WHEC Update

Briefing of worldwide activity of the Women's Health and Education Center (WHEC)

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Lessons From The Field

On 24 October 2022, our initiative http://www.WomensHealthSection.com celebrates its **20th anniversary**. We thank our physician's board for their dedication and expertise to make it a success. For many years, it was widely believed that the United States (U.S.) had the best healthcare system in the world. Although this assumption had been questioned from time to time, it wasn't until the World Health Organization (WHO) report of 2000 that the belief was seriously challenged. In this edition of ***WHEC Update*** the discussion, "best healthcare in the world" will be defined as having the highest quality of care available anywhere in the world, and the "best healthcare *system* in the world" will be defined as including not only the highest quality of care in the world but also *access* to this care as well as having the underlying infrastructure of education and research. Unfortunately, there are no agreed upon or established criteria for measuring the quality of national health care systems. National healthcare systems are extremely complex and involved.

Why do many people believe that the U.S. has the best healthcare system in the world? First, U.S. spends a higher percentage of its gross domestic product (GDP) and more per capita on healthcare than any other country. Secondly, best healthcare institutions in the world are in the U.S.; these include Johns Hopkins, Mayo Clinic, Massachusetts General Hospital. Thirdly, physicians from all over the world come to the U.S. for advanced training. Finally, patients from all over the world come to U.S. for quality-care.

In reviewing the healthcare systems of a number of nations, what can one learn? First, the wide variety of systems is surprising. It seems no two systems are alike. Each of the major industrialized countries' national healthcare systems is truly unique, with major differences from country to country reflecting the history, conditions, politics, and national character of each country. **Careful evaluation of health care systems of the industrialized world reveals that there may in fact be no perfect system.** All the major healthcare systems seem to have their own problems.

In exploring wide variety of healthcare systems, on the international scene, the only system one cannot seem to find – a system – that provides unlimited care with no premiums, no deductibles, no co-pays, no waiting lists, no rationing, and from the physician of one's choice. THIS SYSTEM DOES NOT EXIST.

Lessons learned from other systems – in reviewing multiple national healthcare systems, it becomes apparent that universal health insurance does not mean universal health care. In most countries with universal health insurance, 1% to 2% of the population falls through the cracks. Furthermore, because of evolving technology and increasing demand for services, most countries do not have enough money truly to provide universal care. Most countries in the industrialized world are having problems providing enough money to pay for the national healthcare demands of their populations. Most countries are beginning to face problems with de facto rationing, waiting lines, and lack of enough hospital beds, CTs and MRIs.

As one might suspect, raising healthcare costs and spending is not uniquely an American phenomena. Although no country with universal healthcare is contemplating abandoning their universal healthcare system, the growing trend in countries with national healthcare systems is to move away from central government control and to introduce market-oriented features. Thus, even as Americans debate adopting a government-run system, countries of those systems look more like that of the U.S.

Share your point of view on ***WHEC Global Health Line (WGHL)…..***

Who Has The Best Healthcare System?

Rita Luthra, MD

Your Questions, Our Reply

What happens to the uninsured in America? Where does the money go? Does United States of America have the best healthcare system in the world?

U.S. System Very Good, Could Be Better: The unintended consequences of a handful of public policies (both legislative and regulatory) are partly responsible for many of our problems today. Although employers can deduct healthcare insurance cost, workers cannot deduct the cost of the same insurance if they purchase it individually, and they cannot deduct out-of-pocket expenses such as co-pays and deductibles. This tax-policy encourages consumers to seek out low co-pay, low deductible insurance that is the most expensive.

State health insurance regulations increase the cost of basic healthcare insurance by requiring insurance companies to cover certain types of care (chiropractic, autism, psychiatric, acupuncture, and so on). this means that in most states, it is not possible to buy a basic catastrophic policy. Many state governments have mandated that basic policies not only include basic insurance but a long list of other services. Although one cannot question the value of any one of these add-ons individually, the end result is that the cost of buying basic healthcare insurance in many states has become prohibitive for the average American.

There are both federal and state laws that prohibit selling the same health insurance policy across state lines. Such governmental restrictions tend to inhibit competition and result in more expensive healthcare insurance policies. Many healthcare reformers favor a government-run system, but it is not at all clear that the problems of centralized control are any less significant than the problems of our current system. Competition does spur innovation and lower cost.

Uninsured - according to the recently published report, there are 43 million uninsured Americans. Increasingly, this number has been stable at 14 to 15% of the population under age 65 over the last 20 years. Many of the uninsured are only uninsured for a few months as they change jobs, 9.7 million of the uninsured are undocumented immigrants, and 14 million of the uninsured are poor people who are actually eligible for Medicaid but for one reason or another have not applied for it. Of the uninsured, 18 million have a household income of more than $50,000/year and 9 million have household incomes of more than $75,000/year. Of the uninsured, 11 million have been offered insurance through their employer but have declined. These individuals are typically healthy young people who choose spend their money on things they want rather than on insurance they believe they will never need. All in all, 70% of the uninsured actually have access to health insurance but have not taken advantage of it.

Most of the uninsured people – when they get sick enough – they go to emergency rooms, where by law they must be appropriately evaluated and treated. In 2019 $ 98.9 billion were spent from public and private sources in providing healthcare to the uninsured.

In many ways the U.S. healthcare system is the best in the world. Cardiac deaths have fallen by two-thirds over the past 50 years. Polio has been virtually eradicated from the U.S. Childhood leukemia has a high cure rate. 8 of the top 10 medical advances of the past 20 years were developed in or had roots in the U.S. The Nobel Prizes in Medicine and Physiology have been awarded to more Americans than to researchers in all other countries combined. 8 of the 10 top-selling drugs in the world are made by U.S. companies. The U.S. has some of the highest breast, colon, and prostate cancer survival rates in the world. The U.S. is responsible for more than 53% of drug research dollars.

The U.S. ranks first or second in the world in kidney transplants, liver transplants, heart transplants, total knee replacements, coronary artery bypass and percutaneous coronary interventions per capita. In addition, the U.S. ranks third in bone marrow transplants per capita.

United Nations at a Glance

Mexico became United Nations Member State on 7 November 1945

Permanent Mission of Mexico to the United Nations

Mexico, officially the **United Mexican States**, is a country int eh southern portion of North America. It is bordered to the north by the United States; to the south and west by the Pacific Ocean; to the southeast by Guatemala, Belize, and the Caribbean Sea; and to the east by the Gulf of Mexico. Mexico covers 1,972,550 sq. .kilometers (761,610 sq. miles), making it world's 13th largest country by area; with approximately population of 126,014,024 (2020 census) 10th most populous country. Capital: Mexico City; Religion: 89% - Christianity (78% Catholicism, 12% other Christian), 11%: no religion.

Mexico is a developing country, ranking 74th on the Human Development Index, but has world's 15th-largest economy by nominal GDP and the 11th- largest PPP, with the United States being its largest economic partner. Its large economy and population, global cultural influence, and steady democratization make Mexico a regional and middle power; it is often identified as an emerging power but is considered a newly industrialized state by several analysts. However, the country continues to struggle with social inequality, poverty and extensive crime. In ranks poorly on the Global Peace Index, due in large part to ongoing conflict between the government and drug trafficking syndicates, which violently compete for the US drug market and trade routes. This "drug war" has led over 120,000 deaths since 2006. Mexico's rick cultural and biological heritage, as well as varied climate and geography, makes it a major tourist destination: as of 2018

Mexico is organized as a federation comprising 31 states and Mexico City, its capital. Other major urban areas include Monterrey, Guadalajara, Puebla, Toluca, Tijuana, Ciudad Juarez, and Leon.

Mexico ranks first in the Americas and 7th in the world for the number of UNESCO World Heritage Sites. It is also one of the world's 17th megadiverse countries, ranking fifty in natural biodiversity.

Mexico is a member of UN, the G20, the Organization for Economic Cooperation and Development (OECD), the World Trade Organization (WTO), the Asia-Pacific Economic Cooperation Forum, the Organization of American States, Community of Latin American and Caribbean States, and the Organization of Ibero-American States.

My World Mexico – SDG Action

Established in early 2016, My World Mexico is an initiative supported by the UN Sustainable Development Goals Action Campaign that is aimed on mobilizing people and Organizations towards monitoring, socializing and evaluating the 2030 Agenda and the SDGs in Mexico. Additionally, we promote the My World 2030 survey in order to give people a say about their perception regarding the 2030 Agenda implementation nationwide.

Governed – with practically all of the work done being voluntary, the initiative is mainly formed by the Focal Team and the Operative Team. The first one is focused on managing and reporting the activities being performed by the Operative Team, composed by more than 20 ambassadors and 20 organizations in 28 out of Mexico.

Partners - UN Volunteers Mexico, World's Largest Lesson, SDSN Youth, Project Everyone.

Details: https://sdgs.un.org/partnerships/my-world-mexico

Collaboration with World Health Organization (WHO)

WHO | Mexico

Health Situation

Mexico is a representative democracy divided into 31 states and a Federal district. It is an upper middle-income country of 127 million inhabitants. The official language is Spanish although 76 other languages are spoken among Indigenous populations. Mexico's epidemiologic transition towards chronic diseases is significantly affecting its society as a whole and the Healthcare system in particular. Mexico is among the countries with the highest prevalence globally of children who are overweight or obese and more than 70% of adults are overweight. In 2013, the President of Mexico launched a National Strategy on the Prevention and Control of Overweight, Obesity and Diabetes. Another challenge for Mexico is the significant burden of morbidity and mortality related to injuries. Although transmissible diseases still persist, Mexico has initiated the process of verifying elimination of onchocerciasis and trachoma from its territory.

Health Policies and Systems

The structural reforms prosed by the Executive branches of are oriented towards stimulating economic growth and reducing social inequities and inequalities. The 2003 reform of the General Health Law resulted in the Commission on Social Health Protection to ensure equal access to health for all Mexicans. Despite this tremendous achievement, out-of-pocket expenditures from the health indicated an opportunity to improve the quality and effective access to health services especially primary healthcare connected to a referral/counter-referral system. Historically the Mexican health system has been segmented and fragmented which is also a factor in equitable access to quality health services.

The National Development Plan 2013 – 2018 established five national goals and there cross-cutting strategies associated with health and gender, especially the goal of "inclusive Mexico" which includes several indicators on health, social security and sustainable development.

Cooperation for Health

Mexico is very active in international cooperation in a dual manner, as a receiver of cooperation as well as a donor/partner. The health sector participates in subregional entities such as the Mesoamerican System of Public Health, the Pacific Alliance, the Iberoamerican Community and with Eurosocialism of the European Union. Also Mexico cooperates with the USA and Canada in the development of health promoting strategies for the migrant population. In addition, Mexico participates actively in various organizations and international for as a member of the Organization of American States, UN, OECD, WTO, is a decentralized Agency of the Secretary of External Relations whose mission is to guide, coordinate and facilitate Mexican policies of international cooperation for develop according to national priorities in areas of sustainable human development.

Mexico has nine WHO Collaborating Centers which focus their actions largely in programs of technical cooperation in various countries of the Region.

Details: https://www.paho.org/es/mexico

United Nations Educational, Scientific and Cultural Organization
Collaboration with UNESCO

Mexico joined UNESCO on 4 November 1946

The Monarch Butterfly (*Danaus Plexippus)* Biosphere Reserve, established in 2006, has been included on the World Heritage List since 2008. In this site , located on a mountain range about 100km northwest of Mexico City, several million monarch butterflies from North America gather every autumn, coloring the forest orange as their wings flap and produce a sound reminiscent of light rain. This concentration of wintering monarch butterflies is an extraordinary natural phenomenon, which is exceptional experience to observe.

Launch of the Mexico Media and Information Literacy Network

UNESCO promotes Medica and Information Literacy (MIL) facing the new challenges for freedom of expression, citizen participation, and for the consumption, production and transmission of information, such as information saturation, misinformation, false news and dissemination of hate speech, but above all, it promotes MIL to identify and take advantage of alternative responses to this type of problem.

MIL is a combination of knowledge, attitudes, skills and practice that allow “access, analyze, evaluate, use, produce, and communicate information and knowledge in an ethical, legal and creative way that respects human rights,” therefore its promotion is urgent.

In Mexico, UNESCO and the DW Akademie, led the creation of a plural and multisectoral cooperation group that promotes the development of knowledge, promotion and dissemination of the MIL competences and increasing the recognition of the importance of MIL in the country. The MIL Alliance, created in 2013, already has five regional chapters. The Mexico network would join the Latin American Network.

The Objectives of the Mexico MIL network are:

- Visibilize the urgency of an MIL agenda in Mexico;
- Promote the development of MIL competencies and MIL dissemination action among specific groups, particularly journalists, teachers, young people between the 14 and 24 years of age, and Indigenous people.
- Promote a plural space for dialogue and joint actions to disseminate MIL in Mexico.
- Promote research, analysis and dissemination of good practices around MIL competencies.

Join the reading as a family!

From June 15th to August 15th, 2022, the Holiday Reading Challenge is offered free of charge, which will open and available to the population with library of more than 2,800 digital texts in Spanish and English to share with children and adolescents, during the school break to promote the development of reading skills. UNESCO and Common Lit are aware that the habit of reading is way to open paths not only at the school level, but also to enhance the family and social spirit of each person, as well as being fundamental to the literacy process. Reding helps children and adolescents to express more accurately what they think, develop critical thinking and enrich their vision, culture and knowledge.

Details: https://en.unesco.org/countries/mexico

Bulletin Board

Goal 2

End hunger, achieve food security and improved nutrition and promote sustainable agriculture.

Facts & Figures

1. Almost one third of women of reproductive age globally suffer from Anemia, in part due to nutritional deficiencies.
2. The Global Pandemic is exacerbating world hunger; worldwide, an additional 70 – 161 million people are likely to have experienced hunger as a result of the pandemic in 2020.
3. Number of undernourished people in the world: in 2014 – 607 million; 2019 – 650 million; in 2020 – 720 to 811 million.
4. 22% (14902 million) of children under 5 are stunted;
5. 6.7% (45.4 million) of children under 5 suffer from wasting;
6. 5.7% (38.9 million) of children under 5 are overweight
7. 2.37 billion people are without food or unable to eat a healthy balanced diet on a regular basis.

Small scale farmers are disadvantaged on many fronts, especially if they are women

In almost all countries surveyed, households headed by men achieve greater labor productivity and earn a larger annual income than those headed by women. The difference is threefold.

The Women's Health and Education Center's (WHEC's) Initiatives / Recommendations:

- Achieving food security goes beyond the eradication of hunger. Urgent short-term actions are needed to avert rising hunger, and a transformation of food systems is required to achieve a healthy and sustainable food future for all.
- Setting up a national follow up method for increased knowledge and data on food losses. Measure progress in reducing food losses towards 2030.
- Reduce food losses along production and supply chains including post-harvest losses.
- From 2020 to 2025, the total amount of food wasted should be reduced by at least 20% by weight per capita.
- Gather the most experienced researchers on food losses and form a reference group with researchers and key persons at agencies.
- Synthesis understanding of the major drivers behind the global food security and nutrition trends, but framed around food systems thinking.
- Undated estimates of the cost and affordability of a healthy diet.
- Updated estimates for several nutritional indicators and projects to 2030.

Well before COVID-19 pandemic, the world was already not on track to ending world's hunger and malnutrition in all its forms by 2030. The COVID-19 pandemic, and measures to restrain it have dramatically magnified and increased these challenges. We are now at a critical moment in time that requires new food system approaches and urgent actions at scale to get back on track towards achieving SDG-2 and other SDGs.

Collaboration with UN University (UNU)

UNU-WIDER (World Institute for Development Economics Research)
Expert Series on Health Economics

Motherhood and Flexible Jobs: Evidence from Latin American countries

Authors study the causal effect of motherhood on labor market outcomes in Latin America by adopting an event study approach around the birth of the first child based on panel data from national household surveys for Chile, **Mexico**, Peru and Uruguay. The main contributions are:

1. Providing new comparable evidence on the effects of motherhood on labor outcomes in developing countries;
2. Exploring the possible mechanisms driving these outcomes;
3. Discussion the potential links between child penalty and prevailing gender norms and family policies in the region.

The authors found that motherhood reduces women's labor supply in the extensive and intensive margins and influences female occupational structure towards flexible occupations – part-time work, self-employment, and labor informality – needed for family-work balance. Furthermore, countries with more conservative gender norms and less generous family policies are associated with larger differences between mothers' and non-mothers' labor market outcomes.

Motherhood stands out as one of the key factors in explaining the gender gaps in the labor market, since women are still the primary caregivers, show that while motherhood explained 40% of the gender gap can be attributed to the presence of children at home. The aim of this study is to contribute to the literature and to the policy debate on the factors that affect labor market gender-gaps by providing causal evidence on the impact that the birth of the first child has on female labor outcomes in developing countries. In this study, authors advance in three directions with respect to previous studies (stated above).

The study shows that motherhood has a negative impact in Latin America on women's labor market outcomes: motherhood lowers female labor supply and favors occupational choices towards more flexible jobs, such as part-time jobs, self-employment, and informational work arrangements. Importantly, these effects occur right after childbirth and do not fade in the medium or long term. Since fathers' labor outcomes remain unaffected, motherhood opens gender-gaps in the labor market that persist over time.

For the four countries studied – Chile, **Mexico,** Peru and Uruguay – employment rates of women drop between 17 and 20% after the first child is born. Evidence for Chile suggests that the long-term effect is 16% 10 Years after childbirth. In addition to the negative impact of motherhood on the extension margin of labor supply, the arrival of the first child also affects working hours, thus increasing part-time employment by 16-29% in the medium run and 43% in the long run. Motherhood also triggers and increase in self-employment and labor informality among working women. The medium-run effect on motherhood on self-employment ranges between 17 and 42%, and the effect on informality is between 16 and 50%.

Publisher: UNU-WIDER; Author: Ines Berniell, Lucila Berniell, Dolores de la Mata, Maria Edo, and Mariana Marchionni; Sponsor: The authors are grateful to two anonymous referees for helpful suggestions, as well as to participants of the 'Women's work workshop,' organized by the United Nations University World Institute for Development Economics Research in December 2020. Jessica Bracco and Ana Pacheco provided excellent research assistance. The authors also thank Matías Busso and Hugo Ñopo for their help in obtaining the data. The usual disclaimers apply

Details of the paper can be accessed from the link of UNU-WIDER on CME Page
http://www.womenshealthsection.com/content/cme/

Two Articles of Highest Impact, September 2022

Editors' Choice – Journal Club Discussions
Fully open-access with no article-processing charges
Our friendship has no boundaries. We welcome your contributions.

1. **LGBTQ+ Healthcare: Building A Foundation For Better Understanding;**
   http://www.womenshealthsection.com/content/heal/heal028.php3
   WHEC Publications. Funding: WHEC Global Initiatives are funded by a grant from an anonymous donor. Join us at WHEC Global Health Line for discussion and contributions.

2. **Neonatal Abstinence Syndrome;**
   http://www.womenshealthsection.com/content/obsnc/obsnc010.php3
   WHEC Publications. Funding: WHEC Global Initiatives are funded by a grant from an anonymous donor. Join us at WHEC Global Health Line for discussion and contributions.

Partnership for Maternal, Newborn & Child Health (World Health Organization)
PMNCH Member

Worldwide service is provided by the WHEC Global Health Line

77th Session of The General Assembly (2022 – 2023)

https://gadebate.un.org/en

The UN General Assembly (UNF+GA) is the main policy-making organ of the Organization. Comprising all Member States, it provides an unique forum for multilateral discussion of full spectrum of International Issues covered by the Charter of the UN. Each of the 193 Member States of the UN has an equal vote. The Assembly meets in regular sessions from September to December each year, and thereafter as required. It discusses specific issues through dedicated agenda items or sub-items, which lead to the adoption of resolutions.

Sitting arrangements in the General Assembly Hall changes for each session. During the 77th Session (2022 – 2023), Belize will occupy the first seat in the Hall, including in the Main Committees (followed by all the other countries, in English alphabetical order).

The pandemic is not the only issue the world faces. Racism, intolerance, inequality, climate change, poverty, hunger, armed conflict, and other ills remain global challenges. These challenges call for global action, and the General Assembly is a critical opportunity for all to come together and chart a course for the future. High Level Meetings of the 77th Session are:

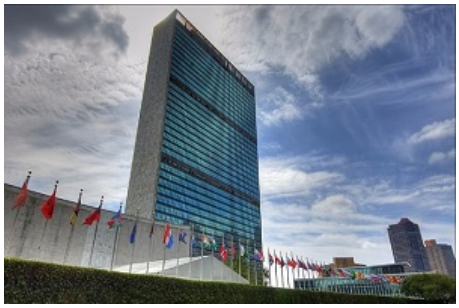
- Opening of the 77th session of the General Assembly: 13 September 2022
- Summit on Transforming Education: 19 September 2022
- General Debate: Tuesday, 20 September to Monday, 26 September 2022 (including Saturday, 24th September)
- High-Level Meeting to mark the commemoration of the 30th anniversary of the adoption of the Declaration on the Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities (21 September 2022
- High-level plenary meeting to commemorate the International Day for the Total Elimination of Nuclear Weapons: 26 September 2022. Details: https://www.un.org/en/ga/77/agenda/

United States of America: H.E. Mr. Joseph R. Biden, Jr., President – Address to GA 21 September 2022
https://gadebate.un.org/en/77/united-states-america

WHEC
Helping Women World-Wide

Our Common Agenda, Our Common Mission

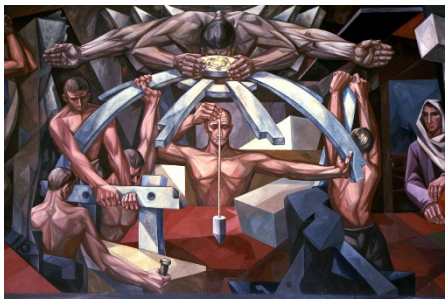
How exactly does the UN bring peace? What is the UN General Assembly?



Words not weapons. That is the fundamental idea at the heart of the UN. Humanity can only survive, and humanity can only thrive through cooperation, not conflict. And that is why the United Nations (UN) exists.

The UN General Assembly Sessions in September, every year, is like the Super Bowl of global diplomacy. It is the only time that almost every world leader gathers in the same place – at the UN HQ (Headquarter) in New York (USA), for one week. There is so much that goes on behind the scenes, to resolve various disagreements and conflicts. It is like global diplomacy speed dating. World leaders come in, they talk to each other for a few minutes, they get to know each other. They exchange ideas. They talk through their differences. And that is when negotiations can happen, and progress can be agreed. Peace is prerequisite to all Sustainable Development Goals (SDGs).

Why the progress is so slow? Yes, there are lots of meetings, lots of reports, lots of discussions. That is how the agreements are reached. That is how best practices can be developed – programs can be planned, developed and implemented. You have to hear all the viewpoints. **Progress takes time**.



The General Assembly does not have power to enforce its decisions. What it does have is moral authority. Every country of the world are represented there. And it has weight in numbers. So that small countries have their voices heard alongside big and powerful countries. Coalition of countries can come together and share their concerns and solutions.

The UN Delivers. Through the UN the world has achieved so much, in the last 75 years since its inception. Yes, we have a long way to go; still lots of conflicts to resolve.

It has galvanized nations of the world around the SDGs and its framework. Good example, is Paris Agreement for Climate change. There is an agreement now and a framework to work on and build on.

So much work of the UN is not represented by the leaders in their meetings and images during this one week of General Assembly Sessions. Every day, all year long, and all around the world, the UN is hard at work. Where it is famine and food shortage, it works through World Food Programme, helping refugees through UNHCR, providing education and safety to children through UNICEF, preserving our culture and heritage through UNESCO, Peace negotiations, humanitarian crises, and various other needs of our lives – UN is hard at work all year round – all 365 days of year. Not just only during the week of September, for General Assembly Sessions, when we see the world leaders at UN HQ in New York.

Fixing the world is not easy (it is really hard) – it takes lots of time, lots of brilliant people and lots of sincere efforts and most importantly cooperation of all.

A voice of every nation.

A Noble and Necessary Pursuit.

From Editor's Desk

WHEC Projects under Development

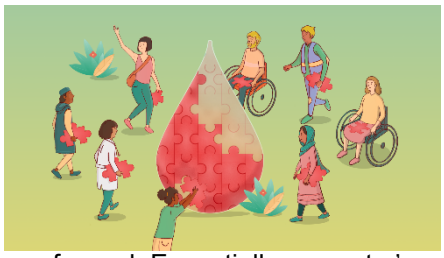
Evaluating National Health Care Systems

in reviewing the health economics literature, there are three measures that have been frequently applied to national healthcare systems:

1. The WHO's *World Health Report of 2000;*
2. National life expectancy data;
3. National infant mortality data.

On close examination, however, all three of these measures have significant flaws.

The WHO is a division of the United Nations (UN). In 2000, the WHO published its first report comparing the healthcare systems of 191 countries. These rankings have widely cited in the public debate over the quality of healthcare in the U.S. Although these rankings are typically presented as objective measures of the relative performance of national healthcare system, the WHO rankings depends on underlying assumptions which actually predetermine the ranking of the healthcare systems being measured. Are these assumptions thoroughly vetted in the report? What is not commonly known is that there is more than one WHO ranking. In the *World Health Report of 2000*, two rankings were actually reported.



The first ranking was called Overall Attainment (OA), and in this ranking the U.S. was internationally ranked as 15th. The second ranking was called Overall Performance (OP), in which the U.S. was ranked 37th. Interestingly, in an extensive review of the English language literature on this subject, the first ranking (OA) is rarely, if ever quoted. Both of these rankings are based on the same underlying data, but the OP index is adjusted to reflect a country's performance relative to how well it theoretically could have performed. Essentially a country's ranking was raised or lowered by the UN officials depending on whether it was believed that, based on county's resources.

The WHO in their report of 2000 used five criteria for measuring the quality of healthcare:

1. Health level: 25%
2. Health distribution: 25%
3. Health responsiveness: 12.5%
4. Responsiveness distribution: 12.5%
5. Financial fairness: 25%

Only criteria 1 and 3 are clinical measures of healthcare systems. The remaining criteria (accounting for 62.5% of the health systems grade) are non-medical, socio-economic criteria, which are pseudo-objective measures that look at inequality of the *distribution* of healthcare services within a country. It would have been more valuable to have examined the quality of care received by each country's poorest citizens.

Other Measures Comparing Systems – there are two other measures of healthcare systems that have been used: life expectancy and infant mortality. For each of these statistics to be meaningful, there needs to be an actual relationship between the healthcare system and the item being measured. Changes in the health system must be reflected in the changes in the measure. Furthermore, it is very important that the measure be uniformly used by all nations involved.

Review of the recent literature suggests that life expectancy is a poor statistic for determining the quality of healthcare system because many people actually die with minimal interactions with the healthcare system (in auto accidents, homicide, and sudden death). Recent research shows that the healthcare systems have minimal impact on longevity in the industrialized world. Studies from multiple countries have found that there is *no* relationship between: life expectancy and the number of physicians in the country, life expectancy and the number of hospital beds per 100,000 people in a country, and life expectancy and healthcare expenditures as a percent of national GDP. According to the article published in *New England Journal of Medicine,* only 10% of premature deaths in the U.S. are related to the healthcare system. The great majority (85%) of premature deaths are related to human behavior, genetic predisposition, and social circumstances.

Infant mortality – theoretically, infant mortality should be a good measure of a healthcare system. But in spite of strict UN definitions of what a live birth is, many countries do not follow them. Switzerland, Finland, France, Norway, Belgium, and Canada all have idiosyncrasies in their reporting techniques about live births that significantly affect their infant mortality rate. It is not known, for instance, how many countries report babies born at 25 weeks gestation or babies weighing 1.5 pounds as live births. It should be noted, however, that overall the industrialized world does for better in this category than the developing world.

It is also noted that countries in the industrialized world that frequently have the best outcomes are for the most part quite ethnically homogeneous. Sweden, Norway, Iceland, France, Italy and Japan generally rank very well but all are much more homogeneous than the U.S., which is quite ethnically and culturally diverse. Currently, whites constitutes 66% of the U.S. population. This number is projected to drop below 50% in the next several decades.

In essence, many observers do not believe that the modest ranking of the U.S. in life expectancy and infant mortality statistics is attributable to the performance of the U.S. healthcare system but to a variety of other factors.

Suggestions for Reform

- Healthcare tax reform should be passed allowing total deductibility of all healthcare expenses. Tax credit or vouchers should be provided for low-income individuals and families.
- Health insurance reform needs to be passes to reduce the cost of health insurance by creating a national market. The laws the limit the sale of healthcare insurances should be *individual* and *portable.* The government should subsidize private insurance for the chronically ill and for those individuals who are uninsurable or have pre-existing conditions.
- Tort reform should become a high priority, establishing a reasonable national cap on non-economic damages in medical malpractice suits. This action would lower the cost of malpractice insurance and decrease the expensive practice of defensive medicine. One researcher estimates such change would reduce the total cost of medical expenditure in the U.S. by 5 to 9% annually.
- It should be noted that healthcare reform cannot occur in a vacuum. It must occur in concert with the addressing of social and economic issues.
- The problem of 10 million undocumented immigrants without healthcare insurance cannot be ignored.
- The U.S. high school dropout rate of 20% is unacceptable and must be deal with.
- Unhealthy behaviors such as smoking, and obesity must be addressed.

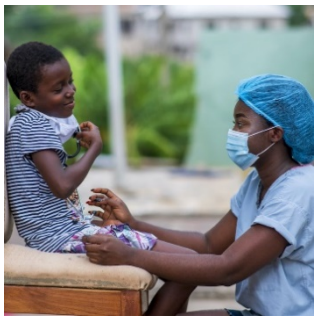
We must be careful that coverage for all does not come at the price of substandard quality, rationing of care, a demoralized healthcare workforce, and inadequate investment in research, education, public health, and health promotion.

The U.S. has a high-quality healthcare system. We should do all we can to protect it as well as improve it.

In The News

Global Issues: Health-for-All

Where does the money go? U.S. Healthcare System at a glance



People often ask the question, “Where does the money go that the U.S. spends on healthcare that other countries don’t? A small percentage may go for inefficiencies and to insurance company profits and executive salaries, but the majority of the excess money pays for a long list of things that American citizens seem to have come to expect:

- Easy access to sophisticated diagnostic tests, including MRIs and CT scans;
- Shortest waiting time for elective surgery in the world;
- Widest choice of physicians and hospitals;
- Easy accessibility to joint replacement;
- High access to renal dialysis, particularly in older patients and in patients with co-morbidities;
- Easy access to cancer screening and the treatment (although a 50% reduction in all cancer cases would only increase life expectancy in the average American by 1.4 years);
- Greater access to healthcare provided to elderly Americans and Americans at the end of their lives who may have poor prognoses.

Furthermore, the U.S. by custom and law has permitted a litigious climate to develop that has significantly increased the cost of medical care due to the practice of defensive medicine by physicians and the payment of high malpractice premiums.

Many healthcare experts believe that healthcare in the U.S. is expensive because most Americans are isolated from the direct purchase of healthcare and even the knowledge of many health care costs. Because of this, most Americans seem to consume healthcare as if it were actually aware of how expensive specific healthcare services were, or if they were responsible for paying a greater portion of their own healthcare.

Healthcare: Who should pay for what?
http://www.womenshealthsection.com/content/heal/heal014.php3

Inspiring Progress and Future Prospects

Evaluating the patterns of previous 30 years and predicting the progress and challenges of future health system are no rocket science. Medical care will be more self-directed in a more tech-savvy population as information will be more accessible and user friendly with higher quality. Health driving factors such as clean water, sanitation and food will take the center stage in humanities struggle and even increase population size. Some lessons are summarized here below:

1. Provide flexibility and allow for changes at the same time.
2. Create as much general-purpose Operating rooms, Intensive care units, and so on to allow for efficiency and flexibility rather than specific specialty needs.
3. With staffing shortages still looming in the hospital of the future, hospitals may need to accomplish more jobs with fewer health professionals.
4. At the same time, outpatient and ambulatory work are on the increase. Prosperous economy is driving this move along with advances in medicine.

The worldwide medical tourism market is estimated to be worth $ 55 billion, and it is projected to continue growing by 20% a year. Increasingly, insurers (especially self-insured firms are providing medical tourism options in their plans as a way to cut costs.

Words of Wisdom

A Moment's Indulgence

I ask for a moment's indulgence to sit by thy side.
The works that I have in hand I will finish afterwards.

Away from the sight of thy face my heart knows no rest nor respite,
And my work becomes an endless toil in a shoreless sea of foil.

Today the summer has come at my window
with its sighs and murmurs; and
the bees are plying their minstrelsy at the
court of the flowering grove.

Now it is time to sit quite, face to face with thee, and to sing
dedication of life in this silent and
overflowing leisure.

- Rabindranath Tagore (1861 – 1941, Kolkata). First non-European to win the Nobel Prize in Literature in 1913.

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