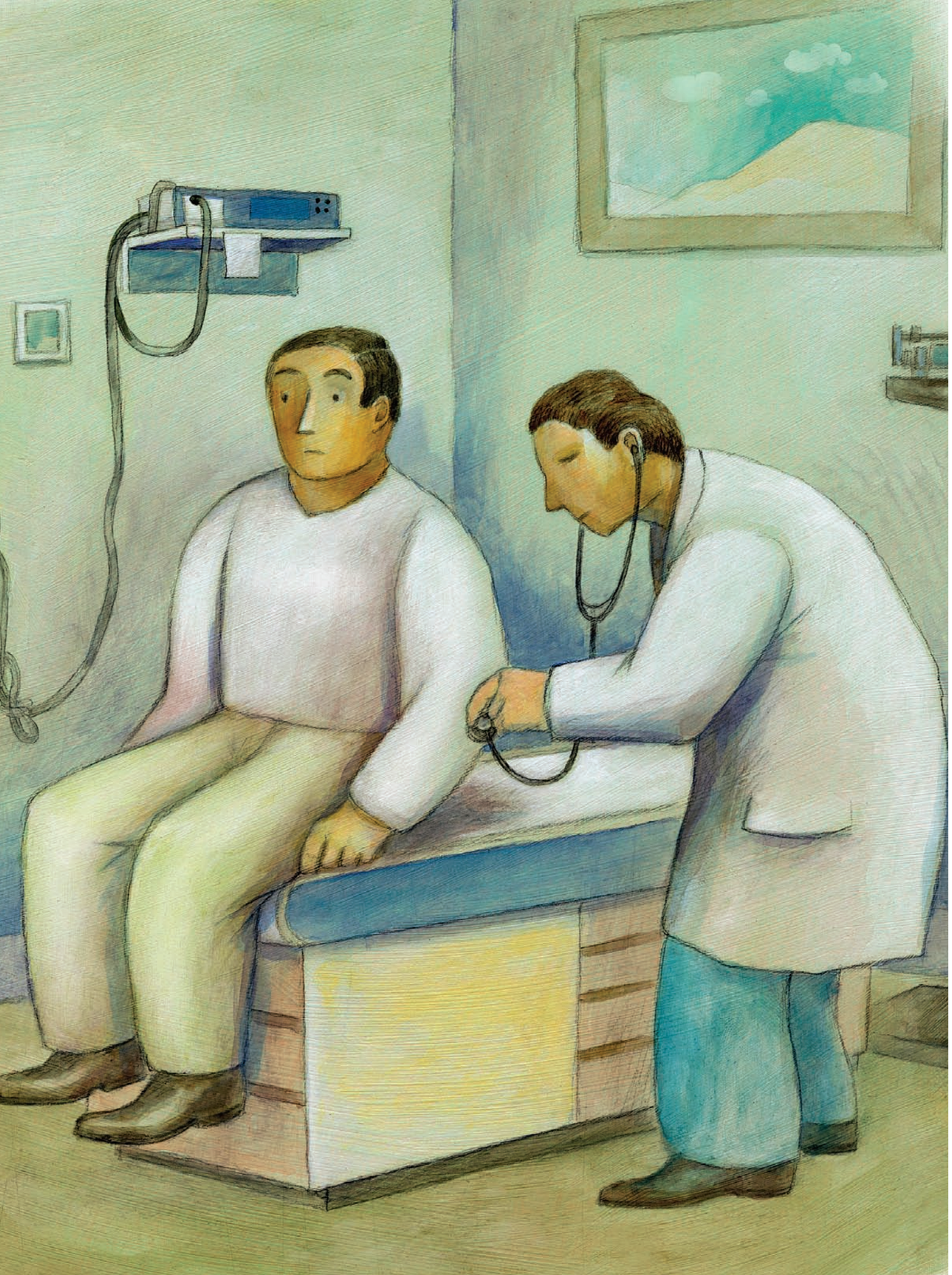

ILLUSTRATION BY JOHN S. DYKES

IN Sickness AND IN Health

Amid contentious debates about the future of health care in Norway and the United States, *Viking* takes a closer look at the two systems, their disparate histories and where they might be headed.

BY CARTER G. WALKER

Kjeld Husebye is a man of two worlds. At first glance he seems characteristically Norwegian with a strong accent and silver hair that complements his handsome, angular features. Yet, Husebye's outlook reveals that he is American as well, having lived and practiced medicine in this country since 1954. He raised his family here, and he has chosen to live here more than 20 years into his retirement. Husebye, an internist and thoracic specialist, graduated from medical school in Norway in 1951, received specialized training in the U.S., and then practiced back in Norway for a matter of months before deciding he wanted to spend his career in the U.S.

He is thoughtful and circumspect when he talks about the differences and similarities between the two countries' health care systems. There are obvious and important benefits to both, he points out. On the world stage, both have strengths that far outweigh the weaknesses. Yet, when it comes to health care reform, a frequent and often contentious topic in both cultures, Husebye is less certain about the exact measures either country should enact. "I used to know the answer to that 34 years ago," he says. "But I don't anymore."

In a debate where there are, perhaps, no right or wrong answers, and a dizzying number of statistics from a number of sources, *Viking* goes in for a check-up.

Origins

Norway's national health care system—ranked 11th best in the world by the World Health Organization (WHO) in 2000—was officially adopted in 1966, but its evolution has been gradual. According to a 1945 article by Dr. Jonn Caspersen, then the deputy director general of the Norwegian Health Service, the concept of health insurance could be traced back hundreds of years in Norway's history. The principle of compulsory sickness insurance was embraced in 1911 and, despite initial opposition, went on to become very popular. The government initially granted sickness insurance to workers in public or private employment with wages beneath a set level. As the plan's popularity grew, so too did the population covered. By 1944, two-thirds of the Norwegian population was covered.

Meanwhile, in the U.S., the concept of medical insurance was introduced in 1929 in Texas, at Baylor Hospital. It did not come to the fore until World War II, when President Roosevelt mandated national wage controls to address the labor shortage and subsequent threat of inflation. Rather than using wages to compete for the diminished pool of available workers, employers turned to benefits and, specifically, commercial health insurance to woo potential employees. Between 1942 and 1945, enrollment in group hospital plans grew from fewer than 7 million to about 26 million subscribers. By 1954, as much as 95 percent of the U.S. population had some form of medical insurance. The relationship between employment and health insurance has been constant in the U.S. for nearly 70 years.

Some argue that many countries, the U.S. and Norway among them, developed health care systems tailored to their own circumstances. At the same time the U.S. was developing commercial and employer-provided health insurance, Great Britain was building the infrastructure for a national health care system in preparation for the inevitable WWII Blitz. Countries whose cities and citizens were casualties of incessant attacks had a public responsibility to treat and care for the victims in state-run facilities and with state funds. Since the war was not fought, for the most part, on U.S. soil, the challenges posed at home were economic more than medical. In response, the idea of commercial health insurance met the needs of the country at the time. It should be noted, however, that the Veterans Administration (VA) established a significant and ongoing system for active military and veterans. As of 2007, the VA provided coverage for 7.8 million Americans.

Following WWII, in Norway the social-democratic Labour Party began building a welfare state in earnest, a large component of which was egalitarian and universal health care. That vision was outlined by a 1948 definition of good health put forth by the WHO: that all citizens were entitled to "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." The vision continues today in Norway and can be seen in the National Health Plan for Norway, 2007–2010.

HEALTH BY THE NUMBERS	NORWAY	U.S.
Total expenditure on health per capita (2005)	$4,307	$6,350
Total expenditure on health as % of GDP (2005)	9	15.2
Percentage of people covered by public health care spending (2003)	100	25.3
Percentage going without needed health care due to costs (2004)	N/A	40
Number of preventable deaths per 100,000 (2002-2003)	80	110
Number of physicians practicing per 100,000 (2005)	356	549
Life expectancy at birth m/f (in years) (2006)	78/83	75/80
Healthy life expectancy at birth m/f (2002)	70/74	67/71
Probability of dying under age five (per 1,000 live births) (2006)	4	8
Probability of dying between 15 and 60 years m/f (per 1,000 population) (2006)	86/53	137/80
Infant mortality, per 1,000 live births (2006)	3	7

SOURCES: WORLD HEALTH STATISTICS (2008), UN'S HUMAN HEALTH (2005), COMMONWEALTH FUND, OECD

All citizens are entitled to a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity." *—World Health Organization, 1948*

How they work

Perhaps a reflection of the country itself, the U.S. health care system is a combination of public and private entities, with the financial burden falling more on the private side. According to 2003 statistics, the U.S. government covers 15 percent of the non-elderly population (27.8 percent of the entire population, since nearly all elderly are covered by Medicare) through programs such as Medicaid, V.A., S-CHIP, and others. Another 62 percent of non-elderly Americans are covered by private employer-provided insurance. A total of 5 percent are self-insured, paying out-of-pocket for private insurance, while another 18 percent of non-elderly Americans, more than 45 million people, have no coverage.

The financing of the U.S system is also public and private, making it a multi-payer system. Individuals and businesses, which were responsible for 55.1 percent of the total health expenditures in 2002, pay through taxes, premiums and direct out-of-pocket premiums. The government, which assumed 44.9 percent of the total cost for health care in 2002, pays through public insurance programs, public employees' premiums, and tax subsidy.

Overall, the U.S. outspends every country in the world per capita on health care. In 2005, the U.S. spent 15.2 percent of its Gross Domestic Product (GDP), or $6,350 per capita, on health care. Those expenses annually cover more than 35 million hospital stays, 64 million surgeries, 900 million office visits and 3.5 billion prescriptions. The total figures represent nearly one-sixth of the U.S. economy. If the current growth pattern can accurately predict the future, by 2050, government health care spending will account for one-third of the GDP. Despite enormous

On Canada

Ranked 30 out of 191 countries in the World Health Organization's 2000 report, Canada's publicly funded health care system provides access to comprehensive coverage for necessary hospital and physician services. Through the Canada Health Act of 1984, the federal government ensures that provinces and territories provide free and universal access to health care. Like Norwegians, Canadians first contact a primary health care professional, such as a family doctor, when health care is needed.

For more information:

Health Canada
http://www.hc-sc.gc.ca/

The Canadian Institute for Health Information
http://secure.cihi.ca/cihiweb/

spending, the U.S. health care system ranked 37 out of 191 countries overall in the 2000 WHO report. The task at hand for health care reform in the U.S. is to figure out how to get better coverage for all Americans while spending less money.

Norway, which spends less and experiences better general health according to the WHO (see sidebar), offers a single-payer health care system and is primarily funded through taxes. The system is organized nationally, regionally and locally, and headed by the Ministry of Health and Care Services.

The National Insurance Scheme (NIS) provides coverage for every citizen, legal resident and worker in Norway. Each person in Norway is assigned to a general practitioner (GP) who is seen as something of a gatekeeper. Though the majority of medical expenses are covered in full—including hospital stays, diagnostic services, specialist care, maternity services, preventive medicine, palliative care and prescription drugs—many Norwegians pay for roughly 15 percent of their annual care out of pocket. Out-of-pocket expenses can be seen as a deductible where patients pay small fees for office visits, dental work, and the like, until they reach a limit (roughly 1615 Kroner, or about $240 in 2006).

There are private doctors, insurance programs and hospitals in Norway—in response to long waiting lists for procedures deemed non-essential, including hip surgery, varicose vein surgery and cataracts, among others—but they are few and far between. The private hospitals and clinics in Norway represent less than 1 percent of the total hospital beds and 5 percent of total outpatient services.

Like the U.S., Norway has seen skyrocketing medical costs and enormous growth in total health care expenditures. In 2005, Norway spent 9 percent of its GDP, or $4,307 per capita, on health care. When it comes to health care reform, Norway's main challenge seems to be increasing the efficiency of the system and reducing waiting periods for care across the board.

The U.S. and Norway, like many countries, have health care systems born of unique circumstances.

Looking ahead

As the populations of both countries continue to age, requiring significantly more care, and as prices for medical services soar at unfathomable rates, debate about health care reform has become louder and more insistent on both sides of the Atlantic.

In late February, President Obama unveiled a plan that would take the U.S. a step closer to universal health care coverage. The plan proposes a $634 billion down payment that would come from $318 billion worth of tax increases, or more specifically a reduction of tax deductions for the wealthy, over 10 years; and $316 billion from cuts from health care. The plan calls for reducing waste and improving quality and efficiency by "adopting state-of-the-art health information technology systems; ensuring that patients receive and providers deliver the best possible care, including prevention and chronic disease management services; reforming our market structure to increase competition; and offering federal reinsurance to employers to help ensure that unexpected or catastrophic illnesses do not make health insurance unaffordable or out of reach for businesses and their employees."

In Norway, the government developed a National Health Plan as a framework for improvement and reform from 2007–2010. The plan focuses on six cornerstones of excellent health care: cohesion of services and interaction both within and outside the health care system; democracy in leadership and legitimacy among the general public; proximity for all to the best care and security; stronger user role to empower all patients and their families; professionalism and quality within the system itself; and the acknowledgement of the direct relationship between work and health.

Whether Norway and the U.S. can achieve their lofty health care goals remains to be seen. It is a dynamic process that changes as quickly as the headlines and can be diverted with every election. But Kjeld Husebye is among the optimistic. It won't be easy, he says, nor will it be quick. But even the mistakes, challenges and stumbling blocks can lead both countries exactly where they aim to go, he says. "Every positive opportunity starts out by breaking down something that was there before … and building upon it." V

Carter G. Walker is an editor, writer and frequent contributor to Viking.