

5-7-2018

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International Reflections for United States Health Care Improvements

A Senior Honors Thesis

Submitted in Partial Fulfillment of the Requirements
for Graduation in the Honors College

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May 7, 2018

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International Reflections for United States Health Care Improvements

Abstract

In 2000, the World Health Organization ranked 151 countries based on the quality of their health care systems. Those rankings found the United States of America to be ranked thirty-seventh on the list of countries. The top three ranked countries include France, Italy, and San Marino, respectively. The bottom three countries include the Central African Republic, Myanmar, and Sierra Leone, respectively (Tandon et al., 2000). By looking the health care systems of these countries, it is easy to see what makes a health care system good, or bad. The health care system of the United States of America currently has aspects of both the higher and lower ranked countries. By using the rankings and understanding the health care systems of the other countries, there are some recommendations that can be made in order to improve the current health care system of the United States of America.

Introduction

The topic of health care is constantly in the media of the United States of America. Constant swaying opinions and inconsistent reports coming the media lead to an uninformed and divided populace, as well as an ambiguous view of the state of health care in the country (Pew Research Center, 2012). Many countries around the globe do not have access to quality health care, or health care at all. Health care systems vary all over the world. Many countries have created systems that are beneficial to their own needs and have been quite successful, others have not had the same fate. While many health care systems have their differences, there are many similarities between the systems that have been successful. While there are many successful

health care systems in the world, the United States of America is still lacking in both access to care, as well as quality of care (Tandon, Murray, Lauer, & Evans, 2000).

Healthy People 2020 is “the federal government's prevention agenda for building a healthier nation. It is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats. The vision of Healthy People 2020 is to have a society in which all people live long, healthy lives. The overarching goals of Healthy People 2020 are to: attain high-quality, longer lives free of preventable disease, disability, injury, and premature death; achieve health equity, eliminate disparities, and improve the health of all groups; create social and physical environments that promote good health for all; and promote quality of life, healthy development, and healthy behaviors across all life stages.” (United States Department of Health and Human Services [USDHHS], 2014, para. 1). One of the goals of Healthy People 2020, is to create better access to quality healthcare throughout the United States of America in order to create a healthier, more productive society (USDHHS, 2014). In order for the United States of America to achieve their overall goal of a healthy society, they first must create and implement a health care system that can assist in the completion of this goal. Without quality health care, the country will not have a healthy, productive population. There are many countries around the world that have beneficial health care systems, some of these countries include France, Italy, and San Marino.

Instrument Description

The instrument that is being utilized as the basis of the comparisons being made within this case study is, “Measuring Overall Health System Performance for 191 Countries”. This instrument was created by the World Health Organization (WHO) to accurately compare and

contrast the performance of health care systems all over the world. The instrument was created in 2000. The instrument uses a variety of factors to assess the overall performance of the health care systems including intrinsic and instrumental goals of each of the health care systems (Tandon et al., 2000). Instrumental goals “are goals that are pursued to attain intrinsic goals” (Tandon et al., 2000, pg. 2). Intrinsic goals are those “whose attainment can be raised while holding other intrinsic goals constant” and those “raising the attainment of which is in itself desirable, irrespective of any other considerations.” (Tandon et al., 2000, pg. 2).

There are three main intrinsic goals of a health system discussed within the instrument. They include “improvement in the health of the population”, “enhanced responsiveness of the health system to the legitimate expectations of the population”, and “fairness in financing and financial risk protection”. When referring to “improvement in the health of the population”, the instrument is looking at both the levels attained by each individual country, as well as the distribution of those levels. When discussing responsiveness, the instrument “refers to the non-health improving dimensions of the interactions of the populace with the health system, and reflects respect of persons and client orientation in the delivery of health services, among other factors” (Tandon et al., 2000, pg. 3). “Fairness in financing and financial risk protection” (Tandon et al., 2000, pg. 3) ensures that those of a lower socioeconomic status do not have as much of a financial burden due to medical expenses as those who are of a higher socioeconomic status and that all residents are safe from large financial losses due to poor health. Using these three intrinsic goals, the instrument is able to rank the one-hundred and ninety-one countries (Tandon et al., 2000). Utilizing this instrument, the top three ranked health care systems, as well as the bottom three ranked health care systems were chosen to provide comparisons to the health care system United States of America in this case study. By better understanding why certain

countries were ranked higher or lower within the instrument, it is easier to comprehend why the health care system of the United States of America is barely ranked within the top forty countries in the instrument.

Description of Health Care Systems in Top Three Ranked Countries

Using the results found in “Measuring Overall Health System Performance for 191 Countries”, it is found that out of the one-hundred and ninety-one countries the top three include France, Italy, and San Marino, respectively (Tandon et al., 2000). All three of these countries are found in Europe, but they vary in many different aspects. Not only do these countries have differences in demographics, government, and economics, they also have differences in their health care systems. In order to understand the differences in health care, one must first have the knowledge of the demographics, government, and economics of each of these countries.

France is a semi-presidential republic, located in Europe. France has a population of 67,106,161 people. France’s population has a median age of 41.4 years and the infant mortality rate in France is 3.2 deaths per one thousand live births. Also, France has a labor force of 30.43 million people and an unemployment rate of 10%. The Gross Domestic Product (GDP) in Purchasing Power Parity (PPP) of France, in US dollars, is 2.735 trillion dollars. The GDP per capita in PPP, in US dollars, is \$42,300. France currently utilizes 11.5% of its GDP on health expenditures. Approximately, 14% of the population is below the poverty line in France and the current external debt of France, in US dollars, is 5.36 trillion dollars (Central Intelligence Agency, 2018c). (See Appendix A).

Italy is a parliamentary republic, located in Europe. The population of Italy is 62,137,802 people. The median age of the population of Italy is 45.5 years and the infant mortality rate is

3.3 deaths per one-thousand live births. Italy has a labor force of 25.76 million people, and an unemployment rate of 11.7%. The GDP in PPP of Italy, in US dollars, is 2.234 trillion dollars. The GDP in PPP per capita of Italy, in US dollars, is 36,800 dollars. Italy currently utilizes 9.2% of its GDP on health expenditures. Approximately, 29.9% of the population in Italy is below the poverty line and the current external debt of Italy, in US dollars, is 2.444 trillion dollars (Central Intelligence Agency, 2018d). (See Appendix A).

San Marino is a small country located in Europe. It is a parliamentary republic with a population of 33,357 people. The median age of the population of San Marino is 44.4 years and the infant mortality rate is 4.3 deaths per one thousand live births. The GDP in PPP of San Marino, in US dollars, is 2.023 billion dollars. The GDP per capita of PPP of San Marino, in US dollars, is 59,500 dollars. San Marino spends 6.1% of their GDP on health expenditures. San Marino has a labor force of 21,960 people and the unemployment rate of San Marino is 8.6%. Current data for the percentage of the population below the poverty line and the external debt of San Marino is unavailable (Central Intelligence Agency, 2018e). (See Appendix A).

In order to understand why the health care systems of France, Italy, and San Marino are different, one must understand the similarities and differences between the three countries. Out of the three countries, San Marino has a much smaller population. While both France and Italy have populations over sixty million, San Marino only has a population slightly over thirty thousand. The median age is the highest in Italy at 45.5 years, this increased median age suggests that Italy has a larger elderly population, which could impact the health care system of Italy. The infant mortality rate is higher in San Marino than both France and Italy, both of which are very similar when it comes to infant mortality rate (Central Intelligence Agency, 2018c) (Central Intelligence Agency, 2018a) (Central Intelligence Agency, 2018e). France has the

largest GDP of the three countries, and it also spends the largest percentage of their GDP on health expenditures (Central Intelligence Agency, 2018c).

Now that there is an understanding of the differences and similarities between the three countries, it is easier for one to understand what makes each country's health care system different. Health care systems vary in a variety of ways. Health care systems can vary on coverage, finances, services, and other factors.

France's health care system was ranked first overall by the instrument discussed above (Tandon et al., 2000). France has a health care system that is available to all citizens. In France, coverage is universal. Universal coverage is the idea that "all residents are entitled to coverage from noncompeting statutory health insurance (SHI) funds, which are statutory occupation-based entities" (The Commonwealth Fund, 2017, para. 1). "SHI eligibility is universally granted under the PUMA (Protection universelle maladie, or universal health care coverage) law." (Durand-Zaleski, AP-HP, and Université Paris-Est, Paris, France, 2017, para. 1). In other words, universal health care is available to all residents from health insurance groups that do not compete and, therefore, do not have to offer competitive offers or prices. This also means that everyone has the right to coverage, and these insurance groups cannot deny anyone coverage based on their current state of health. This coverage comes with employment in France which is based on entitlement. If you are employed, you are entitled to health care. This entitlement comes alongside employment for those who earn a salary or are self-employed. It can also come as a benefit for those who have been unemployed, and it is also an entitlement for those who are students, as well as those who are retired (The Commonwealth Fund, 2017). For those not included in those categories, the state will cover the costs. France is capable to cover these people considering that those that are not covered only make up 0.4% of the population of

France (The Commonwealth Fund, 2017). France will also cover health care costs for non-residents as long as they have applied for residency to France. France will also cover those who are visiting from other countries in the European Union, and those who are visiting from outside of the European Union are covered only for emergency care (The Commonwealth Fund, 2017). While the government covers health care for those listed above, there is also complimentary private health insurance that is provided through certain employers, or means-tested vouchers. This private health insurance is used for user charges, as well as services that are excluded from the coverage offered by the state or the basic employer insurance offered (The Commonwealth Fund, 2017). (See Appendix B).

The government of France plays a very large role in the distribution of the health care offered to citizens. “The Ministry of Social Affairs, Health, and Women’s Rights is responsible for defining national strategy.” (Durand-Zaleski, AP-HP, and Université Paris-Est, Paris, France, 2017, para. 1). Negotiations between the state, provider representatives, and statutory health insurance occur in order to plan and regulate the health care. Following negotiations, the outcomes are translated into laws, which are then passed by the French Parliament. The central government of France is also responsible for allocating budgets among different sectors and regions. The ministry is represented throughout the regions by regional health agencies. Regional health agencies are responsible for population health as well as health care including preventative services. Health care for the elderly and disabled populations is placed under the jurisdiction of the General Councils. The General Councils are based at the local level. (Durand-Zaleski, AP-HP, and Université Paris-Est, Paris, France, 2017). All of these organizations work together to ensure that the health care system runs smoothly and that all needs are met. (See Appendix B).

In order to afford the services offered by the health care system, the public finances most of the system. In 2014, 76.6% of the health care system was publicly financed (Durand-Zaleski, AP-HP, and Université Paris-Est, Paris, France, 2017). The statutory health insurance “is financed by employer and employee payroll taxes (50%); a national earmarked income tax (35%); taxes levied on tobacco and alcohol, the pharmaceutical industry, and voluntary health insurance companies (13%); and state subsidies (2%).” (Durand-Zaleski, AP-HP, and Université Paris-Est, Paris, France, 2017, para. 4). Voluntary health insurance (VHI) is usually complementary and is used to cover “copayments for usual care, balance billing, and vision and dental care (minimally covered by SHI).” (Durand-Zaleski, AP-HP, and Université Paris-Est, Paris, France, 2017, para. 9). (See Appendix B).

While services like vision and dental care are not always covered, most other services are. Those services are defined at the national level and are uniform across the country. The SHI covers hospital care, outpatient care, specialists, midwives, prescription drugs, medical appliances, and prescribed health care-related transportation and home care. Long-term hospice and mental health services are also partially covered (Durand-Zaleski, AP-HP, and Université Paris-Est, Paris, France, 2017). Another benefit of this system is that there is a full reimbursement for targeted services that would otherwise be considered preventive and, therefore, have limited coverage. Targeted services, including “immunization, mammography, and colorectal cancer screening” (Durand-Zaleski, AP-HP, and Université Paris-Est, Paris, France, 2017, para. 13). There has also been a full reimbursement push for targeted populations, such as drug users. (Durand-Zaleski, AP-HP, and Université Paris-Est, Paris, France, 2017). (See Appendix B).

The financing as well as the organization of the French health care system is collectively agreed upon at the national level. The agreements made at the national level provide incentives to those who comply with their rules, but some health care professionals opt out. In France, there are about 220,000 general practitioners and about 120,000 specialists (Durand-Zaleski, AP-HP, and Université Paris-Est, Paris, France, 2017). As an incentive for adults to register with a primary general practitioner or specialist, there is a “voluntary gatekeeping system” that offers financial incentives (Durand-Zaleski, AP-HP, and Université Paris-Est, Paris, France, 2017, para. 20). These incentives insure that citizens are registering with a general practitioner and, therefore, receiving medical care and medical monitoring that is necessary to live a healthy, productive life. (See Appendix B).

Many may wonder about the quality of the health care that is provided to citizens in France. There is a common connotation that when something is of lower cost, it is of lower quality. This is not the case in France. France has set up many strategies to ensure the quality of the health care that they offer. “SHI and the health ministry fund ‘provider networks’ in which participating professionals share guidelines and protocols, agree on best practices, and have access to a common patient record. Regional authorities fund telemedicine pilot programs to improve care coordination and access to care for specific conditions or populations, like newborns or the elderly.” (Durand-Zaleski, AP-HP, and Université Paris-Est, Paris, France, 2017, para. 32). There are also required continuous learning activities that many health care professionals must complete. In order to ensure that they are staying on track, they are audited on a four to five-year cycle. Not only must individuals be audited, hospitals must also follow a four-year accreditation cycle. The reports look for particular indicators which are tracked through technical information found online, data reports on hospital activity, and data regarding

the ability of the hospital to control infections that are hospital-based (Durand-Zaleski, AP-HP, and Université Paris-Est, Paris, France, 2017). (See Appendix B).

A problem that is common among countries and health care systems is disparities in health care among different social classes. France tried to combat these disparities with multiple public health policies including the 2004 Public Health Act and the 2015 Touraine law. “The 2004 Public Health Act set targets for reducing inequities in access to care related to geographic availability of services (so far, only nurses have agreed to limit new practices in overserved areas), financial barriers (out-of-pocket payments will be limited by state-sponsored complementary insurance), and inequities in prevention related to obesity, screening, and immunization.” (Durand-Zaleski, AP-HP, and Université Paris-Est, Paris, France, 2017, para. 56). This act made it possible for many to get the services they need regardless of their geographic location or their financial situation. This is especially important, due to the fact that everyone is paying into the health care system, there is a common belief that everyone should have access to everything that is offered to those who are paying. The 2015 Touraine law covers many different aspects of health care. The main priority of the 2015 Touraine law is prevention. Those who worked to create the 2015 Touraine law found that the health care system was created around the idea of treatment, and if they were able to prevent a lot of these diseases from happening in the first place, it would create less of a strain on the system. The health bill giving priority to prevention is a step towards a larger presence of public health in France, as it will begin to prevent a lot of health care spending by preventing the disease or injury from occurring in the first place. The bill also focuses in care pathways, innovation, and efficiency (Government Valls I, 2014).

Italy's health care system was ranked second overall by the instrument, "Measuring Overall Health System Performance for 191 Countries" (Tandon et al., 2000). Similar to France, Italy offers universal coverage. The Italian National Health Service was established in 1978. The Italian National Health Service has a focus on universal coverage and utilizes health needs as its guiding principles. It is regionally based and organized at all levels of government. Due to the structure in the Italian constitution, the central government is in control of the distribution of tax revenue for publicly financed health care and has the power to define what will and will not be covered within the system (Donatini and Emilia-Romagna Regional Health Authority, 2017, para. 1). (See Appendix B).

In order to cover all citizens, the health care system is publicly financed. "The National Health Service (NHS) covers all citizens and legal foreign residents. Coverage is automatic and universal. Since 1998, undocumented immigrants have had access to urgent and essential services. Temporary visitors receive health services by paying for the costs of treatment." (Donatini and Emilia-Romagna Regional Health Authority, 2017, para. 2). Approximately, 75.8% of health spending in Italy was publicly financed in 2014. The rest of the system is financed by supplementary private insurance which can be purchased by anyone in Italy that deems it necessary to purchase. This system is predominantly financed by means of a corporate tax which is nationally pooled when taxes are collected. The amount that is expected to be contributed by each individual tax payer is proportionate to their earnings. In Italy, it is found that there are large financial disparities between regions. This is seen especially due to the fact that regions are permitted to produce additional revenue, which has led to even larger disparities between regions (Donatini and Emilia-Romagna Regional Health Authority, 2017). Due to the fact that regions can choose what they cover and how much they charge for it, there can be

disparities between regions due to changes in coverage and availability of health services. The National Health Service does not allow citizens to opt out of the system. Therefore, there is not private care or substitutive insurance. This is different from France, as people are allowed to drop out of the French health care system. Both Italy and France do both offer supplementary private health insurance (Donatini and Emilia-Romagna Regional Health Authority, 2017). (See Appendix B).

In Italy, there is some privately financed health care available to citizens. There are two types of private health insurance; corporate and non-corporate. Corporate private health insurance is an insurance provided by companies to their employees, and in certain cases, their families as well. Non-corporate private health insurance is insurance purchased by individuals for their families (Donatini and Emilia-Romagna Regional Health Authority, 2017). Some people choose a private health insurance to give themselves more freedom among their provider. Some also choose a private health insurance as they may have a high rate of hospitalization and a private provider may offer a “daily rate of compensation during hospitalization” (Donatini and Emilia-Romagna Regional Health Authority, 2017, para. 6). These policies are provided by both nonprofit and for-profit organizations, the majority choose to work with a non-profit organization for their coverage (Donatini and Emilia-Romagna Regional Health Authority, 2017). (See Appendix B).

The Italian health care system covers a wide variety of services. Both primary care and inpatient care are free to citizens. A list of criteria is used to decide whether or not something is covered by the health care system. A set of positive and negative lists are created using criteria related to the necessity of the medical need, effectiveness, efficiency of delivery, and other factors. Positive lists include services that are to be offered to all residents. Some examples of

items included in positive lists include prescriptions, inpatient care, preventative services, outpatient care, in-home care, primary care, and hospice care. Negative lists include services not offered to patients. Some examples of items included in negative lists include cosmetic surgeries, orthodontics, laser eye surgery, and cataract surgery (Donatini and Emilia-Romagna Regional Health Authority, 2017, para. 9). The only service that is not usually covered is dental care. In Italy, dental care is covered for children up to sixteen years of age, populations that would be considered vulnerable, and those with an economic or emergency need for dental care (Donatini and Emilia-Romagna Regional Health Authority, 2017, para. 11). (See Appendix B).

Not only is health care divided into sectors, prescription drugs are as well. The Italian government controls the classification of prescription drugs. Prescription drugs are divided into three tiers which are based on both clinical-effectiveness as well as cost-effectiveness. These tiers are known as classe A, classe C, and classe H (Donatini and Emilia-Romagna Regional Health Authority, 2017, para. 10). “The first tier (classe A) includes lifesaving drugs and treatments for chronic conditions and is covered in all cases; the second (classe C) contains all other drugs and is not covered by the NHS. There is an additional tier (classe H) comprising drugs that can be delivered only in a hospital setting.” (Donatini and Emilia-Romagna Regional Health Authority, 2017, para. 10). These classes provide a national guideline when it comes to medicine and, therefore, prevents changes in prescription recommendations from doctor to doctor and streamlines the process of prescribing medications. (See Appendix B).

The organization and financing of the Italian health care system is different from that of France. While France collectively agrees upon decisions involving health care at the national level, Italy has a much more independent system. In Italy, primary care physicians are self-employed, therefore changing the structure of the health care system. Local health units are also

given the opportunity to pay supplementary fees in order to meet certain performance targets, or for fees involving the delivery of certain treatments. While many practitioners choose a more individual and independent route, many have been leaning towards a group modeled practice. There is an incentive for practitioners to work together in this sense because it can allow them to see more patients, as well as share a common patient electronic health system (Donatini and Emilia-Romagna Regional Health Authority, 2017). (See Appendix B).

The Italian Ministry of Health has twelve directorates that are each assigned to different areas of health care. These directorates oversee areas such as “health care planning; essential levels of care and health system ethics; human resources and health professionals; information systems; pharmaceuticals and medical devices” (Donatini and Emilia-Romagna Regional Health Authority, 2017, para. 36). Some of these directorates also assist in ensuring that the Ministry of Health remains functional and operating. There are also some nongovernmental groups that support the Ministry of Health including the National Health Council, the National Institute of Public Health, the National Committee for Medical Devices, and the National Pharmaceutical Agency. Each of these nongovernmental groups provides specific services to the Ministry of Health that may be difficult for the Ministry of Health to provide for itself (Donatini and Emilia-Romagna Regional Health Authority, 2017). (See Appendix B).

The quality of healthcare in Italy is monitored at both the national and regional levels of government. The national and regional levels of government also monitor waiting times and ensure that services are advertised are actually being provided to the public. “Legislation passed during the 1990s covers three main components of quality: input (quality of infrastructure and human resources); process (appropriateness and timeliness of interventions); and outcome (health status and patient satisfaction).” (Donatini and Emilia-Romagna Regional Health

Authority, 2017, para. 47). As discussed, there are some disparities between regions in terms of quality and availability of care. In Italy, there is a clear divide between the Northern and Southern regions. The Northern regions are more industrialized and surpass the medical capabilities of the Southern regions. The Northern regions have more hospital beds available, more advanced technology, and a larger number of private sector facilities. In order to prevent some of this inequality, Italy has created an “equalization fund” which uses the funds to reduce inequalities and promote medical advancements across the country (Donatini and Emilia-Romagna Regional Health Authority, 2017). (See Appendix B).

San Marino is much different from France and Italy. Due to the fact that the country is much smaller, there is not as much readily available information regarding its health care system. The healthcare in San Marino is state funded. Health care is provided to the citizens of San Marino at a low cost due to the establishment of a network of clinics as well as hospitals (Pacific Prime International, 2018). In San Marino, all citizens and long-term residents (who are registered) are entitled, by law, to equal access healthcare. While there is a high standard of healthcare, options for treatment are quite limited and certain procedures require the patient to leave the country and get the procedure somewhere else. San Marino’s health care is administered through the The Institute of Health and Social Security. The Institute of Health has a salary-related healthcare system that requires both employers and employees to register with the national health insurance fund and pay contributions. For employees, these contributions are automatically deducted from their salaries. Employers must also make contributions regularly on behalf of their employees, as required by law. (Pacific Prime International, 2018). (See Appendix B).

Salary contributions made by employees are contributions made towards coverage for the rest of their family members. “Certain groups are exempt from making contributions but still qualify for state-funded healthcare, these are: the unemployed, old age pensioners, and people on long-term sickness benefit or maternity leave.” (Pacific Prime International, 2018, para. 4). The national insurance fund provides many services to the people of San Marino. The services included are “treatment by specialists, hospitalization, prescriptions, maternity and rehabilitation.” (Pacific Prime International, 2018, para. 5). Appointments with your primary care physician, as well as referred appointments with consultants are free of charge. Prescriptions in San Marino are free of charge, although some require a co-pay from the recipient. Many citizens in San Marino purchase a private health insurance plan to supplement their state supplied coverage. Many choose to purchase some form of private health insurance for a variety of benefits including “avoidance of long waiting lists, freedom to choose which doctor you can visit and more comfortable conditions should you require a stay in hospital.” (Pacific Prime International, 2018, para. 6). (See Appendix B).

In San Marino, there is one state hospital, appropriately titled the San Marino Hospital. This hospital is different from hospitals in other countries as one can “only be admitted through the emergency department or through a referral by their doctor.” (Pacific Prime International, 2018, para. 7). The San Marino Hospital is similar to that of other European nations. Due to the fact that it is a public facility, there is usually longer wait times for non-emergency services. A person’s treatment and quality of facilities are based on the quality of their health insurance. If a patient has private insurance, they are entitled to have a private room. Those who have national insurance are usually required to share a room with a few others. To supplement San Marino only having one hospital, there are many health centers and clinics spread throughout the

country. These health centers and clinics provide outpatient care and most specialist services. Usually, standard medical services as well as some emergency services are carried out by health centers instead of the hospital. While these hospitals are available to all, there are still private medical facilities all over the country. These private practices are run by a staff of doctors that are independent from the public health care system. These private practices are funded on contributions made directly to these facilities. While these practices are known for quality of service and comfort, the medical care that their patients are being administered has almost no difference from the facilities in their public counterparts. The only difference between public and private care is that large cost that comes with private care (Pacific Prime International, 2018). (See Appendix B).

While France, Italy, and San Marino each have their own health care systems, they each are very successful and provide quality medical care to their citizens. This care may be distributed in different formats, but each is successful in their own methods. With an understanding of the demographics, economics, and healthcare of France, Italy, and San Marino, one will better understand why some countries are ranked at the bottom of the list, as well as why the United States of America is barely ranked within the top forty countries.

Description of Health Care Systems in Bottom Three Ranked Countries

Once again, using the results of “Measuring Overall Health System Performance for 191 Countries”, it is found that the lowest ranked countries are Central African Republic, Myanmar, and Sierra Leone, respectively (Tandon et al., 2000). Central African Republic and Sierra Leone are found in Africa and Myanmar, formerly known as Burma, is located in Southeast Asia. These countries each have differences in demographics, economics, and government. They also

vary in health care. Due to the fact that these countries are much more impoverished than France, Italy, and San Marino, there is much less information available about all aspects of the countries. Having an understanding of the demographics, economics, and government of each of these countries will allow for a better understanding of the health care systems of each of these countries. (See Appendix A).

The Central African Republic is a presidential republic located in Africa. The Central African Republic has a population of 5,625,118 people. The median age in the Central African Republic is 19.7 years. The infant mortality rate in the Central African Republic is 86.3 deaths per one thousand live births (Central Intelligence Agency, 2018b). The Central African Republic's Gross Domestic Product (GDP) in Purchasing Power Parity (PPP), in US dollars, is 3.185 billion dollars. The Gross Domestic Product (GDP) in Purchasing Power Parity (PPP) per capita, in US dollars, is seven hundred dollars (Central Intelligence Agency, 2018b). Only 4.2% of the Gross Domestic Product (GDP) is spent on health expenditures in the Central African Republic. The unemployment rate in the Central African Republic is 8% and the Central African Republic has a labor force of 2.194 million people. The external debt of the Central African Republic, in US dollars, is 691.5 million dollars. There is no information currently available on the percent of the population of the Central African Republic below the poverty line (Central Intelligence Agency, 2018b). (See Appendix A).

Myanmar, formerly known as Burma, is a parliamentary republic located in Southeast Asia. Myanmar has a population of 55,123,814 people and the median age in Myanmar is 28.2 years. The infant mortality rate in Myanmar is 35.8 deaths per one thousand live births (Central Intelligence Agency, 2018a). Myanmar's Gross Domestic Product in Purchasing Power Parity, in US dollars, is 303.3 billion dollars. The Gross Domestic Product in Purchasing Power Parity

per capita, in US dollars, is \$5,800 dollars. Myanmar spends 2.3% of its Gross Domestic Product on health expenditures (Central Intelligence Agency, 2018a). Myanmar has a labor force of 22.13 million people and an unemployment rate of 4%. Myanmar has an external debt, in US dollars, of 8.2 billion dollars and 25.6% of the population lives below the poverty line (Central Intelligence Agency, 2018a). (See Appendix A).

Sierra Leone is a presidential republic located in Africa. Sierra Leone has a population of 6,163,195 people and a median age of nineteen years. The infant mortality rate in Sierra Leone is 68.4 deaths per one thousand live births. In Sierra Leone, the Gross Domestic Product in Purchasing Power Parity, in US dollars, is 10.9 billion dollars and the Gross Domestic Product in Purchasing Power Parity per capita, in US dollars, is \$1,700 dollars (Central Intelligence Agency, 2018f). Sierra Leone spends 11.1% of their Gross Domestic Product on health expenditures. Sierra Leone has a labor force of 2.863 million people and an unemployment rate of 9.1%. Sierra Leone's current external debt, in US dollars, 1.503 billion dollars and 70.2% of the population lives below the poverty line (Central Intelligence Agency, 2018f). (See Appendix A).

Sierra Leone, Myanmar, and the Central African Republic share similarities and differences when it comes to demographics, economics, and government. Sierra Leone and the Central African Republic both have very similar populations, but Myanmar has a much larger population. Both Sierra and the Central African Republic have median ages near 19, while Myanmar has a median age closer to 30. While the Central African Republic is ranked 189 out of 191, it has a much higher infant mortality rate than Myanmar and Sierra Leone. While Sierra Leone is ranked 191 out of 191, they spend a larger percentage of their Gross Domestic Product on health expenditures than Myanmar or the Central African Republic. Sierra Leone also has the

largest percentage of the population that lives under the poverty line. (Central Intelligence Agency, 2018b) (Central Intelligence Agency, 2018a) (Central Intelligence Agency, 2018f). The health care systems of Myanmar, Sierra Leone, and the Central African Republic share similarities and differences as well. Due to the fact that these countries are developing nations, information is not as readily available as it is for developed nations. While there is information available about these nations, it is not as extensive as that of the information available for nations like France and Italy. (See Appendix A).

The Central African Republic was ranked 189 out of 191 countries. Due to the widespread political turmoil in the country, the health care system has become less of a concern for the country. “Healthcare in the CAR is dysfunctional in every area, and at every level. There is an estimated one doctor for every 3,000 people, and one nurse for every 1,000.” (Pacific Prime International, 2018a, para. 2). There is also an HIV/AIDS epidemic in the Central African Republic. “In 2016, Central African Republic had 8,700 (6,600 – 12,000) new HIV infections and 7,300 (6,000 – 8,800) AIDS-related deaths. There were 130,000 (110,000 – 160,000) people living with HIV in 2016, among whom 24% (20% - 29%) were accessing antiretroviral therapy. Among pregnant women living with HIV, 81% (61% - >95%) were accessing treatment or prophylaxis to prevent transmission of HIV to their children. An estimated <1000 (<500 - <1000) children were newly infected with HIV due to mother-to-child transmission.” (UNAIDS, 2018, para. 1). The combination of political turmoil, and the HIV/AIDS crisis has led to malfunctions and mishaps within the nonexistent health care system available to the citizens of the Central African Republic.

Currently, there is no health care system outside of the capital of the Central African Republic, Bangui. Outside of Bangui, any existing health system is brought together by the non-

governmental organizations (NGOs) and international donors present in the Central African Republic. Other than the hospitals and health posts that these groups have made available, there are not many other health professionals that are available, and the population of the Central African Republic is quite dispersed throughout the country. When unanticipated medical emergencies appear, there is an outbreak of a disease, or there is an increase in food insecurity, these dispersed groups must compete for the attention of limited non-governmental organizations and donors in order to receive the resources necessary to fix the issue at hand (Green, 2012). In many of the rural areas of the Central African Republic, the only health care that is available is basic first aid. “Although malaria remains the leading cause of morbidity and mortality, only 26% of people in rural areas have access to treatment for it, according to a draft report by donors and government officials.” (Green, 2012, p. 1). The more readily available health care option for citizens are traditional healers. Traditional healers are usually untrained, and lack the proper medical training (Green, 2012). (See Appendix A).

One of the major problems for the Central African Republic, are its surrounding countries. Many of the neighbors of the Central African Republic take away a lot of the attention from the Central African Republic, as they are facing other issues like war or political turmoil. In order for the Central African Republic to gain any ground, the government needs to take more steps to tackle the many health care problems that burden the country. This effort cannot be completed by only the government. Non-governmental organizations and other outside actors will need to assist the country which will allow for small advances to be made in the health care field in the Central African Republic (Green, 2012). (See Appendix B).

Myanmar, formerly known as Burma, was ranked 190 out of 191 countries. Due to changes in the political structure of the country, there have been changes to the health care

system as well. In Myanmar, the Department of Public Health is responsible for health care and basic health services. The Department of Public Health also houses a Disease Control Division as well as a Central Epidemiology unit. Myanmar also has a Department of Medical Services that provides and oversees health facilities. There is also a Department of Health Professional Resource Development and Management that is responsible for training medical and health personnel. As there is a more organized system of health in Myanmar, compared to the Central African Republic, there are still many problems within the country. In Myanmar, there are both private and public health care facilities. There are private facilities for the more affluent, charity hospitals for the poor that are operated by private sector employees, and privatized non-profit clinics run by community based groups as well as religious based societies (Latt et al., 2016). These different health care facilities each provide different levels of care as well as different levels of quality. (See Appendix B).

In order for the citizens of Myanmar to get the health care that they need, the government of Myanmar needs to allocate more of their funds towards healthcare services for the public. “Generally speaking, the larger amount of services causes reduction of the cost per service, improving skills for services.” (Latt et al., 2016, p. 132). While Myanmar has some donors that assist their health care system, there needs to be a network that connects the donors in order to better prevent donors from providing funds for the same purpose. If donors are placed in a network, their donations can be better allocated and allow for a better distribution of funds to all sectors of the healthcare system in Myanmar (Latt et al., 2016). (See Appendix A).

Sierra Leone was ranked 191 of 191 countries. In Sierra Leone, a network of health facilities delivers health care to citizens. “This network consists of 1040 peripheral health units, including community health centres, community health posts, maternal and child health posts

and 40 hospitals (23 government owned and the remainder owned by private, nongovernmental and faith-based organizations).” (African Health Observatory, 2014, para. 1). Sierra Leone is making attempts to better their health care system by implementing policies like the Free Health Care Initiative and the Basic Package of Essential Health Services (African Health Observatory, 2014, para. 2). These policies have been put in place in order to better the health of women and children. The Free Health Care Initiative is a donor-backed initiative created by the government of Sierra Leone to give free healthcare to “pregnant women, new mothers, and children under five.” (Health Poverty Action, 2010, p. 1). The Basic Package of Essential Health Services “is aimed at the achievement of a reduction in maternal and child mortality by 30% in 2010. It will be the basis of service delivery in all primary and secondary health care services.” (Government of Sierra Leone Ministry of Health and Sanitation, 2010, p. 13). (See Appendix B).

These two policies are advancing the presence of health care in Sierra Leone. Since these policies have been put in place, the health of citizens has changed drastically. “The introduction of the Free Health Care Initiative increased the health service coverage in 2010. The number of children coming for care at the health facilities increased by 2.5-fold. Antenatal care attendance increased by 3-fold and the proportion of women delivering in institutions reached 54% in 2010. However, maternal and child health status is still poor and the prevalence of major communicable diseases is high. To reverse the downward trend, it is necessary to strengthen community sensitization and improve the quality of services provided at antenatal care centres.” (African Health Observatory, 2014, para. 5). While there have been great strides in the health care sector, there is still much to be done. Sierra Leone is lacking in human resources, equipment, and infrastructure. “With regard to human resources, the total workforce in the public health sector increased by 13.4% from 7,164 in 2009 to 8,125 in 2010. However, only six

of the 11 targets of this strategic objective were partially achieved. The major challenge here is a lack of appropriate technical assistance guidance at national and international levels, especially as delays have been experienced in getting support from technical partners, including WHO.” (African Health Observatory, 2014, para. 6). The government of Sierra Leone has also begun to invest in drug and medical products. This investment is a step in the right direction for Sierra Leone as it will make these products and medicines more affordable for the citizens, as most live below the poverty line (African Health Observatory, 2014). (See Appendix B).

While the Central African Republic, Myanmar, and Sierra Leone are beginning to take steps in the right direction, there is still a long road ahead. The current state of the economics, demographics, and government in each of these countries does impact their ability to advance. Many of the programs that these countries are beginning to put in place may seem similar to that of the programs in place in France, Italy, and San Marino. The programs that have been put in place by the Central African Republic, Myanmar, and Sierra Leone are beginning to set the foundation for universal health care system development in these countries. If these developing nations can achieve universal health care, they will be able to have more productive and successful societies. These societies, in turn, will allow them to advance from their developing nation classification to the title of developed nation.

Description of the United States of America Health Care System

According to “Measuring Overall Health System Performance for 191 Countries”, the United States of America is ranked 37 of 191 countries (Tandon et al., 2000, p. 18). In order to understand the current state of the United States of America’s health care system, one must first understand the demographics, economics, and government of the country.

The United States of America is a constitutional federal republic with a population of 326,625,791 people. The median age in the United States of America is 38.1 years and the infant mortality rate in the United States of America is fourteen deaths per one thousand live births (Central Intelligence Agency, 2018g). The United States of America's Gross Domestic Product in Purchasing Power Parity, in US dollars, is 18.62 trillion dollars. The Gross Domestic Product per capita in Purchasing Power Parity, in US dollars, is \$57,600. The United States of America currently spends 17.1% of their Gross Domestic Product on health expenditures (Central Intelligence Agency, 2018g). The labor force of the United States of America is 159.2 million people and the unemployment rate is 4.9%. The external debt of the United States of America, in US dollars, is 17.91 trillion dollars and 15.1% of the population lives below the poverty line (Central Intelligence Agency, 2018g). (See Appendix A).

The health care system of the United States of America is quite complex. Currently, the health care system of the United States of America is quite ambiguous. The United States of America does not use a universal health care system. In 2010, the Affordable Care Act was signed into law by President Barack Obama. The Affordable Care Act is also known as "Obamacare". The Affordable Care Act "established 'shared responsibility' between the government, employers, and individuals for ensuring that all Americans have access to affordable and good-quality health insurance." (The Commonwealth Fund, 2017a, para. 1). While the Affordable Health Care Act was a step towards a more universal health care, there are still 27.6 million people in the United States of America that do not have health insurance (Kaiser Family Foundation, 2017, para. 3). In the United States of America, the Centers for Medicare and Medicaid Services administers Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Medicare is a federal entitlement program for adults 65 and older

and some people with disabilities. Medicare is federally funded through taxes that are removed from the paychecks of all who are employed. Medicaid and CHIP are federal and state funded programs that provide health services to the impoverished population of the United States of America (The Commonwealth Fund, 2017a). These programs work with the federal government to provide specific populations with the health care that they need. (See Appendix B).

The Affordable Care Act has three main goals. The first goal is to “make affordable health insurance available to more people. The law provides consumers with subsidies (“premium tax credits”) that lower costs for households with incomes between 100% and 400% of the federal poverty level.” (U.S. Centers for Medicare & Medicaid Services, 2018, para. 1). The second goal is to “expand the Medicaid program to cover all adults with income below 138% of the federal poverty level.” (U.S. Centers for Medicare & Medicaid Services, 2018, para. 1). The final goal is to “support innovative medical care delivery methods designed to lower the costs of health care generally.” (U.S. Centers for Medicare & Medicaid Services, 2018, para. 1). These three goals are creating a foundation for the creation of a universal health care system for the United States of America. (See Appendix B).

Recently, the Affordable Care Act has come under scrutiny by President Donald J. Trump. President Donald J. Trump has made plans to replace the Affordable Care Act. President Donald J. Trump has proposed the Better Care Reconciliation Act, also known as, “Trumpcare”. There are many differences between Obamacare and Trumpcare. The two acts vary in the categories of taxes, individual mandates, employer mandates, pre-existing conditions, subsidies, cost-sharing, financing of Medicaid, and the expansion of Medicaid (Lee, 2017). While most of the changes are not very major, some will make an impact on the health care system and the economy of the United States of America.

While there are many public sources of health care available in the United States of America, they vary from the large amount of private insurance available. “Private insurance is regulated mostly at the state level. In 2014, state and federally administered health insurance marketplaces were established to provide additional access to private insurance coverage, with income-based premium subsidies for low and middle-income people. In addition, states were given the option of participating in a federally subsidized expansion of Medicaid eligibility” (The Commonwealth Fund, 2017a, para. 2). States were given this option due to the fact that some of the funding for Medicaid comes from the states individually. Private insurance is more prevalent than public insurance in the United States of America. “In 2016, private health insurance coverage continued to be more prevalent than government coverage, at 67.5 percent and 37.3 percent, respectively. Of the subtypes of health insurance coverage, employer-based insurance covered 55.7 percent of the population for some or all of the calendar year, followed by Medicaid (19.4 percent), Medicare (16.7 percent), direct-purchase (16.2 percent), and military coverage (4.6 percent).” (Barnett & Berchick, 2017, para. 4). (See Appendix B).

While many Americans are insured, there is still a large population of Americans that are uninsured. In early 2016, 27.3 million individuals were uninsured, which equates to 8.6% of the population. These numbers had decreased from 9.1% in 2015. (The Commonwealth Fund, 2017a, para. 4). The large uninsured population has caused some problems in the country as many of the uninsured need care and they cannot afford it and, therefore, do not seek it out. This can create even larger issues. If a person has a medical problem that they ignore due to the inability to afford care, it can develop into a larger, more expensive problem. In the end, the cost of this care could be absorbed by the government leading to more debt and the need to expand the percentage of the Gross Domestic Product spent on health expenditures.

The health care system of the United States of America offers many services to the public. “The ACA requires all health plans offered in the individual insurance market and small-group market (for firms with 50 or fewer employees) to cover services in 10 essential health benefit categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health services and substance use disorder treatment; prescription drugs; rehabilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including dental and vision care. Each state determines the range and extent of specific services covered in each category by selecting a benchmark plan that covers all 10 categories; most states choose one of the largest small-group plans as the benchmark.” (The Commonwealth Fund, 2017a, para. 7). The services offered can vary as some private insurers prevent their customers from leaving their network of providers. This can prevent someone from getting the care that they need as those who are within the network of providers may not have the capabilities to treat the patient and the patient would be penalized and have to pay more for an out of network provider (The Commonwealth Fund, 2017a, para. 7). Those who use Medicare also see a difference in access to services as Medicare provides some, but not all of the services listed on the Affordable Care Act. (See Appendix B).

Recommendations for Changes to the United States of America Health Care System

While no health care system is perfect, the health care system of the United States of America has a long way to go in order to reach a more universal health care system. In order for the United States of America to reach a universal health care system, the country should look to countries like France, Italy, and San Marino for inspiration. Not only should the United States of America look to the highest ranked countries for inspiration, they should also look to the lowest

ranked countries for inspiration as well. There are many aspects of the health care systems in France, Italy, and San Marino that the United States of America could utilize, or slightly modify to advance the country towards a more universal health care system. If the United States of America were to take an approach to healthcare more like that of France, there could be better health care coverage across the nation.

If the United States of America used the universal coverage that France uses, and have citizens pay into the system through a variety of platforms. This format would allow all citizens of the United States of America to get the health care that they need, at a cost that they can afford. The elimination of competing insurance companies could hurt the United States in terms of jobs provided by insurance companies, but if all of the insurance companies were combined into one large public insurance company, it would allow people to keep their jobs, and offer more coverage to citizens across the country. “First, the French experience demonstrates that it is possible to achieve universal coverage without a ‘single-payer’ system. To do this, however, will require a statutory framework and an active state that regulars NHI financing and provider reimbursement.” (Rodwin, 2003, p. 4). An NHI-style framework is possible in the United States of America, but it still would require some changes to the American government. “This suggests that this NHI in the United States could similarly emerge from our patchwork accumulation of federal, state, and employer-sponsored plans so long as we recognize the legitimate role of government in overseeing the rules and framework within which these actors operate.” (Rodwin, 2003, p. 6).

The United States could also learn from Italy. Due to the large amount of private practices in the country, the Italian idea that doctors work “on contract” and earn funds based on the number of patients they see could allow the private practices to run without much change to

their current operations under the Affordable Care Act. The United States of America could also learn from San Marino in that many of the health centers in San Marino offer specialist services internally. Offering specialist services from within reduces the amount of time it takes for doctors to issue referrals and allows patients to receive all of their care in one stop. This could reduce the possibility of patients not following up on referrals, as they may have conflicts with work or other personal matters.

The United States of America can also learn from the lowest ranked countries. The lowest ranked countries give the country an outline of things that the country should avoid. While the lower countries are considered “developing nations”, human health does not change. The United States of America should take the health care systems of the lowest ranked countries into account, as they can provide insight into what causes health care systems to perform poorly.

While the health care system of the United States of America is constantly changing, and currently, is quite ambiguous, there is a lot to learn from the other nations of the world. The United States of America is on the verge of laying the foundation for a universal health care system and a few changes to the law could lead to a return to a health care system that provides care based on socioeconomic status, and what citizens can afford. If the United States of America was to develop a more globalist view of health care, the citizens of the country could greatly benefit, and the United States of America could have a more productive and successful populace and nation.

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Appendix A

Health Characteristics by Country

Country Name	Country Ranking (out of 191)	Population	Median Age (in years)	Percent of GDP Spent on Health Expenditures	Infant Mortality Rate (per 1,000 live births)
France	1	67,106,161	41.4	11.5%	3.2
Italy	2	62,137,802	45.5	9.2%	3.3
San Marino	3	33,357	44.4	6.1%	4.3
United States of America	37	326,625,791	38.1	17.1%	14.0
Central African Republic	189	5,625,118	19.7	4.2%	86.3
Myanmar	190	55,123,814	28.2	2.3%	35.8
Sierra Leone	191	6,163,195	19.0	11.1%	68.4

Appendix B

Health Services Offered by Country

Country Name	Country Ranking (Out of 191)	Outpatient Services	Specialist Services	Dental Services
France	1	National Government	Yes - Supplementary	Yes
Italy	2	National Government	Yes - Supplementary	Yes
San Marino	3	National Government	Yes - Supplementary	Yes
United States of America	37	National Government & Private Insurance	Yes	No
Central African Republic	189	NGOs and Donors	N/A	No
Myanmar	190	NGOs and Donors	N/A	No
Sierra Leone	191	National Government	N/A	No