrisome; it suggests that the uninsured receive a lower level of inpatient care than the insured.

One point of equality in the US healthcare system should be emergency room service. Emergency rooms treat all patients regardless of insurance status for conditions requiring urgent care. A study by Peter Jackson measured the mean charges, length of stay, and probability of staying overnight for different types of insurance. Medicare's statistics were all significantly higher than private insurance, Medicaid and the uninsured, which reflects the age of the population covered by Medicare. The other three groups should have had similar numbers for charges, length of stay, and probability of staying overnight because emergency room care depends on the medical condition, not the ability to pay. However, the mean charge for the uninsured was \$378.40, about one-third of the means for the privately insured (\$1065.05) and those on Medicaid (\$924.57). The average length of stay was 0.04 days for the uninsured compared to 0.28 and 0.26 for the privately insured and Medicaid. The uninsured's probability of staying overnight was also one-third that of the other groups (Jackson, 65). These data seriously challenge, if not totally refute, the idea that emergency rooms treat patients based on medical condition and not ability to pay.

A possible reason for this significant disparity in care is that the uninsured often come in with less serious conditions because they have no other place to receive care. However, two pieces of evidence refute this idea. First, 16% of the insured had no procedure done on them, compared to only 11.6% of the uninsured (Jackson, 66). If the insured are less likely to have a procedure done when they come to the emergency room, it suggests that they are the group that comes in with less severe problems. Furthermore, when Jackson studied the breakdown of diagnoses given to the different insurance groups, the percentages for each diagnosis were similar for every type of insurance (Jackson, 66). The uninsured and the insured are coming into the emergency room with the same conditions, but the insured's length of stay is seven times the average for the uninsured. So, despite the theory that emergency room care should be solely based on the patient's need for treatment, insurance status clearly affects the patient's medical care.

There is also evidence that certain subgroups of the population may have generally worse health outcomes regardless of the form of health coverage. A study on Medicare patients found that blacks and low-income patients (black and white) have fewer visits to physicians, mammograms, and flu immunizations. However, they are hospitalized more often and have higher mortality rates (Gornick, et. al., 797). This study indicates that some groups of the population, given the same coverage, have worse health outcomes, and this particularly accentuates the effects of other variables on health outcomes. In this study, the under-utilization of preventative care by the low-income patients may be caused by a lack of education about recommended screenings and checkups.

Norwegian Healthcare System

In terms of coverage, the National Insurance Scheme (NIS) covers everyone who is either a resident or employed in Norway. The NIS is a social security scheme that covers retirement and disability pensions, unemployment compensation, and other benefits, in addition to health insurance. Everyone with insurance receives free in-patient hospital care; all drugs and treatment are covered. Out-patient care is highly subsidized by NIS, so that the patient is only responsible for a small co-payment. Furthermore, there is a yearly ceiling of Nkr 1615 (US \$263.63) on the co-pay, so that any co-payments for the year in excess of that amount are subsidized by the government. In terms of pharmaceuticals, there is a “Blue list” of drugs that are fully covered and a “white list” of ones that are not. While a comprehensive listing of drugs is difficult to find, the NIS is responsible for funding 57% of the pharmaceutical industry via reimbursement through the blue prescription plan. Non-reimbursable (white list) prescriptions only constitute 11.9% of the funding, so it would seem that the majority of important medications are covered (Facts and Figures, 40). In terms of equality, it would be useful to find the specific drugs on each list to ensure that all essential medications are covered.

The Norwegian healthcare system is divided into three levels: the national level, the five health regions, and the municipalities. The Ministry of Health and Care Services is the national organization responsible for overall regulation of the healthcare system. The five health regions are responsible for regulating specialist care, and the municipalities oversee primary care. The system receives 85% of its funding through public sources, and the remaining 15% from private sources (Johnson, 42). The public sources of funding are taxes. Since the tax system in Norway is based on a progressive income structure, a person’s contribution is based on the individual’s ability to pay. The

majority of the funding for the healthcare system comes from these taxes, so to a great extent, individuals contribute to the healthcare system based on their ability to do so. The private sources of funding come from co-payments, which have the aforementioned ceiling to prevent undue burden on an individual. Other sources of private funding are out-of-pocket payments for white list pharmaceuticals, physiotherapy, dentistry, and other services, which can place a significant burden on individuals with long-term disease (Johnson, 146).

There is a small private sector of the health system. Private providers are mainly concentrated in dental care and substance abuse treatment. They also provide services which are not always covered by the NIS, such as plastic surgery, which is only covered if the physician deems it psychologically necessary. These services comprise a tiny part of the total; in 2004, there were 284 private hospital beds and 13, 000 public beds (Johnson, 21).

The average health outcomes of the Norwegian system are very good, but despite the coverage provided by the NIS, sources indicate that inequality is persistent in health outcomes. Education has a direct correlation; the more educated are less likely to report a persistent health problem, a perceived health condition, or a chronic condition than the less educated (Krokstad). The trend in education is consistent with the overall trend in healthcare; higher socioeconomic status is correlated with better health (Johnson, 147-48). As with the US, there are certainly other variables that can influence health outcome that have nothing to do with the healthcare system.

However, a significant issue in Norway is also the effective distribution of care. While citizens are universally provided with the same insurance, the quality of treatment

differs between the urban and rural populations. The rural population in Norway is scattered and sparse in many areas; thus, they must travel longer distances to reach hospitals. Furthermore, the tertiary-level hospitals are nearly all in the cities, so these services are only available in urban areas. Specialist care is unsurprisingly concentrated in urban areas as well. It is more expensive to run hospitals in remote rural areas, so the government has implemented income redistributing plans amongst the healthcare regions to attempt to compensate for these issues (Johnson, 148-49).

Unlike with the US, education has no influence on the utilization of primary care in Norway. Those with a lower level of education do have a higher rate of hospitalization and a lower usage of specialist care, as is the case in the US (Johnson, 148). The similarity in these trends is consistent with Gornick's study on utilization of services by Medicare patients. Even though Norway provides coverage, its citizens (like the citizens covered by Medicare) do not receive equal treatment, though it may not be consequence of a fault in the healthcare system.

Comparison

The US system and the Norwegian system are clearly drastically different. In evaluating the two, one must consider the basic goals of a healthcare system. According to the World Health Organization (WHO), "the objective of good health itself is really twofold: the best attainable average level – *goodness* – and the smallest feasible differences among individuals and groups – *fairness*" (World Health Organization, xi). It is obvious that the US and Norway have different basic philosophies regarding these concepts. The crucial difference in the systems stems from a different idea of fairness.

With what amounts to a single-payer system, Norway's healthcare is based on equal access for everyone according to their need. The US system defines fairness with a heavy emphasis on Libertarian theory; "the freedom to possess and use ones property as one chooses" (Chandler, 24). The idea is that one is free to spend money on healthcare if one desires, but one is not compelled to do so. These two different perspectives are the subject of much debate. Michelle Chandler puts it aptly:

In the healthcare setting, the ethical principle of social justice ultimately entails a conflict between the individual good and the good of the aggregate. This issue is further complicated by varying perspectives regarding the optimal allocation of valuable, limited, and potentially life-extending medical resources (Chandler, 18).

The US resolves this conflict in favor of individuals of at least moderate wealth; if one can pay, one has the opportunity to access every form of medical care available. The allocation of medical resources is based on one's ability to pay for it, whether that be through insurance or out of pocket. Norway sides with the greatest good for the aggregate, and its resources are allocated based on need. Limited resources must be utilized such that they will generate the greatest health improvement in proportion to their cost.

Comparing the health outcomes of the two countries sheds light on the effectiveness of these differing approaches to healthcare. As a general indicator of overall health, life expectancy and probability of early death are a good starting point.

Table 2 shows the US and Norwegian statistics.

	PROBABILITY OF DYING (per 1000)								LIFE EXPECTANCY AT BIRTH (years)			
	Under age 5 years				Between ages 15 and 59 years				Males		Females	
	Males		Females		Males		Females		Males		Females	
	1999	Uncertainty interval	1999	Uncertainty interval	1999	Uncertainty interval	1999	Uncertainty interval	1999	Uncertainty interval	1999	Uncertainty interval
126	6	5 – 7	5	4 – 6	109	99 – 115	60	57 – 64	75.1	74.8 – 75.4	82.1	81.6 – 82.6

182	8	8-8	8	7-8	148	139-157	85	83-87	73.8	73.0-74.6	79.7	79.4-80.0
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Table 2: Probability of Dying and Life Expectancy. 126- Norway; 182- US. (World Health Organization, 161,163)

As seen in Table 2, Norway has a longer life expectancy than the US in addition to a lower probability of dying early in life. This could indicate a superior level of healthcare in Norway, and it is likely that these data do demonstrate a higher average level of care. However, the differences in these data do not necessarily coincide with inferior healthcare. These results are influenced by many variables in addition to the healthcare system, so the differences in life expectancy and early death are probably greater than the difference in level of care.

One statistic that decisively indicates a difference in the healthcare systems is WHO's measurement of fair financing of healthcare. The level of fairness in financing is a measure of individual household income spent on healthcare compared to average for that country. Norway number ranks 8 to 11, whereas the US ranks 54 to 55 out of the 191 participating nations in the WHO report (WHO, 188-9). This large difference reflects the significantly higher inequality of the US system in terms of individual contribution. Given the differing philosophies governing the two systems, these data are unsurprising. The US system does not strive for equality in contribution; the Norwegian system explicitly does.

WHO continues its evaluation of healthcare by measuring responsiveness. Responsiveness is an attempt to measure not health outcomes, but the non-health aspects revealing how patients are treated by their providers. WHO assesses seven elements to obtain a measure of responsiveness: dignity, autonomy and confidentiality (jointly termed respect of persons); and prompt attention, quality of basic amenities, access to social

support networks during care and choice of care provider (encompassed by the term client orientation) (WHO, 32). Dignity, autonomy and confidentiality pertain to the patient's perception that she is treated with dignity, is involved in choosing her treatment, and is in control of who has access to her medical records. Prompt attention entails both immediate action in emergency and reasonable wait times for non-emergency situations. The quality of basic amenities includes things like food and cleanliness. Evaluating each of these elements on a scale of 0-10, the US scored an 8.10 and ranked number 1 in level of responsiveness. An 8.10 was substantially higher than the 7.44 registered by the second-place country, Switzerland. Norway scored a 6.98 and ranked number 7-8 (WHO, 184). The resulting difference in rankings of the two systems could come from many areas; longer wait times in Norway could cause poor prompt attention scores. Or, the difference could come from a lower level of respect from physicians. Regardless, it is clear that the patients' expectations in these areas are more fully met by the US system.

While the overall level of responsiveness is higher in the US than Norway, the distribution of responsiveness is tied at 0.995, where 1 is perfect equality of distribution and 0 is total inequality (WHO, 184). Distribution of responsiveness reflects the difference in responsiveness ratings among vulnerable groups in the population such as the poor. Given the difference in equality of care between the two systems, the fact that they have the same rank in distribution of responsiveness is surprising. One explanation is that the poor have lower expectations for respect and client orientation, so they give higher marks for a level of care than other groups would (WHO, 32).

Another indicator of the difference in quality and equality of the systems is the infant mortality rate. In 2003, the US had an infant mortality rate of 6.8 deaths per 1,000

live births (National Center for Health Statistics, 166). Norway's rate was 3.5 per 1,000, about half that of the US rate (Johnson, 10). Furthermore, subsets of the US population have even higher infant mortality; blacks have 13.5 deaths per thousand (National Center for Health Statistics, 166). These striking differences could indicate lower quality of care in the US and are even more likely to demonstrate inequality in care. However, public health statistics such as infant mortality are heavily influenced by factors outside of the healthcare system. Low birth weight, nutrition, and living conditions are just some of the variables that could contribute to a higher infant mortality in the US.

In addition to the differences in health outcomes, the difference in cost of the two systems is substantial. The US spends \$5,635 per capita on health expenditures, while Norway spends \$3,807 when adjusted for purchasing power parity (PPP) (National Center for Health Statistics, 374). Norway's spending is still high; it is second only to the US (expenditure per capita adjusted for PPP is distinct from the % GDP, where Norway ranks fourth). The US expenditure is clearly substantially higher than any other country at 148% that of Norway's. One reason the US spends so much money on healthcare is connected with the high responsiveness rating; providing fast non-emergency service and high quality patient amenities is expensive. These costs do not explain the huge difference in spending; a major issue with the US system is the efficiency of its expenditure.

One striking example of the difference in the cost-effectiveness of spending in the two systems is the public coverage of medicines. Norway spends 6.4% of its public healthcare expenditure on medicine, while the US spends 6.2%, yet Norway covers 2/3 of the financing of drugs through public expenditure (Facts and Figures, 98). The US only

provides prescription coverage through Medicare Part D, which is only a partial coverage, and while the fraction of drug financing through public expenditure is unavailable, it is certainly far lower. The difference in the two systems is enormous; how is it possible that for a minute difference in percent expenditure there is such a large difference in coverage?

Another indicator of efficiency is WHO's health system performance index. This index attempts to measure how efficiently health systems translate expenditure into health. Health was judged by disability-adjusted life expectancy (DALE), which factors in non-fatal health outcomes to evaluate the average number of years lived without a disability. WHO developed a ratio of achieved levels of health to health under a system of maximum efficiency by employing econometric models to estimate the maximum DALE per current level of expenditure. Norway ranked 18 in health performance with an index of 0.897; the US ranked 72 with an index of .774, again out of the 191 participating countries (WHO, 200-1). This substantial difference in performance stems from two issues. The achieved DALE in Norway is higher than the US, and the maximum projected DALE is lower because Norway's health expenditure is lower. The econometric models employed for this index might be questioned, as Oman has a DALE ranking 72 overall, but ranks number one in this measure of efficiency. However, expenditure is lower and achieved DALE is higher in Norway relative to the US, so the precision of the models is not of concern in comparing these two countries.

Summary of Findings

After examining the data, the benefits and consequences of the US and Norwegian systems become somewhat more clear. With respect to equality of care, the Norwegian system is significantly better than the US system. The enormous disparities in the US populations with different health coverages and incomes are apparent through the data presented earlier. While specific data comparing Norway's socioeconomic classes and health outcomes are lacking, Norway's superior average statistics, like life expectancy and infant mortality, indicate that it has both a high quality and equality of care.

The quality of care in each system is not as straightforward. Again, Norway's higher life expectancy and lower infant mortality rate probably indicate a higher average quality of care. They certainly demonstrate higher average health outcomes. However, the responsiveness index addresses aspects of healthcare treatment that reflect quality of treatment which would not be encapsulated by statistics such as life expectancy, and the US system is superior in this respect.

Conclusions

At the center of the healthcare debate is the issue of fairness. The Norwegian system conceptualizes fairness in terms of need; each person's healthcare needs should be met to the fullest extent possible regardless of that person's financial situation. The US system views healthcare more like a market commodity, and consequently those who are wealthy but have few or no healthcare needs should not be forced to contribute more money to compensate for those who have great need and little wealth. These conflicting

ideas raise the basic question of whether or not healthcare is a right, and if so, to what extent is it a right?

While an in-depth discussion of ethics is beyond the scope of this paper, the notion of healthcare as a right has direct relevance to comparing these systems, and it therefore needs some discussion. It may not be true that totally equal access to all forms of healthcare is demanded by moral obligation, and in fact Norway's "white list" of prescription medication indicates that even its universal coverage does not strive to provide this access. In fact, it may not be ethical to require equal healthcare for all; those who engage in activities such as smoking and drinking are knowingly worsening their health. Is it fair to force others who take better care of themselves to pay for these increased medical costs? However, few would seriously argue that no form of healthcare should be available to anyone that cannot pay for it. US Emergency departments treat patients regardless of ability to pay, and although the practice of that theory has been questioned, the principle demonstrates that, even though the US system allows for disparity in care, it has a built-in goal of providing a minimal level of care to all. Medicaid and Medicare reinforce this goal, although again in practice they fall short of achieving it.

Norway provides far beyond this minimal level to all its citizens, and due to more efficient expenditure it does so at a lower cost than the US. However, there are significant barriers to implementing a universal system in the US, as well as are potential drawbacks to doing so. The difference in the mean cost of an emergency room visit for the insured and the uninsured makes it apparent that healthcare providers minimize cost when treating uninsured patients, but on the other hand, how do you control cost in a

universal system where there is no incentive not to run expensive tests? The US already spends an enormous amount on healthcare, and further increases in cost could have disastrous consequences.

Another major drawback of a change in the US system could be the effect on R&D of pharmaceuticals and technology. The pharmaceutical industry invested 27,095 million Euro in the US for R&D compared to 125 million for Norway. Furthermore, over the past decade there has been a continuing trend of spending more in the US and less in Europe (Facts and Figures, 104). This is consistent with Norwegian Royal Commission findings that “new technology is not highly prioritized for certain patient groups, such as the elderly, those with chronic diseases and mental disorders, and drug and alcohol addicts” (Johnson, 148). In contrast, the US system may be “viewed as ‘unjust’ by allowing for the expenditure on marginal procedures for a small percentage of patients at the financial expense of many” (Chandler, 21). The resources that perhaps could be utilized to help a great number of people are used for expensive procedures that do little to add to one’s health outcome. However, this current construction of the US system allows for vast amounts of money to be funneled into treatment of uncommon disease, and without a system like the US present, there would be no incentive for research to be done in these areas. In other words, if the US shoulders the burden of R&D because its system allows for large, inefficient expenditure, R&D globally could be decimated by a conversion of the US system to one similar to Norway’s.

If some sort of universal coverage is to be instituted in the US, it must be done carefully. The political barriers are great; the task of overcoming the public’s wariness of “universal health insurance” and the establishment of the large private insurance

companies probably renders implementation of a system like Norway's impossible in the US. A more feasible solution would need to incorporate the private companies in the comprehensive coverage, rather than attempting to do away with them completely. In addition, whatever change was made in order to provide coverage would still need to allow for the high-end, expensive treatments currently offered to those who can afford it; otherwise, the population that is well-off under the current system will not be likely to support a change.

The data presented in this paper just scratches the surface of the issues involved in effective healthcare. Without more explicit data on wait times and inequality in the Norwegian system, it is difficult to conclude the extent of the difference in quality and equality of care from the US system. However, it is clear that improvements in the US system are needed, and that through examining and learning from systems such as Norway's, the US can implement a more comprehensive form of coverage to improve the large disparity in care.

References

- Chandler, Michelle. The Rights of the Medically Uninsured: An Analysis of Social Justice and Disparate Health Outcomes. *Journal of Health and Social Policy*, 21, 2006. 17-36.
- DeNavas-Walt, Carmen, Bernadette D. Proctor and Robert J. Mills. U.S. Census Bureau, Current Population Reports, P60-226. *Income, Poverty, and Health Insurance Coverage in the United States: 2003*, U.S. Government Printing Office, Washington, DC, 2004. Available at: <http://www.census.gov/prod/2004pubs/p60-226.pdf>
- “Facts and Figures 2006.” Norwegian Association of Pharmaceutical Manufactures, Oslo, 2006. Available at: http://www.lmi.no/tf/2006/files/english/facts_and_figures_2006.pdf
- Gornick, Marian; et. al. Effects of Race and Income on Mortality and Use of Services Among Medicare Beneficiaries. *The New England Journal of Medicine*, 335 (11), 791-799.
- Institute of Medicine. *Care Without Coverage: Too Little, Too Late*. National Academy Press, Washington, D.C. 2002. Available at: http://books.nap.edu/openbook.php?record_id=10367&chapselect=yo&page=R155, Washington and Lee University
- Jackson, Peter. The Impact of Health Insurance Status on Emergency Room Services. *Journal of Health & Social Policy*, 14, 2001. 61-73.
- Johnsen JR. *Health Systems in Transition: Norway*. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2006. Available at: <http://www.euro.who.int/Document/E88821.pdf>
- Krokstad et al. *J Epidemiol Community Health*. 2002; 56: 375-80. Available at: <http://jech.bmj.com/cgi/reprint/56/5/375>
- National Center for Health Statistics. *Health, United States, 2006 With Chartbook on Trends in the Health of Americans* Hyattsville, MD: 2006. Available at: [http://www.cdc.gov/nchs/data/06.pdf](http://www.cdc.gov/nchs/data/hus/06.pdf)
- U.S. Department of Health and Human Services. “The Personal Responsibility and Work Opportunity Reconciliation Act.” *HHS Fact Sheet*. Available at: <http://www.acf.dhhs.gov/programs/cse/new/prwora.htm>
- World Health Organization. *The World Health Report 2000*. World Health Organization, Geneva, Switzerland. 2000. Available at: http://www.who.int/whr/2000/en/whr00_en.pdf