Title

Health as a Right versus a Privilege in the United States, the United Kingdom, and Japan: What is an Ideal Health Insurance System?

Author

Krasnoff, Masha

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Undergraduate

Masha Krasnoff

Abstract: The concept of "right versus privilege" is inherent in a nation's system for funding health care. Privatized health care, such as that in the U.S., promotes an inequitable distribution of healthcare resources that leave several populations without access to health care needs. Completely nationalized medical care, like that found in the United Kingdom, provides more broad-based and equitable care but access to specialized health care on a timely basis is difficult, and there is little incentive to offer more costly technological diagnostic or preventative advancements. Japan, which has a hybrid public/private healthcare system, appears to offer the best model for equitable and advanced medical treatments, and clearly provides the best outcomes. However, the growing elderly population places an extreme burden on all three countries, and Japan's health care system, due to its culture, is more vulnerable to this change in population demographics. Ideally, a national healthcare system has a moral obligation to provide for the countries' citizens, and this can best be accomplished by analyzing the approaches of three different countries (the privatized U.S., the socialized U.K., and the hybrid Japan) to create a health insurance system that is equitable, not financially burdensome, and which promotes the best outcomes for all its patients.

Health as a Right versus a Privilege in the United States, the United Kingdom, and Japan: What is an Ideal Health Insurance System?

Background: A country's healthcare insurance system is a dynamic interaction with the country's sociocultural and political values in addition to its population's prevailing health needs. The differences in sociocultural and political values, as well as the country's health needs, are reflected by the implemented policies. Moreover, the differences in each country's resulting healthcare insurance interactions are illustrated by its funding, access, and the structure of a regulating organization, and prior implemented policies. The healthcare system’s funding, access and institutional oversight are indicative of a country’s view as to whether healthcare is considered healthcare a right or a privilege. Regarding healthcare as a right or privilege has vast effects on a population's health outcomes, disparities, and standard of care. Therefore, the underlying attitudes that shape a country's health insurance system are not just of political concern, but also bear impact on both individual and population health. While developed countries, in general, are experiencing an increase in life expectancy and quality of life, it is essential to examine the multifaceted derivation of differences in health not only within countries

but also between countries (25). With the current American healthcare insurance system under considerable reform, one can consider the underlying attitude change in sociocultural and political values, our current health needs, and whether the U.S. regards healthcare as a right or a privilege. Thus, we can evaluate the underlying structural attitudes of U.S. health insurance and their consequences on individual and public health by comparing with two other public health insurance systems with varying health outcomes and limitations: the United Kingdom and Japan. The analysis of implemented policies among these three developed nations highlights that while no healthcare structure is ideal, there are improvements that could be made by cross-comparison and learning from the strengths of other developed systems.

The United States: U.S. healthcare coverage on the public scale remains fragmented and inconsistent. The United States does not have national health insurance, and coverage consists of both private and public programs. Private health insurance that is provided primarily through employer-sponsored insurance covers 56% of the non-elderly population in the U.S. (KCMU/Urban Institute Analysis of 2011 ASEC Supplement to the CPS). A minority of private health insurance is obtained through other non-group organizations and are usually for single coverage plans as opposed to family coverage plans, and nearly 20% of the non-elderly U.S. population depends on Medicaid. The remaining 18% is uninsured for numerous reasons: one's employer does not offer employer-sponsored insurance (ESI), one cannot afford to pay for insurance or one is ineligible for financially-assisted coverage. Enacted in 2010, the Affordable Care Act (ACA) aimed to increase rates of those with health insurance coverage and reduce the rate of uninsured non-elderly Americans from 44 million in 2013 to below 28 million in late 2016 (15). Federally funded health insurance includes Medicare for those over 65 years of age, those with an eligible disability, and those with a diagnosed terminal illness, such as ALS and

end-stage renal disease. Another component of federal health insurance is Medicaid. Medicaid is available for those with incomes below 133% of the national poverty level who do not qualify for Medicare, for children whose families earn more than a salary eligible for Medicaid and who cannot afford to buy private insurance, for those who have served in the military, and for American Indians. An important caveat to the expansion of Medicaid under the ACA is that there are differences in state implementation of these policies, state-based exchange, in which individual states can determine criteria for qualifying coverage requisites and rates (24). Thus, the U.S. is indeed a melting pot not only for ethnic diversity but also the channels by which people receive or do not receive health care coverage.

A stemming issue that gives rise to fragmented coverage and methods of coverage is whether healthcare in the U.S. is considered a right or a privilege. Specifically, the divide in attitude towards healthcare comes down to an economic versus moral argument (2). Though in a perfect world, health care should be offered to all human beings as a fundamental right due to the inevitability of disease as part of the human experience, there are dangers to both sides of the argument. After World War II, former President Harry Truman was reviled for trying to implement the notion of national health insurance as a shift into socialism, beginning with legislating socialized medicine. A primary fear of transitioning to a national health insurance system is the slippery slope to entering an entirely socialist society from one that values individualism, democracy, and capitalism. From an economic standpoint, historical arguments of which groups are eligible for federally funded healthcare derived from a utilitarian perspective of one's capacity to work and contributing to public welfare. Notably, there is the historical agreement of aiding military veterans and American Indians due to their social environment of dealing with disability, a lower education, and cultural barriers to assimilating with American

healthcare exchange systems. Similarly, poor bachelors who are not disabled are expected to work because of their projected capacity to return social investment and to work for dependents who have already served their role as producers in a capitalist society and are no longer members of the work force. A free market system for insurance providers has been considered more appropriate for the American consumer supply and demand model.

Limitations: Opponents of free market insurance systems argue that privatized health insurance leads to the fragmented coverage that exists today due to state government having little control over the offered rates and coverage policies applied by federal law. Therefore, the free market system provides healthcare that is a luxury limited to those of higher income - higher education does not always translate to higher income but rather a luxury that individuals of higher income and education can afford. Furthermore, while health conditions may differ based on ethnic backgrounds, health problems do not discriminate based on income, race or education. The imposed disparity in access to healthcare resulting from a free market insurance system shows the flaw in a privatized health insurance system due to the universality of human health conditions and our increasing dependence on healthcare to subsist through life expectancies that were a mere fantasy less than 80 years ago (16).

Similarly, proponents of a national health care system in the U.S. suggest that the problem of the U.S. the excessive cost of health care in the U.S. - far more than any other developed country - would be mitigated by a national health care system. Compared to 12 other developed and high-income countries, including the United Kingdom, Sweden, France, Germany, and Japan, the U.S. ranks first in highest health care spending (approximately $9,000 per capita annually) despite lowest life expectancy and higher prevalence of chronic conditions compared to these same 12 countries (26). However, the U.S. average life expectancy is not

uniform and serves as another example of disparate health outcomes due to fragmented coverage. The U.S. possesses a heterogeneous population with varying health lifestyle behaviors, genetic predispositions, and access to health coverage based on state implementation. U.S. life expectancy varies greatly, due to unequal distribution of physicians, varying access to healthcare, and a heterogeneous population. As one would predict, life expectancy may be up to six years greater in states with a higher capita SES (such as California, New York, and several other states along the U.S. east coast). Thus, the U.S. possesses a private health insurance model regardless of federal legislations given differences in state coverage policies and within-state population compositions. Furthermore, given the sociopolitical climate of the U.S. being composed of individual states with varying population compositions, we see a greater disparity in health outcomes due to fragmented coverage across and within states. Yet another element of a free-market insurance system is that the U.S. healthcare system is mostly private. Not only among American insurance providers but also within oversight and ownership of U.S. health facilities, there is no regulation on the use of biotechnology that is commonly used to increase profitable patient spending, as well as no cap on many other patient costs- such as hospitalization, treatment costs, and outpatient facilities. By shifting to a public social insurance system, the barrier of cost to accessing care would decrease the prevalence of chronic conditions, improve disparities in state average life expectancies, as well as provide regulation on avoiding exploitation of patient costs.

Another barrier to transitioning to healthcare as a right in practice is the regulated cap of practicing physicians in the U.S. The government funds the training of nearly 30,000 physicians annually with around 768,000 doctors practicing throughout the United States (4). This would be a sufficient number of physicians if they were equitably distributed relative to population and

income concentration in different areas of the country. The estimated shortage of primary care physicians will be approximately 52,000 doctors by 2025 (3). While government programs attempt to redress this unequal distribution by erasing medical school debt for those willing to practice in areas where physicians are greatly needed, the shortage remains since there are now a greater number of graduating advanced practice nurses and physicians' assistants, rather than physicians. In addition, the baby boomer generation presents greater demands on the physician population as a consequence of adult-onset chronic diseases, and complications from obesity and diabetes. However, a solution to the physician shortage for the above factors would be to reallocate tasks which can be done by professionals with less training. According to Berwick and Hackbarth, a comprehensive solution to the demand-supply gap is an approach consisting of clinicians including not just medical doctors but also nurse practitioners and physician assistants, non-clinician licensed practitioners- such as various pharmacists and alternative medicine professionals, patients themselves, and technology (6).

There are several drawbacks to involving a more expansive health-care providing team beyond licensed clinicians. Creating arbitrary occupational boundaries of what responsibility is most appropriate for one's level of training poses further implications. For instance, one confronts the liability of a less knowledgeable patient trusting a differently trained professional- such as questions or referrals to be made that the clinical professional cannot answer or provide. Additionally, there may be the loss of accountability that would exist in a traditional aspect of a healthcare provider working as a team with the patient. Second, encouraging a patient-sought health plan can be supported by unmoderated pseudo-medical information and advice that is present on the internet which can transfer to proposed technology. As a result, we may experience a crisis of patients treating themselves with inaccurate, futile, and potentially

dangerous guidance. Beyond self-induced malpractice, we may also end up facing a re-emergence in distrust of the healthcare field among particular populations that are more likely to depend on technology. Due to technology becoming increasingly affordable, universally convenient and accessible, as well as being cheaper than paying for varying health insurance rates and co-payments, individuals with lower SES may be indirectly forced to depend on technology rather than consulting with a licensed clinical professional. Lastly, incorporating numerous realms of healthcare approaches can result in opposing or incompatible health treatment plans. While herbal medicine and nutrition may focus on supplements and the human body's properties of self-healing, the treatment advised by these realms may not be entirely appropriate for a multitude of terminal illnesses. From a moral perspective, the availability of more healthcare fields would promote a patient's autonomy, it may violate the principle of beneficence by providing advice that may be futile or harmful given the patient's condition.

The sparsity of physicians among a population with widely varying SES levels, the fear of a socialist medical system threatening individualism and capitalism, an increasing amount of baby boomer dependents, the resulting swelling of chronic diseases, and soaring life expectancy challenge the current American health insurance system in place. While proposed solutions to each contributing factor have their drawbacks, we may ponder broader improvements to the fragmented health insurance coverage and insufficiency of clinical professionals that other developed countries' systems may suggest.

The United Kingdom: The U.K. healthcare system provides a stark contrast to the American mix of private and public health insurance providers. English citizens pay around 9% of their gross income in taxes to support the nation’s comprehensive coverage plan, known as the National Health Service. The National Health Service is regulated by the National Institute for

Health and Care Excellence (NICE) and covers essential medical services including primary care, emergency services, reproductive health, mental health, and several other specialties. Compared to the United States which spends around 15% of its gross domestic product (GDP) on healthcare expenditures, the United Kingdom spends a mere 8% of its GDP on healthcare expenditures. According to the Commonwealth Fund, the U.S. had the lowest life expectancy at birth, 78.8 years in 2013 compared to the median average of 81.2 among other developed countries. Despite better health outcomes and access to care, there are limitations to a public social insurance system. The cost of English health coverage is far more efficient compared to the United States whose population health ranks last among 12 other developed countries. In particular, the United Kingdom had a life expectancy at birth of 81.1 in 2013 and has experienced the highest drop in deaths due to healthcare from 2002 to 2007, a rate comparable Japan's drop of health-care related deaths (4). Despite better improvements in health outcomes, life expectancy, and access to care, a public social insurance system has its own set of limitations.

The U.K. has a lower standard quality of care due to factors such as outdated facilities, long wait times due to large patient volumes, and inaccessibility to specialists or follow-up care. It has been suggested that the U.K. system does not appropriately address clinical error or update facilities and technology to current standards (22). Specifically, according to Mosadeghrad (2014), good healthcare quality is defined as "consistently delighting the patient by providing efficacious, effective and efficient healthcare services according to the latest clinical guidelines and standards" (12). Furthermore, due to the implemented cap on funds for healthcare expenditures as supported publicly and federally, quality assurance and improvement measures are made on a priority basis, rather than a need basis. Decisions are made on a priority rather

than need basis in the U.K., due to caps on healthcare expenditures. Surprisingly, the U.K. has taken extensive measures to model quality improvement after that of American private health institutions, such as emphasizing improvements in cancer, mental health, learning disabilities, and diabetes through the “Building the NHS of the Five Year Forward View” plan of 2015/16. However, American healthcare quality improvement measures are targeted to attracting patients as part of the free market choice and are not always transferable to the U.K.’s public insurance system.

Another drawback to the U.K.'s construct of a public health insurance model is that the demographic shift of lifestyle-induced chronic noncommunicable diseases, such as obesity, diabetes, and cardiovascular disease, demands more health coverage and access to specialists, follow-up care, and prevention measures via social services. Similar to the population structure shift in the U.S. due to increased life expectancy, improved management of communicable diseases, and improving quality of life through palliative care and specializing clinical professionals, there is the parallel issue of reduced access to specialty services. In England, 15 million people suffer from chronic conditions that are related to lifestyle factors, such as chronic kidney disease, COPD, hypothyroidism, and cardiovascular disease (22). It is estimated that 25% of the U.K. population will be over 65 in 2020, dramatically increasing the burden of caring for those with age-related and other chronic diseases.

The reduced access to follow-up and specialized care is reflected in the U.K.'s average or below-average performance in international benchmarks for standard of care (19). According to the Organization for Economic Co-operation and Development (OECD), the U.K. faces a grim rate of fatality after ischemic stroke that is below the OECD average of 20 other developed countries. Similarly, while access to social services such as preventive screening is above OECD

average, outcomes for breast, cervical, and colorectal cancer survival are all below the OECD benchmark. Lastly, according to the Commonwealth Fund's Mirror, the U.K. performs at the international criterion for timeliness of care and below the benchmark for mortality and life expectancy. In sum, even the effort of improving health outcomes and prevalence of chronic conditions is only met within essential medical services, the U.K.'s public health insurance system has maintained a static expenditure level that cannot adequately address the changing needs of its population.

Similar to the U.S., Japan has a patient-as-a-consumer marketplace. But unlike the U.S., Japan resembles the U.K. by having a public health insurance model. Japan’s hybrid health insurance approach has remarkably better health outcomes than most of the OECD's compared countries. Japanese health insurance is a social system implemented on a national level with few differences between its 47 prefectures. Japan has had universal health insurance since after World War II and by law, all Japanese citizens are required to have health insurance coverage. Individuals are covered via two forms of insurance coverage. Employees' Health and Pension Insurance or Social Insurance, known as Shakai Hoken, is provided by employers for their employees. In contrast, National Health Insurance, known as Kokumin Kenko Hoken, is administered by local governments for those who are unemployed or self-employed (13). Those who are uninsured pay 100% of their fees out-of-pocket (OOP) or their fees are waived depending on age or income. The uninsured are excluded from OOP payments if they reach the upper payment limit more than three times a year depending on the individual's income, age, and what type of care is received (outpatient, inpatient, or both). Additionally, individuals with specific diseases necessitating frequent health care are excluded from OOP. The above-mentioned forms of insurance coverage are components of a social and public insurance

coverage system. By law, hospitals must be nonprofit and are run by physicians. Patients are free to choose an institution or healthcare provider and cannot be denied coverage. Hence, all Japanese citizens are ensured coverage and affordable access to care. Moreover, to provide public insurance for its increasing elderly population, the Ministry of Health, Labor, and Welfare introduced the Long-Term Care Insurance system (LTCI) in 2000. The LTCI was passed specifically to target social support and long-term care for the elderly, particularly in transitioning the elderly in hospitals to nursing homes. Passed on a national level, each Japanese prefecture determines the premiums based on income levels within LTCI while deriving 50% of the service cost via subsidies and 40% via premiums. As a comprehensive policy, LTCI coverage extends care at institutions, community-based care such as home, day, and preventive care.

Japan's social health insurance system is both efficient and equitable (28). Tokita defines efficiency as Japan's superior health outcomes in life expectancy and low infant mortality rate achieved by a relatively low healthcare cost. Specifically, according to the OECD, Japan's life expectancy at birth is 84 years, four years above the OECD international benchmark of 80 years (20). In addition, infant mortality, defined as the frequency of deaths among children younger than one year per year per 1000 live births (21). Though globally among developed countries, infant mortality rates have steadily gone down since 1970 and hold an OECD benchmark average of 6 infant mortalities per year per 1,000 live births (11). Japan holds one of the lowest infant mortality rates compared to the OECD average of 2 infant mortalities per year per 1,000 live births. Moreover, Japan also holds health outcomes that are above the OECD benchmarks for cancer survival rates. According to the Japan Times, Japan has an average ten-year survival rate of 58.2% depending on the type of cancer and cancer stage. While the U.S. has the best breast cancer five-year survival rate (89.3% relative to the OECD benchmark of 84.2%), Japan

ranks first and second for colorectal and cervical cancer five-year survival rates (68% relative to a 59% international average and 70.2% relative to a 66.4% international average, respectively) (7). In addition to better quality of health, Japan's insurance system costs less for both the insured and on behalf of government spending. Tokita's definition of health cost consists of a ratio between health expenditures and a country's Gross Domestic Product. Famed for having one of the most cost-effective health expenditures for above-average health quality and outcomes, Japan used to spend a mere 8.6% of its GDP on health expenditures relative to the OECD average of 11.3% and has jumped to 10.2% GDP spending in 2014 relative to a 12.3% OECD average (8). Despite considerable growth, Japan has maintained the goal of assuring affordable insurance coverage despite the introduction of a cost-hefty LTCI policy. Therefore, Japan has continued to offer efficient and accessible insurance coverage by adjusting health expenditures to ensure a low health cost for its citizens. It is important to note that Japan maintains accessible health care and coverage for its citizens under equitable terms. Tokita defines equity in health coverage as all citizens being given the same quantity and quality of medical care (28). The equity of Japan's social health insurance system is demonstrated by all citizens having a source of insurance coverage via fewer than ten types of different insurance policies- depending on employment status, income, and age. Moreover, depending on one's income, the individual must pay no more than 30% of the medical service provided while the social insurance covers the remaining 70% or more. Hospitals are run as true non-profits and draw income only from the pharmaceutical and biotechnological services provided. Diagnostic services may therefore fund greater access to healthcare, fewer disparities in health outcomes, and ultimately no individuals being rejected from medical care due to the removal of barriers via cost.

While Japan maintains the admirable traits of efficiency and equity, there are systematic limitations in its health insurance structure. Japan is experiencing a surge in its "aging population" that is creating numerous social and economic consequences (18). Currently, more than one quarter of Japan's population consists of individuals 65 and over. By 2055, the proportion of individuals 65 and over is projected to increase to 40% with the total population decreasing from 127 million to 90 million (23). As an immediate medical consequence, there will be an increased burden on medical providers to care for problems associated with older age. This growing problem of caring for health problems of the elderly is reflected in Japan's implementation of the LTCI in 2000 as a means to segregate the epidemiological-medical demands of the elderly. The Japanese Ministry of Health, Labor, and Welfare recognized that separate attention must be devoted to maintenance care, such as in nursing homes, to care for the geriatric problems found among the growing elderly Japanese population. Another immediate consequence can be found in the economic impact of caring for an increasing aging population. According to Tokita et al. 1997, the medical costs of elderly care are around 5 times greater than care for the younger individuals (27). The economic consequence of devoting more limited resources towards an increasing elderly population will place a large burden on producers to provide more support in terms of funding and resources. Moreover, in the context of Japan's social insurance and its limited cap on supply, there will be a further reduction in resources. All these factors may create the potential for a severe economic crisis. According to the Japan Times, Japan has hit a record-low for birth rate (less than 1 million per year, specifically 941,000 births in 2017) (5). As outlined in numerous demographic analysis sources, Japan has been experiencing a persistent negative growth trend in population 1977 and a particularly steeper decline since 2007 (10). A negative growth rate requires that producing members of an economy

enter the work force at a younger age and to retire at a later age. In addition, the prevalence of so many older, experienced workers limits job opportunities for younger individuals, discouraging younger people from having families. The result of Japan's demographic shift is that fewer people can contribute to the economy, the economy can support fewer people, and a lower birth rate is attained due to economic deflation. Several economists predict a socioeconomic drought via the equation of National Medical Expenditure (NME). Tokita explains that NME = patient ratio * medical expenditures per capita * total population. By dissecting the NME equation, he explains that NME has a direct effect on the working population. Japan's NME will inevitably increase due to a larger patient ratio and higher medical expenditures per capita, given that there will be a higher capita of elderly patients needing medical care. Japan cannot continue to rely on pharmaceutical and biotechnology service costs as its main source of funding. In Japan alone, individuals receive MRIs eight times more frequently than the British and twice as frequently as Americans- and that is taking into context the American incentive to excel in medical innovation and imaging techniques. Economists warn that Japan has the highest public debt relative to its GDP, a whopping 240% debt of its GDP in 2017, whose economic implosion has been triggered by the shifting demographic of producers versus dependents (1).

The largest criticism of Japan's social insurance system is the lack of an intervening quality control oversight on behalf of Japan's Council for Quality Health Care (JCQHC). While Japan's 47 prefectures hold some responsibility in overseeing quality, they do not hold accountability in collecting health standard and outcome data with an emphasis on improving quality of care. Another contributing influence is the lack of competition between hospitals and healthcare providers in Japan. Data regarding health outcomes and quality control is not collected- resulting in the illusion of no qualitative differences between the medical institutions.

Compared to its OECD competitors, Japan falls below the standard of requiring regional reporting of national quality assessment frameworks including categories of safety, effectiveness, patient-centeredness, and access (18). The JCQHC has set out three legislative frameworks that outline minimal standards of care but fail to enforce a quality assurance protocol at the level of institutions and providers. The three frameworks of minimal standards include Japan's Medical Service Act, the Health Insurance Act- consisting of the national and social branches of insurance coverage, as well as the LTCI Act (18). The above legislations assure minimal health care safety while leaving much room for professional freedom and professional autonomy. By not having specific guidelines for care protocols, hospitals have little incentive for improving the standard of care. As mentioned, a further consequence of little incentive for improving standard of care is the continuing absence of competition among healthcare providers.

The shortage of physicians adds another factor affecting quality of care. According to the OECD average, the international benchmark of physicians per 1,000 capita is just over three physicians (17). Japan falls below this benchmark on its national average of 2.5 physicians per 1,000 capita; however, in practice, more than half of the 47 prefectures have less than 2.5 physicians per 1,000 capita. Due to the unregulated demand of patients in Japan, there is a "free-for-all" relationship between a sea of patients and few providers in reach. In addition to the structural lack of quality assurance, the shortage of physicians in Japan induces understaffing. Understaffing leads to longer wait times, shorter consultation times, a tendency to rely on diagnostic tools rather than physical exams, and further constraints on medical resources. Although Japan thrives on medical innovations and the use of biotechnology, as a public insurance system, there is still the thematic lack of oversight for quality assurance- not just for standard of care but also of adequate resources.

In an analysis by Nomura and Nakayama, the authors describe Japan's physician shortage and lack of quality assurance as a developing "tragedy of the commons" (14). Due to the unregulated demand for few healthcare resources, individuals feel tempted to "maximize [their] own take from the commons, even when it becomes overcrowded", a behavior that depletes the supply as well as other dependents of the supply (14). The authors draw the analogy of the tragedy of the commons as the Japanese demand of patients being herdsmen with insurance coverage and medical resources comprising the commons- the limited supply. Therefore, even Japan's social insurance system is not ideal, given the changing population dynamics and ultimately limited financial resources.

However, Japan's social insurance system provides a model that offers improved health outcomes, longevity, and equity to medical care. Japan's social insurance system may work for its given sociopolitical environment but must become more responsive to the country's changing demographics. Meanwhile, we may also acknowledge the cross-cultural trend across these developed countries towards an aging population following post-war economic re-awakenings. Yet despite this trend toward a mostly older population, the implementation of a public versus private health insurance has varying impacts on a country's population. As discussed above, a public health insurance may provide increased access to care with decreased disparities but potentially poorer health outcomes on a public scale due to understaffing, budgeting caps, and strain on limited medical resources. Conversely, a private health insurance may encourage biotechnological advances and preventive health services while presenting the limitation of lower prevalence in healthcare coverage and greater disparities in health outcomes.

Several factors affect longevity. Leppert describes the sociopolitical context for Japan's low infant mortality rate which includes the health literacy of Japanese citizens via public health

education, accessibility to reproductive planning, a community-focused approach to social support and equitable access to comprehensive insurance coverage (9). Tokita discusses this on a broader level by including factors of "diet, climatic conditions, life-style, the quality of dwellings, and the availability and accessibility of public services", as well as social support towards the elderly (28). Though on a smaller scale, the U.S. and the U.K. are also experiencing an inflating elderly population from the baby-boomer generation after World War II. Japan prioritizes care of the elderly due to its communal orientation of social support, while the U.S. and the U.K. promote westernized orientations of individualism that is biased against the elderly. As a result, the U.S. and the U.K. may focus on alleviating secondary health outcomes of aging, such as cosmetic care to maintain an illusion of youth. In contrast, Japan accepts aging as a normal process of life whose level of functioning can be significantly improved by balanced diet, social support, and proactive health behaviors, such as seeking care rather than attempting to repress the presence of symptoms. A shared predisposition the three countries may end up sharing alike will be the long-term effects of stress from caregiving for an increasingly elderly population. Described as a chronic stressor, caregiving presents physiological stress responses from worsening or flare-ups of symptoms, financial burden, and the physical demand of aiding in daily tasks. Given the demographic shift that Japan, the United States, and the United Kingdom will be facing due to their aging populations, we may witness a necessary reform within their insurance systems that would benefit their changing social and health needs.

What can be learned from these comparisons? Evidently, Japan's social insurance system provides far better outcomes than the privatized and fragmented coverage currently offered in the U.S. However, Japan has a significantly more homogeneous population than the melting pot of the United States. Therefore, Japan's social insurance system consisting of two main branches

may not be a size-fits-all for the needs of American citizens with varying health needs and SES. Equity in access to care may be more challenging due to the American shortage of physicians in more rural areas or areas that would bring in less profit, which underscores the American view that health care is not a national right accessible to all Thus, improvements in the American insurance system ought to begin with creating an affordable and comprehensive coverage plan that limits the power of the pharmaceutical industry and its lobbyists to promote their own self-serving interests at the expense of the American population. In addition, a more successful plan to increase recruitment to more desolate and/or impoverished areas. Moreover, the transition towards a public insurance system would require that care is accessible and affordable with fewer disparities in access and health outcomes. Improvements in the American health insurance system would have to begin with a grassroots and bottom-up change in healthcare being a right, equity in access, and greater health literacy among the general public. On the other hand, Japan would benefit most by including a more comprehensive legislative framework for protocols that parallel the OECD average evaluations. Specifically, the JCHCQ ought to begin with a quality assessment that includes the components of safety, effectiveness, patient-centeredness, and access within and across hospitals. Secondly, Japan would benefit from identifying a different funding source aside from pharmaceutical and biotechnology service costs and by capping pharmaceutical and biotechnology service fees and their frequency of usage. For instance, a compromise to maintain its social insurance system would be for Japan to charge citizens a social security tax that covers a portion of the federal funds of insurance coverage. Lastly, the JCHCQ would slow the start of an economic crisis by limiting health expenditures to be spent relative to its GDP. By tackling its public debt and easing the potentially crisis-state of its economy, producers can continue to contribute to the economy and increase Japan’s birth rate.

What can Japan and the United Kingdom learn from each other in improving their insurance systems? The largest discrepancy between Japan's insurance system and the U.K.'s insurance system is the breadth of coverage. While the U.K. and Japan both view healthcare as a right, as opposed to a privilege, the U.K. national coverage funds only essential medical services. By having a damage-control model of focusing on primary and emergency care, health literacy is reduced among the English public due to the discouragement of seeking preventive and specialty care due to lack of coverage. Therefore, the United Kingdom would benefit from encouraging preventive and patient-centered care. Additionally, the United Kingdom may benefit from a greater presence of reproductive planning due to its growing population that may soon outgrow its supply of resources and providers and should incentivize medical innovation and progress. Japan would benefit from introducing more heterogenous groups to its country in order to insulate the impact of a dwindling population. Japan may significantly benefit its economy and social growth by encouraging immigration to Japan while safeguarding for overcrowding. A possible solution to this gray area of immigration would be to encourage immigration for young producers for the economy while maintaining an enforced limit of incoming citizens.

However, the United States may serve as an example for the U.K. in terms of encouraging biotechnological advances and innovations that are used in high quality diagnostic techniques. By increasing fund allocation for research and development, the U.K. could become an exemplary insurance system with its broad insurance coverage if it was paired with updated facilities and its excellent assurance of quality care.

There are several preferable traits we can identify based on this three-country insurance system analysis and comparison. A public health insurance system should reduce inequity in access and health outcomes by creating a level playing field of reduced barriers of cost and

physician supply. Maintenance of quality assurance and improvement oversight is crucial in maintaining a free market arena of choice for patients and encouraging healthy competition of improving provided care and outcomes. There must also be genuine incentive for biotechnological advancements.

Regardless of a country's population characteristics and whether it orients towards a public or private health insurance system, it is the country's moral obligation to provide a standard of healthcare for its citizens. Propensity to illness is a defining quality of any living organism and the human experience. With recent biomedical advancements, efforts to ameliorate disease demonstrate that improving health is necessary to providing one's natural right to life. With the given resources to alleviate disease and precursors to illness such as poverty and violence, negligence by inaccessibility to care among marginalized social groups is a moral sin. Beneficence, or the moral duty to do good and not do harm, can be exercised by acts of altruism and removing acts of negligence that result in health disparities. By extension, health disparities among minorities, the elderly, the poor, and vulnerable communities are immoral acts of negligence that do harm and limit one's natural right to life. In contrast, viewing health as a privilege denies the natural right to life by equating one's health to a commodity and a good. By equating health to a commodity, the logic of the moral permissibility of health disparities becomes implied when hypothetically accepting that not every human being is entitled to healthcare.

Via this cross-country comparison, one may conclude that while no health insurance system is ideal, measurements through policies must be taken toward a reduction in healthcare disparities and outcomes in establishing healthcare as a right. Given a public or private health insurance system, reforms and interventions ought to be made in extending access across social

groups and decreasing the costs in one's health given lack of access, as seen with decreased life spans and poorer health outcomes. Specifically, differing policies can be implemented given the population's needs and burdens depending on numerous legislative factors, such as caps on budgeting and medical resources, which interact with the sociopolitical climate. Therefore, while each country can make improvements in learning from each other, it is each country's moral duty to provide healthcare access for all of its civilians unconditionally, as health and the natural right to life is not a commodity but an attainable given.

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