Chapter 1

Global Health in Developed Societies: Examples in the United States, United Kingdom, Sweden, and Israel

Carol Holtz

This chapter will give examples of developed countries and their major health issues and trends. Many of the health issues will be reviewed in greater detail within other chapters of this text. These countries were chosen because they vary in healthcare systems and geographic areas.

Many of the developed countries are currently working on controversial legal, religious, and ethical issues that directly relate to health care and healthcare systems of delivery. Specifically, the following topics address:

- Access to health care for all residents
- Issues of funding for nonlegal residents (illegal aliens) and healthcare services provided by government and nongovernment organizations
- Options for termination of an unwanted pregnancy
- A women’s right to determine what happens to her body (birth control, abortion, contraception, genital mutilation, sexual assault and/or abuse, sterilization, child molestation, prostitution)
- Sex education in schools, clinics, and public health facilities

United States

Location

The United States is located in North America, bordering both the Atlantic and Pacific Oceans, between Canada in the north, and Mexico in the south. It includes 50 states, the District of Columbia, and several territories and possessions.

Population Statistics

The US population as of 2005 was 295,734,000. Tables 1-1 through 1-4 show age distribution, health statistics, ethnicity, and religion.
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**Table 1-1  Age Distribution**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–14 yrs</td>
<td>26%</td>
</tr>
<tr>
<td>15–64 yrs</td>
<td>67%</td>
</tr>
<tr>
<td>65 yrs +</td>
<td>12.4%</td>
</tr>
</tbody>
</table>

Source: CIA, 2005.

**Table 1-2  Population Size and Health Statistics**

<table>
<thead>
<tr>
<th>Statistic</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population growth rate</td>
<td>.93%</td>
</tr>
<tr>
<td>Birth rate</td>
<td>14.14 per 1000 population</td>
</tr>
<tr>
<td>Death rate</td>
<td>8.25 per 1000 population</td>
</tr>
<tr>
<td>Net migration rate</td>
<td>3.31 immigrants per 1000 population</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>6.5 per 1000 live births</td>
</tr>
<tr>
<td>Male life expectancy</td>
<td>74.89 years</td>
</tr>
<tr>
<td>Female life expectancy</td>
<td>80.67</td>
</tr>
<tr>
<td>Fertility rate</td>
<td>2.08 children born per woman</td>
</tr>
<tr>
<td>HIV prevalence rate</td>
<td>.6%</td>
</tr>
<tr>
<td></td>
<td>950,000 people with HIV/AIDS</td>
</tr>
</tbody>
</table>

Source: CIA, 2005.

**Table 1-3  Ethnic Groups**

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White (Caucasian or European-Americans)</td>
<td>77.1%</td>
</tr>
<tr>
<td>Black (African-Americans)</td>
<td>12.9%</td>
</tr>
<tr>
<td>Asians</td>
<td>4.2%</td>
</tr>
<tr>
<td>Native Americans and Pacific Islanders</td>
<td>.3%</td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
</tr>
<tr>
<td>*Hispanic</td>
<td>*13%</td>
</tr>
</tbody>
</table>

* The US Census Bureau does not include Hispanic (Latino) as a separate category because a Hispanic (Latino) can be of any race or ethnic group, yet 13% identified themselves as Hispanic, making this the largest minority group in the United States.

Source: CIA, 2005.
Economy
The United States has the largest and most technologically powerful economy in the world with a per capita GDP of $40,000 annually. It is a market-oriented economy. Twelve percent of the population lives below the poverty line. The unemployment rate is approximately 5.5%, but rates vary among ethnic groups, gender, socioeconomic groups, and geographic locations. It is the leading industrial power of the world, highly diversified and technologically advanced. Its products include steel, petroleum, motor vehicles, aerospace, telecommunications, chemicals, electronics, food processing, consumer goods, lumber, and mining. Products include wheat, corn, other grains, fruits, vegetables, cotton, beef, pork, poultry, dairy products, forest products, and fish (CIA, 2005).

Health Trends and Issues
Monitoring the health of any country is essential for identifying and prioritizing public health and research needs. It is necessary for identifying important information such as diseases and conditions and for determining new health policy priority areas, funding, and programs. The overall health of the United States is improving because of funding devoted to health education, public health programs, health research, and health care. During the past 50 years many diseases have been eradicated or greatly controlled. Heart disease deaths have declined because of public health education emphasizing healthy lifestyles, such as decreasing cigarette smoking, lowering cholesterol through medications and diet, and new technology in heart procedures and surgery. In spite of the 1964 Surgeon General’s report published over 40 years ago, 25% of men and 20% of women in the United States continue to smoke. With respect to infectious diseases, HIV/AIDS rates have declined because of new antiretroviral medications. Home, workplace, and motor vehicle safety have also helped to extend lives by lowering unintentional injuries for adults and children. Rates of acute infectious diseases of children such as measles, mumps, and rubella have decreased due to immunizations (CDC, 2004a).

### Table 1-4 Religions

<table>
<thead>
<tr>
<th>Religion</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protestant</td>
<td>52%</td>
</tr>
<tr>
<td>Roman Catholic</td>
<td>24%</td>
</tr>
<tr>
<td>Mormon</td>
<td>2%</td>
</tr>
<tr>
<td>Jewish</td>
<td>1%</td>
</tr>
<tr>
<td>Muslim</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>10%</td>
</tr>
<tr>
<td>None</td>
<td>10%</td>
</tr>
</tbody>
</table>

Source: CIA, 2005.
Although the United States is the most developed nation with a state-of-the-art healthcare system of delivery, it is important to note that the United States does not have the longest male and female life expectancy rate. For example, in 1999, life expectancy in Japan was 3 years longer for men and 4 years longer for women than the US life expectancies. In 2002 the infant mortality rate actually increased for the first time since 1958. Overweight, obesity, and physical inactivity are currently significant risk problems for adults and children and lead to chronic diseases such as diabetes, hypertension, and heart disease. For the first time ever, children are developing significantly high rates of type 2 diabetes. Overall rates for cancers have declined since the 1990s for males and have remained stable for females. For people over 65, activities of daily living (ADLs) have not declined since 1992 (CDC, 2004).

The National Governor's Association reports that the US healthcare system is not cost-effective for the amount of money spent yearly. The United States spends more than any other developed country ($1.7 trillion annually) in the world, which is equal to $5267 per person on health care. Neither public nor private funding can be sustained indefinitely. As costs continue to go upward, fewer people will be able to afford private health insurance and will need to apply for Medicaid and the State Children's Insurance Program (SCHIP) or Medicare (National Governors' Association, 2005).

The United States clearly is the leader in healthcare spending, as a percentage of GDP, as compared to other developed countries (see Figure 1-1).

A growing number of Americans, often referred to as the working poor, are caught in the middle by earning too much money to be eligible for Medicaid, not old enough for Medicare, and also can not earn enough to pay for a private healthcare policy. In addition

![Figure 1-1](image)

**Figure 1-1** The United States exceeds other industrialized nations in total health spending as a percentage of GDP.

to cost, the problem is accessing health care. Many other industrialized countries, such as Iceland, Japan, and Sweden, spend less money and have even better health care than the United States. The National Governors’ Association (2005) believes that the United States must increase the total efficiency of the healthcare system.

Tables 1-5 and 1-6 compare US male and female life expectancies with other selected developed countries.

US infant mortality in 2001 was the fifth highest of industrialized countries, with 6.8 deaths per 1000 live births, compared to Iceland, with the lowest rate of 2.7 deaths per 1000 live births. The United States also has one of the highest rates of all types of cancers also one of the highest obesity rates. In 2003 the United States reported deaths from medical errors ranging from 44,000 to 98,000. State governments are working towards developing an improved information technology system that will help make more efficient healthcare services to not only enhance patient healthcare delivery, but also to restructure medical data that could be better standardized, stored, and shared more easily. For more effective surveillance systems and research studies, healthcare providers could be rewarded for high quality and effective care. Consumers could make more informed decisions about choices of healthcare providers to compare prices with quality of services. Under certain circumstances the government has the potential to influence others to extend coverage to those who are currently uninsured (National Governors’ Association, 2005).

**TABLE 1-5  Male Life Expectancies in Selected Developed Countries for 2001**

<table>
<thead>
<tr>
<th>Country</th>
<th>Life Expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>74.4 yrs</td>
</tr>
<tr>
<td>Iceland</td>
<td>78.3 yrs</td>
</tr>
<tr>
<td>Japan</td>
<td>78.1 yrs</td>
</tr>
<tr>
<td>Sweden</td>
<td>77.6 years</td>
</tr>
</tbody>
</table>


**TABLE 1-6  Female Life Expectancies in Selected Developed Countries for 2001**

<table>
<thead>
<tr>
<th>Country</th>
<th>Life Expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>79.8 yrs</td>
</tr>
<tr>
<td>Japan</td>
<td>84.9 yrs</td>
</tr>
<tr>
<td>Switzerland</td>
<td>83 yrs</td>
</tr>
<tr>
<td>Spain</td>
<td>82.9 yrs</td>
</tr>
</tbody>
</table>

Population Characteristics

The racial and ethnic composition of the United States has changed. The Hispanic (Latino) population and Asian and Pacific Islander ethnic groups have grown rapidly in the past 10–20 years. In 2002, the Hispanic population became the largest ethnic minority, representing 13% of the total population, and the Asian population made up 4% of the US population. During the past 50 years the US population of adults age 75 and older grew from 3% to 6%, and by 2050, the older adult population is projected to make up 12% of the US population. In 2002, greater than 50% of African-American and Hispanic children and those older than 65 years lived at or near poverty levels (CDC, 2004a).

Leading Health Indicators and Causes of Deaths

The following are the leading health indicators by rank order (CDC, 2002a):

- Physical activity
- Overweight and obesity
- Tobacco use
- Substance abuse (drugs and alcohol)
- Responsible sexual behavior
- Mental health
- Injury and violence
- Environmental quality
- Immunizations
- Access to health care

Table 1-7 gives the 10 leading causes of deaths in the United States in rank order.

Utilization of Health Care

The CDC (2004b) related that the US healthcare system has undergone a dramatic change over the last decade. New technology, drugs, procedures, and tests have changed the manner in which care is delivered. The growth of ambulatory surgery has been influenced by improvements in noninvasive and minimally invasive techniques. The growth of managed care and payment by insurers and other payers has been an attempt to control healthcare costs, which has also had a major impact on healthcare utilization.

The following are factors that decrease the utilization of health care (CDC, 2004a):

- Decreased supply of hospitals and healthcare providers
- Improvement in public health and sanitation, such as cleaner water
- Better public health education of risk factors and methods to make behavioral changes to reduce risks
• New treatments or cures for diseases
• Public policy or guidelines that recommend decreased utilization
• Shifts of care sites, such as from inpatient to outpatient surgery
• Payer pressures to decrease costs
• Changes in practice patterns, such as those that emphasize more self-care, alternative sites, or alternative medicine

The following are factors that increase the utilization of health care (CDC, 2004a):
• Increased supply of healthcare facilities and providers
• Population growth
• Aging population
• New procedures and technologies
• Guidelines or policies that recommend increased utilization
• New threats, such as HIV or bioterrorism
• New drugs
• Increased healthcare coverage
• More aggressive treatments for patients
• Changes in consumer demand, such as cosmetic surgery and hip replacements
Many types of preventive care or treatment of illnesses are performed at an increasing rate in outpatient clinics or physicians’ offices. For example, the use of prenatal care services, which begins in the first trimester of pregnancy, has been steadily rising. Children are receiving their childhood immunizations at a high level. The chickenpox vaccine (varicella) has been widely distributed as well. Women are getting Pap smears and mammograms at increasing rates, and older adults are increasingly getting vaccines for influenza and pneumonia (CDC, 2004a).

On the other hand, inpatient utilization health care has been declining. Admissions and length of hospitalization stays have decreased. Many procedures that used to be done within the hospital are now done in clinics, physicians’ offices, outpatient surgery centers, and rehabilitation centers, leaving more complex procedures and illnesses to be treated within the hospital. Inpatients now have higher acuity levels whereas inpatient mental health treatment has significantly declined (CDC, 2004a).

Access to Health Care and Disparities in Access

The best health care in the world is meaningless for those who do not have access to health insurance coverage or who cannot afford it. The continued increases in healthcare costs combined with economic changes have caused a number of US residents to be without any health insurance, giving them less access to health care.

With respect to healthcare cost, the highest expenditure is partly due to prescription drugs. In spite of the great expenditure, accessing health care is dependent on many variables. These include the supply of healthcare providers and the ability to pay for the services. Between 1994 and 2002, 16–17% of the US population younger than 65 years of age had no health insurance. In 2002 individuals with private insurance decreased, and those with Medicaid increased, with no significant changes for the rates of the uninsured. In 2002, 11% of children under 18 years lacked health insurance. Working males are less likely than working females to have health insurance (CDC, 2004a).

The United States has been growing more racially and ethnically diverse. Residents also are living longer. The National Center for Health Statistics (CDC, 2004a) describes major areas where disparities exist between race and ethnicity and socioeconomic status. Those residents who live in poverty are more likely to be in poor health and less likely to receive adequate health care. Poor people were four times more likely to have psychological stress. There are large disparities in infant mortality rates and life expectancy rates between those in poverty and others in the remainder of the population. In addition, adults under 64 years who are Latino or Native American (American Indian) are more likely to be uninsured than those in other racial or ethnic groups. Diseases or medical conditions such as diabetes or obesity increase with age and are more likely to be found in non-Hispanic blacks and Latinos than non-Hispanic whites (European-Americans). Some of these disparities may be the result of socioeconomic status, culture and health practices, stress, environmental exposures, discrimination, and access to health care (CDC, 2004a).
Health and health care are unevenly distributed in the United States. Underrepresented minorities are less likely than the majority population to have good health care and health (see Table 1-8) and have fewer opportunities to access diagnostic procedures and tests, surgical procedures, and therapeutic medications.

Petersen, Wright, and Peterson (2002) studied African-American and Caucasian patients and interventional cardiac procedures and found that African-Americans had far fewer cardiac interventions and procedures.

Dr. David Satcher (former US Surgeon General) and colleagues (2005) reported that from 1960 to 2000, the United States made progress in decreasing the black-white gap in civil rights, housing, education, and income, but inequality still exits in health care and general health status. A study conducted by Callahan and Cooper (2005) reveals that young adults who were 19–24 years old are the most likely to be uninsured in the United States. The researchers collected data from 11,866 subjects. Results indicate that 27% of women and 33% of men had no health insurance. Almost one third of the young adults are uninsured. Only half of the employers of this group pay any health insurance for their employees. The consequences for this group of noninsured people are that these young adults are at the highest risk period for unintended pregnancy, sexually transmitted diseases, substance abuse, injuries, and other chronic medical diseases. Uninsurance in adults is related to less frequent healthcare screenings, delayed diagnosis of illnesses such as cancer, poor care for chronic diseases, and higher rates of mortality when hospitalized. This study also found that Latino young adults were more likely to be uninsured than any other ethnic group.

There are significant disparities in accessing health care in the United States depending on race, ethnicity, and socioeconomic status. Those living in poverty are significantly less likely to access health care and are generally in poorer health than others. In addition,
those in poverty are four times more likely to have serious mental health problems. Infant mortality rates and life expectancy rates also differ among racial and ethnic groups (CDC, 2004a). The United States does ration health care by not providing universal coverage to its entire population, but rather relies on a market economy to adjust supply and demand. The United States provides less access to health care to more people than any other developed country. Those who get charity treatment are most likely to get less than adequate health care (Lamm & Blank, 2005).

Reschovsky and Staiti (2005) conducted a study that addressed both physicians’ and patients’ perspectives on quality of health care for rural America as compared to urban America. Data were collected from 12,406 physicians and 59,725 patients, representing 48 US states. Results of the study indicate that rural areas had far fewer physicians than urban areas, but the overall perception was that health care was adequate for this area. A decreased rural supply of healthcare providers did not necessarily mean lower quality of care. Because of a lower population density and fewer physicians, patients in rural areas often had to travel longer distances for care, wait longer for appointments, and wait longer in doctors’ offices, yet there were no perceived differences of unmet medical needs within the two groups. Nevertheless, physicians in rural areas reported greater difficulty in helping patients (by referral) receive specialty medical care, when needed. This was because of a lack of qualified medical specialists in rural areas. Rural residents were poorer and more likely to lack adequate insurance or be able to pay out of pocket expenses for health care (CDC, 2004a).

Medication Usage
Utilization of medications differs according to third-party coverage (insurance) and availability. Noninstitutionalized Americans increased their drug usage from 39 to 44% from 1988–1994 to 1999–2000. Not only was drug usage higher, but the numbers of drugs used per person also increased. Nearly half of the US population takes at least one prescription medication, and almost 1 in 6 take three or more medications. These medications are predominately for lowering cholesterol to reduce the risk of heart disease, controlling depression, and/or controlling diabetes. Numbers of people taking medications and numbers of medications taken increase with age, with 5 out of 6 people 65 years or older taking at least one medication and nearly half taking three or more (CDC, 2004d).

Fertility
In 2002 birth rates for teenagers continued to decline with 43 births per 1000 women (2002), while birth rates for women aged 35–44 increased. More women are postponing birth for education and careers, and infertility interventions make it more possible for women to give birth at later ages (CDC, 2004a).

Other trends differ by racial and ethnic groups. In 2002, the birth rates for Hispanic (Latina) women ages 15–44 years was 64% higher than for non-Hispanic white women,
with 94.4 births per 1000 Hispanic women as compared to 57.4 per 1000 white women (CDC, 2004a).

Health Behaviors

Cigarette smoking in the United States has decreased to 25% for men and 20% for women. It is strongly associated with low education and low socioeconomic levels. Between 1997 and 2003 teenage smoking had also decreased from 36% to 22%. Smoking during pregnancy, which causes a higher incidence of preterm and low-birth weight babies, declined from 20% in 1989 to 11% in 2002, yet teenage smoking during pregnancy for 2002 was higher at 18%. Low birthrate babies, who have higher risks for deaths or disabilities, have increased in numbers from 7% of all births in 1990 to 7.8% in 2002 (CDC, 2004a).

Cigarette smoking rates are decreasing in the United States and are expected to continue decreasing in the future (see Figure 1-2).

Overweight and obesity has become a nationwide problem among children and adults in all age groups. Obesity causes about 300,000 deaths per year in the United States and is perhaps second only to smoking as a preventable cause of death. Estimates of deaths from obesity are based on body mass index (BMI), which is defined as weight in kilograms divided by height in meters squared. BMI is correlated with body fat and is the measure recommended by the National Heart, Lung, and Blood Institute for use in clinical
much of this problem relates to inactivity and overeating, especially of the high-fat “junk” foods. In 2003, 33.3% of high school students had no moderate or vigorous physical activity, females having less activity than males. Within the adult population 20–74 years of age, obesity increased from 47% in 1976–1980 to 65% in 1999–2002. Obesity across the lifespan also varies by race and ethnicity. In 2002, 50% of non-Hispanic African-Americans, 39% of Mexican-Americans, and 31% of non-Hispanic white adults were obese. From the time period of 1976–1980 to the time period of 1999–2002, the rates of overweight and obesity in children 6–11 years of age went from 7% to 16%, and for adolescents 12–19 years, the obesity rate more than tripled from 5% to 16%, respectively (Flegal, Williamson, Pamuk, & Rosenberg, 2004; CDC, 2004a).

According to the CDC statistics, overweight and obesity are clearly rising for all age groups (see Figure 1-3).

Alcohol use for those 18 years and older was reported by 41% of males and 20% of females, with the most common usage by 18–24 year olds. Illegal drug use among 12–17 year olds was 12% in 2002. Males 26–34 years had a rate of 222 per 100,000 for cocaine-related visits to emergency rooms (CDC, 2004a).

![Figure 1-3](image-url)

*Age-adjusted by the direct method to the year 2000 by U.S. Bureau of the Census estimates using the age groups 20–39, 40–59, and 60 years and over.

**Figure 1-3** Age-adjusted* prevalence of overweight and obesity among US adults, age 20 years and over.

*Source: CDC, 2004.*
Morbidity

Morbidity (disease rate) includes the limitation of activities due to chronic illness. The rate was 6–7% for children under 18 years during 1997–2002. As adults age morbidity caused by chronic illness increases. In 2002, 14% of those 65 years and older were limited in at least one ADL (CDC, 2004a).

Mortality (death rate) reflects the statistics of life expectancy and infant mortality. They are the key measures to evaluate the overall health standard of a population. For the United States there is an upward trend in life expectancy. The total population life expectancy increased from 74.5 years in 1990, to 77.4 years in 2002. Yet, also in 2002, the infant mortality increased from 6.8 per 1000 live births to 7 per 1000 live births. Racial and ethnic disparities are evident in mortality statistics. A national health objective for 2000 was to reduce the infant mortality rate (IMR) in the United States to 7 per 1000 live births, and for 2010 further reduce the rate to 4.5 infant deaths per 1000 live births. In addition, a goal was to erase the racial and ethnic disparities of infant mortality. When examining the subregions of the United States (see Tables 1-9 and 1-10), the infant mortality disparity rates are evident (CDC, 2004a).

Despite the fact that Americans smoke less and have lowered their cholesterol and that deaths from heart disease and stroke are declining in the general population, deaths are not declining within specific racial and ethnic groups in the United States. Those who have no change in health statistics are African-Americans, Hispanics (Latinos), those who are poor, and those with less than a high school education. African-American men and women have the highest rates of hypertension, diabetes, and hospitalizations for stroke. African-American women also have higher rates of obesity. Hispanics (Latinos) were most likely to lack health insurance, have influenza or pneumonia vaccines, and had the poorest rates of good health. Native Americans (American Indians) had the highest rates of cigarette smoking and alcohol use. Reasons for the disparities include access to health

TABLE 1-9 US Regions with High Infant Mortality Rates (2002)

<table>
<thead>
<tr>
<th>US State/Region</th>
<th>Per 1000 live births</th>
</tr>
</thead>
<tbody>
<tr>
<td>District of Columbia</td>
<td>13.5</td>
</tr>
<tr>
<td>Mississippi</td>
<td>10.4</td>
</tr>
<tr>
<td>Alabama</td>
<td>9.7</td>
</tr>
<tr>
<td>Louisiana</td>
<td>9.5</td>
</tr>
<tr>
<td>South Carolina</td>
<td>9.3</td>
</tr>
</tbody>
</table>

National infant mortality rate = 7 per 1000 live births

Source: CDC, 2004a.
care, trust of the healthcare providers, cultural and language barriers, and genetic predisposition to heart diseases and stroke (Young, 2005).

Child Health

Wise (2004) revealed the following about the determinants of child health in the United States. In 2002 about 17% of all children and 18.5% of those under 6 years lived in poverty with incomes below 100% of the federal poverty level ($14,348 in 2002). Half of those living in poverty live at 50% of the federal poverty level, placing them within the “severely poor” group. Children who are poor disproportionately suffer more problems with low birth weight and overall higher infant and child mortality and morbidity rates. Medicaid eligibility expansion for poor children and the State Children’s Health Insurance Program (SCHIP) for poor children eligible for Medicaid have made a significant difference in facilitating access to health care for poor children.

Almost 60% of all deaths in childhood occur during the first year of life, and 40% of all deaths in childhood occur during the first month of life. Death in newborns is usually from prematurity, low birth weight, congenital anomalies, or other genetic disorders. The United States has increased the survival rates of premature babies mainly through advances in technology and the neonatal intensive care units. In spite of this advanced technology the United States still does not rank among the best in infant mortality rates among developed countries. This is mainly because of the high rate of premature births in the United States. With the ever-increasing rates of survival of premature babies also comes long-term health problems. African-American babies continue to have twice the infant mortality rates as Caucasian babies. The difference is attributed to the higher rates of low birth weights and premature babies of African-American women who live in poverty (Wise, 2004).

<table>
<thead>
<tr>
<th>Race/Ethnic Group</th>
<th>Per 1000 live births</th>
</tr>
</thead>
<tbody>
<tr>
<td>European-Americans (whites) (non-Hispanic)</td>
<td>7</td>
</tr>
<tr>
<td>African-Americans (blacks)</td>
<td>13.9</td>
</tr>
<tr>
<td>Hispanics</td>
<td>5.9</td>
</tr>
<tr>
<td>Asian/Pacific Islanders</td>
<td>5</td>
</tr>
<tr>
<td>American Indian/Alaskan Natives</td>
<td>9.1</td>
</tr>
</tbody>
</table>

Source: CDC, 2004a.
The US mortality rates for children have fallen sharply during the past few decades. The greatest reduction has been from prevention and treatment of acute infectious diseases. Deaths from unintentional injury remain the leading cause of childhood death at present in the United States. Children having complex chronic conditions have the second highest death rates. Hospitalization costs for children ages 1–18 (from highest to lowest in cost) are from the following causes: asthma, mental disorders, trauma, respiratory infections, ear infections, other infections, epilepsy, diabetes, and congenital anomalies. Mortality rates for African-American male adolescents (15–19) rose dramatically, mainly because of homicide and suicide. In addition African-American children also had significant death rates from sickle cell disease (Wise, 2004).

Child health outcome trends (according to a study by the National Health Interview Survey of 40,000 households) revealed that little has changed in the rates from the years 1962 to 2000 of children with acute illnesses (any disease that requires restriction of activity for less than 3 months). For young children the rate remained stable and declined slightly for school-aged children. For chronic illnesses such as asthma, type 2 diabetes, and behavioral disorders, there was an increase in rates during the past several decades. Obesity is now considered a chronic problem with children, also causing other problems, such as type 2 diabetes (Wise, 2004).

The CDC reported that more children than ever had health insurance in 2003, but their parents often had less coverage (CDC, 2004c). More than 70% of indigent children under 18 years are covered by some form of public insurance, either federal or state. Still about 3.9 million children in 2003 did not have any form of health care. More specifically, 12% of Hispanic (Latino) children, 5% of non-Hispanic African-American children, and 3% of Caucasian children had no health care. Also, more than 4 million children aged 2 to 17 years lacked dental care.

Blumberg, Halfon, and Olson (2004) report that the first 3 years of a child’s life are critical for development. Early exposure to malnutrition, viral infections, drugs, and environmental toxins can result in harmful consequences to the neurological development, resulting in alterations in cognitive and emotional development. These effects are not always recognized immediately and may not be discovered until the child is older. Other consequences of exposure to a compromised environment may result in cardiovascular disease or diabetes later in adulthood. Ideally, a child who has a positive caring relationship with parents and other caregivers will have opportunities for learning skills needed throughout the child’s life. Today there are great obstacles that impede the growth of a child towards a safe and healthy life. Children need regular health checkups that include immunizations and treatment for illnesses, intellectual stimulation, as well as good nutrition and a safe and caring home environment.

Health Care for the Older Adult

Lamm and Blank (2005, p. 23) state, “One of the challenges in America’s future is to retire the baby boomer without bankrupting the country or unduly burdening future
generations.” Ways to provide health care and services to the elderly include society (the government) funding of health care or social insurance. The US healthcare retirement system is now unsustainable and healthcare expenditures have grown in the past 40 years to 2.5 times the rate of inflation, which is now greater than 15% of the GDP. About 3 times more is spent on the elderly than on children in the United States.

The most rapidly growing segment of the US population during the past decade is the group of people 65 and older. With the increases in life expectancy, more health care is needed for maintaining and improving quality of life. The United States has made progress in vaccinating 90% of children by the time they are 2 years old, but immunization rates for adults 65 years and older range from 23% to 49% with great racial and ethnic disparities. The US Public Health Service has established a national health goal of 90% immunization rate for older adults by 2010 for influenza and pneumonia vaccines. These can be given in the traditional sites of physician offices or health clinics, but they can also be given in nontraditional sites, such as grocery stores and senior centers. Recommendations from the CDC for immunizations for older adults include (Weber, 2004):

- Tetanus-diphtheria vaccine—All adults, every 10 years
- Influenza vaccine—Adults 50 and older, annually
- Hepatitis A vaccine—Adults at risk
- Hepatitis B vaccine—Adults at risk
- Measles, mumps, and rubella vaccine—Susceptible adults
- Varicella (chicken pox) vaccine—Susceptible adults
- Meningococcal polysaccharide vaccine—Susceptible adults

For older adults, oral health care is not covered by Medicare, and many have difficulty in accessing this care. The well elderly as well as the chronically ill elderly will need good oral care for routine cleaning, problems with tooth loss, dental caries, and periodontal diseases. Periodontal diseases are chronic and can carry organisms and spread endotoxins causing other problems, such as systemic infections. At present there are not enough dentists trained to meet the needs of the elderly nor are there funds for many residents to pay for these services (Lamster, 2004; CDC, 2004e).

In addition to medical care benefits, the federal government also has a federal food and nutrition program for older adults who qualify. The US government appropriates about $1 billion annually for all food and nutrition assistance programs for older adults, funded through the Older Americans Act (OAA). OAA nutrition programs only reach 6-7% of the people who need them. This program is run by the US Department of Health and Human Services of the US Department of Agriculture. The federal government’s special Supplemental Nutrition Program for Women, Infants and Children (WIC) is funded at $5 billion and reaches about 50% of eligible women, infants, and children. This program began in the 1970s (Friedland, 2005a; Wellman, 2004).
Occupational Health

Safety in the workplace continues to be a challenge. In 2002 workplace injury and illness affected 2.5 million people. This includes manufacturing, service industries, and mining, including gas and oil. Mining had the highest death rates with 24 deaths per 1000 employed workers. Pneumoconiosis deaths, which are related to occupational exposures to dust, remain a challenging problem. Fortunately, between 1992 and 2002 the overall occupational injury death rates have decreased 23% to 4 deaths per 1000 employed US workers (CDC, 2004a).

Medical research suffered recently when the medications Vioxx and Bextra were removed from the store shelves when the federal government revealed that the drug companies had overlooked potentially harmful side effects. In addition, there were ethics investigations about medical research conducted for drug companies (Guterman, 2006). Seminario (2003) states that the scope of US workplace injury and illness is enormous. In 2002, there were more than 5000 work-related deaths from traumatic injuries and an estimated 50,000 to 60,000 died from occupational diseases. The number of reported workplace injuries was over 6 million. The Occupational Safety and Health Administration (OSHA) estimated that reported injuries are underestimated by as much as 50%. Much progress has been made in decreasing work-related diseases and deaths. Muscular and skeletal disorders are the biggest sources of problems reported. These come from repetitive motion injuries, which create medical problems such as carpal tunnel syndrome and back injuries.

Occupations with the most repetitive motion injuries are as follows (Seminario, 2003):

- Truck driver
- Nursing aids, orderlies, attendants
- Laborers, nonconstruction
- Assemblers
- Janitors
- Registered nurses
- Stock handlers and baggers
- Construction workers
- Supervisors, sales jobs
- Carpenters
- Cashiers
- Maids and housemen
- Sales workers
- Clerks
- Welders
- Cooks
Villarejo (2003) reported that of US hired farm workers, who are mostly Mexican immigrants, two-thirds of them are living in poverty. Very little data has been collected related to their health issues. At least half are undocumented; only 20% have any health insurance either from the government or their employer. The Federal Migrant Health Program serves about 13% of all workers plus their dependent families. Only 10% receive food stamps or WIC, and 13% receive Medicaid (federal health benefits for those eligible by low income and number of family members, under 65 years, and not able to receive Medicare). Half are under age 29, and 80% are male. Less than half earn below $10,000 per year. Most have only 6 years of education and the majority has access to health care only when absolutely necessary, visiting hospital emergency rooms or clinics. Less than half of the workers have ever been to a dentist. Infectious diseases most often reported were parasites from poor drinking water in work camps, and tuberculosis at a rate six times greater than the general US population. In addition, HIV/AIDS and sexually transmitted diseases were at much higher rates than the general US population.

Complementary and Alternative Medicine

The CDC (2004f) reports that 158 million people in the United States used complementary and alternative medicine (CAM) medical interventions for health, at a cost of $230 million. One study of 31,000 adults conducted by the CDC (2004f) revealed that 36% of the US adult population uses CAM. If prayer for health is also considered, the percent rises to 62%. CAM is defined as a group of diverse medical and healthcare systems, practices, and products that are not at present considered to be part of conventional medicine. When used with conventional medicine, it is considered complementary, and when used alone or in place of conventional medicine, it is considered alternative. Types of CAM include those offered by providers, such as acupuncture and chiropractic, plus others which do not need a provider, such as yoga, massage, special diets, vitamins, herbs, or botanical products. Prayer for health was also included as a type of CAM. The CAM interventions were most often used to treat back pain, colds, neck pain, joint pain or stiffness, depression, or anxiety. Fifty-five percent of US residents use CAM with conventional methods, 26% use CAM at the suggestion of their conventional medical care providers, and 13% use CAM because they believe it is less expensive than conventional medicine. In addition, 28% use CAM because they believed that their conventional medicine was not helping them.

The CDC (2004f) reported that there is some strong scientific evidence from randomized clinical trials for the use of acupuncture and some herbal medicines and manual therapies. More research is necessary to prove the safety and efficacy for other practices and medicinal plants. Unregulated or inappropriate use of some CAM (traditional) medicines or practices can sometimes have harmful effects. For example, the herb ephedra (ma huang in Chinese) is traditionally used to treat respiratory congestion in China, but in the United States it was marketed as a diet additive, which has caused some deaths from heart attacks or strokes. Twenty-five percent of modern medicines are made from plants that
were first used in traditional medicine. Many other traditional medicines from plants or herbs are currently being tested for prospective modern use for malaria, HIV, and sickle cell anemia.

The National Center for Complimentary and Alternative Medicine (NCCAM) of the National Institutes of Health recommends that people who are considering the use of CAM should review the following key points:

- As an informed consumer, review the scientific studies (published in refereed journals) done of the products that are being considered for use.
- Consult a conventional healthcare provider before starting any use.
- Learn more about the background and competency of a healthcare provider who is practicing a therapy such as acupuncture.
- Check for health insurance coverage before starting treatments or care.
- Check about the components or ingredients that make the products and where they come from.
- Check about the safety of the manufacturing process. How do they avoid contamination? The US Food and Drug Administration does not require testing of dietary supplements. If dietary supplements claim to diagnose, treat, cure, or prevent disease, they are considered an “unapproved new drug” which is being sold illegally.

Payment for Health Care

The United States spends $1.7 trillion or almost 15% of the gross domestic product (GDP) on health care. The United States spends $5267 per person on health care, which is 53% more than any other country, as shown in Table 1-11 (Anderson, Hussey, Frogner, & Waters, 2005).

Residents of the United States often must pay higher prices than other developed countries for pharmaceuticals, hospital stays, and physician visits. For example, the cost of an average hospital stay in the United States in 2002 was $2434 compared with $870 in Canada. Some of the possible reasons that the US costs are so high are that: (1) the United States is paying higher prices for health care; (2) the population is aging; (3) other countries have constrained the supply of healthcare resources, especially for elective healthcare procedures, creating long waiting lists and lower costs; (4) the threat of malpractice litigation creates a more costly defensive medicine practice in the United States; and (5) excessive costs of administering of US health care. From 1970 to 2002, the United States had a healthcare policy based on demand of the consumers, better access to new and expensive technologies, and shorter or nonexistent waiting lists. As compared to other Western European countries, the lengths of hospital stays are generally shorter with a greater use of high-technology equipment, such as CTs and MRI scanners. Administrative costs for health care in 2002 include 3% of the total budget for the federal
Medicare program, 6.7% of the federal and state Medicaid program, compared with 12.8% for private insurance programs (Bodenheimer, 2005). During the 1990s the costs of health care were decreased because of decreased payments to physicians and hospitals, but more recently, hospitals increased their market power by consolidation and were able to demand higher prices (Bodenheimer, 2005).

The US healthcare system does not necessarily result in better health care nor patient satisfaction, as compared to other Western European countries that spend much less on health care (Anderson, Hussey, Frogner, & Waters, 2005). The federal government has predicted that with an average growth rate of 7.2% through 2013, costs will be rising from $1.6 trillion (14.9% of the gross domestic product) to $3.6 trillion (18.4% of the gross domestic product) (Bodenheimer, 2005).

The four major factors that make up the healthcare system include: (1) healthcare purchasers, which includes employers, governments, and individuals; (2) medical insurance groups, who receive money from the purchasers and reimburse the providers; (3) governments, who are insurers and purchasers in Medicare and Medicaid programs; and (4) payers, who are both purchasers and insurers. Healthcare providers include physicians, nurses, and other healthcare professionals. Also included are hospitals, nursing homes, home care agencies, and pharmacies. The suppliers include the pharmaceutical, medical suppliers, and computer industries. Each dollar spent on healthcare services is an expense to payers and income to providers and suppliers. Payers would like to reduce healthcare costs, and providers and suppliers generally resist cost containment (Bodenheimer, 2005).

### Table 1-11 Per Capita Expenditures on Health Care by Selected Nations (2005)

<table>
<thead>
<tr>
<th>Country</th>
<th>Per Capita Expenditure in US Dollars</th>
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<tbody>
<tr>
<td>United States</td>
<td>5267</td>
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<tr>
<td>United Kingdom</td>
<td>2160</td>
</tr>
<tr>
<td>Canada</td>
<td>2931</td>
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<tr>
<td>Japan</td>
<td>2077</td>
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<tr>
<td>Norway</td>
<td>3083</td>
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<tr>
<td>Switzerland</td>
<td>3446</td>
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<tr>
<td>Sweden</td>
<td>2517</td>
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<tr>
<td>Mexico</td>
<td>553</td>
</tr>
<tr>
<td>Turkey</td>
<td>446</td>
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Seventy-five percent of people in the United States who are under 65 have private health insurance, which is mainly obtained through the place of work. Health insurance is usually provided through a managed care organization such as a health maintenance organization (HMO), preferred provider organization (PPO), and point of service plans (POSs). For those over 65 years, and for those who are disabled, Medicare, a federally funded program, provides health care. Medicaid, a federal and state governmentally funded program, provides health care for low-income individuals and families (CDC, 2004a). There were 15.2% or 43.6 million within the US population in 2003 without any form of health insurance. Working age adults were more likely than children or older adults to lack coverage for health care. The minority population of the United States disproportionately lacks health insurance coverage. In 2003 about 33% of Latino/Hispanics lacked any type of healthcare insurance, while 17.4% of non-Hispanic African-Americans, and 11% of Caucasians lacked health insurance (Bodenheimer, 2005).

Medicaid was passed in 1965 under Title 19 of the Social Security Act to assist states to pay for health care for the very poor. It was designed to give states flexibility so that services would be provided for specific groups of people. To be eligible, a person must be aged, blind, disabled, or a member of a single-parent family with dependent children. Some are eligible who make a higher income, but have exceptionally high medical costs. Pregnant woman can be eligible for care with 133% of poverty level income. Also those who participate in adoption or foster care may be eligible. Each state, the District of Columbia, and the US territories have different eligibility programs. In 2004, 42.4 million people were enrolled in this program (Friedland, 2005b).

Sweden

The kingdom of Sweden is a Nordic country in Scandinavia, in Northern Europe. The present king is Carl XVI Gustaf and the prime minister is Goran Persson. It has a subarctic climate and has light all summer and very little light during the winter. It is divided into 21 different counties, each with a county administration board and a county council. Each council is divided into many municipalities. In 2004 there were 290 municipalities in Sweden. Sweden has a very high standard of living because of its high-tech capitalism and an extensive social welfare system (Government Offices of Sweden, Ministry of Health and Social Affairs, 2004).

Sweden has one of the highest levels of health care in the world, a very low infant mortality rate, and a high average life expectancy. Those in the population who have chronic illnesses have a good quality of life due to excellent health care. Death rates from diseases such as diabetes and heart disease are declining. The older adult population is growing, and more people are able to live a higher quality of life than in previous years (Government Offices of Sweden, Ministry of Health and Social Affairs, 2004).
The goal of the Swedish healthcare system is for the entire population to have equal access to good health care, which is provided by need, and funded by the Swedish government, representing all of its citizens. The government health welfare system includes health and medical care, care of the elderly, pharmaceutical care, psychiatric care, and dental care. The healthcare system is directed by the Medical Responsibility Board, the Pharmaceutical Benefits Board, the Medical Products Agency, the National Board of Health and Welfare, the Swedish Council on Technology Assessment in Health Care, and the state-owned National Corporation of Swedish Pharmacies (Government Offices of Sweden, Ministry of Health and Social Affairs, 2004).

Health care is administered by 21 different county councils throughout the country. Eighty-nine percent of the councils’ budgets are used for health and dental care. Municipalities are responsible for care of the elderly and psychiatric care. For those needing psychiatric care the municipalities also take care of their housing, employment, and financial support. Healthcare agencies within Sweden consist of 9 regional hospitals, 70 county and provincial hospitals, and 1000 health centers. The costs consist of 9.1% of the GDP, which is equal to $196.8 billion dollars. The out-of-pocket costs paid by patients are about 15% of the total healthcare expenditures (Government Offices of Sweden, Ministry of Health and Social Affairs, 2004).

There are different categories of charges for health care within the Swedish healthcare system:

- **Outpatient healthcare charges**—Charges are for visits to a district nurse, doctor, or specialist. Costs vary among the different councils and depend upon the type of healthcare provider used. The maximum that any one person pays for health visits per year is 900 SEK ($115 US). This maximum cost also includes children under 18 within the same family.

- **Pharmaceutical charges**—The maximum cost per year for medications is 1800 SEK ($230 US). After this cost is reached, a free pass is given, which is good for 12 months from the date of the first purchase.

- **Charges for a portion of dental treatments**—These charges vary depending on the type of treatment and materials used. It also covers orthodontia work.

- **Costs for inpatient care**—When a patient is admitted to a hospital the local council can charge the patient a maximum of 80 SEK ($10.24 US) per day (Government Offices of Sweden, Ministry of Health and Social Affairs, 2004).

Swedes have an extensive social welfare system in which the government pays for child care, maternity and paternity leave, healthcare costs above a ceiling amount, retirement pensions, and sick leave. Parents get 480 days paid leave of absence from their jobs from the time of the birth of a child to his or her eight year. Child care is free and guaranteed for all children 1–5 years old. For the aging adult, the Swedish Social Security Insurance...
Agency provides an old age pension. It also provides for loss of income if a person is unable to work because of illness or is caring for a child (Government Offices of Sweden, Ministry of Health and Social Affairs, 2004). The government is concerned about environmental health and has recently passed a law concerning smoking in public restaurants. As of May 1, 2005, all pubs, restaurants, and cafes are smoke free (2004).

During the 1990s Sweden’s welfare state was in crisis due to economic challenges and lack of political support. Some spending cuts and reforms were made, but the healthcare system was left mostly intact. For the first time, the private healthcare sector competed with the public healthcare providers. The new private healthcare services (5–15% of all health care) began to somewhat undermine the egalitarian system of equal quality health care for all the citizens. At present there are choices of health services, and the more wealthy citizens are using private healthcare services while the others use the traditional public health services (Government Offices of Sweden, Ministry of Health and Social Affairs, 2004).

Statistics
The country of Sweden has a population of 9 million people (Wikipedia, 2004). Its gross national product per capita is $27,271 USD, which is ranked as the 26th highest in the world. Life expectancy at birth is 78 years for males and 83 years for females. Healthy life expectancy is 71.9 years for men and 74.8 years for females. The infant mortality rate (under 12 months) is 3 per 100,000 live births, which is among the lowest in the world. The child mortality rate (under 5 years) is 5 per 100,000 males and 3 per 100,000 females. Total health expenditure per capita is $2512. The total fertility rate is 1.6. Because Sweden has socialized medicine, the government pays 85.3% of the total health expenditure. The remaining 14.7% of healthcare expenditure is paid privately by out-of-pocket payments. About 23% of the population is 60 years old or older (WHO, 2005).

Patient’s Rights
The Swedish healthcare system is responsible for ensuring and maintaining patients’ rights. Information is given to patients about their healthcare problems, treatments, options, and costs. Questions are answered about any other concerns about their health issues. The purpose is to prevent injuries and minimize risks resulting from injury or serious illness. Each council and municipality has a patients’ committee. Patients may report problems to the Medical Responsibility Board (Government Offices of Sweden, Ministry of Health and Social Affairs, 2004).

Dental Care
The dental health of the nation has improved considerably for all age groups during the last few decades. The numbers of children who need tooth fillings has declined as well as the number of older adults who need total tooth extractions. There are still many
differences in level of dental care among county councils. The criteria for good dental care consist of the following:

- Having high standards with a particular emphasis on preventive care
- Satisfying safety concerns
- Being easily accessible
- Respecting patients’ rights
- Having good communication between patients and dental healthcare personnel

Mental Health
The Swedish government takes the responsibility of providing mental health care as a part of basic health and medical care. Patients with slight or moderate mental health needs can get care by primary care healthcare providers. Compulsory mental health care is regulated by the Compulsory Mental Care Act. Patients with serious mental health problems are treated in a special psychiatric care setting, even if they refuse care. This is especially true if he or she threatens the personal safety, physical, or mental health of others. Forensic mental health care provides for care for people who have committed serious crimes and also for those who suffer from mental illness (Government Offices of Sweden, Ministry of Health and Social Affairs, 2004).

Sex Education
Sweden is a pioneer country for family planning for the world. In Sweden attitudes toward teenage sex education are considered liberal. Sex education is a high priority and has been taught in schools since the 1950s. Since 1975, abortion has been free and given on demand. Contraceptive counseling is free, and Planned Parenthood is available in youth clinics. Screening for sexually transmitted diseases is included. Contraception and emergency contraception is low in cost and sold over the counter. Teenage pregnancy is rare. Since the 1990s the economy has been stagnant and rates for teen abortions, sexually transmitted diseases, smoking, and drug use have increased (Edgargth, 2002).

United Kingdom
The United Kingdom of Great Britain and Northern Ireland is a country located in Western Europe. As a member of the European Union, it is usually known as the United Kingdom or UK, or inaccurately known as Great Britain, Britain, or England. The United Kingdom has four parts consisting of England, Wales, and Scotland located on the Island of Great Britain; and Northern Ireland, located on the island of Ireland. The capital and largest city is London. The United Kingdom has a population of 59,553,800 people. As of August 2007, England’s government is headed by Gordon Brown, who is prime minister, and Queen Elizabeth II. The queen’s role is mainly ceremonial. The government is a constitutional monarchy with executive power given to the prime minister (Wikipedia, 2005).
The United Kingdom is a leading world financial power and trading center, with a capitalist economy. The economy is ranked fourth largest in the world, and the United Kingdom has a per capita income of $30,309 (2005 estimate), making it the 16th highest in the world. During the past 20 years the government has decreased private ownership and has continued the growth in the direction of a welfare state. This country produces 60% of its food and needs with only 1% of its labor force. It has coal, natural gas, and oil. Insurance, banking, and other business services contribute to the high per capita income. It is Europe’s largest manufacturer of cars, armaments, computers, petroleum products, televisions, and mobile phones. It is ranked sixth in the world for tourism. Languages spoken are mainly English, but other indigenous languages include Welsh, Scottish Gaelic, Irish Gaelic, Cornish, Lowland Scots, Romany, and British Sign Language (Wikipedia, 2005).

Healthcare System

The National Healthcare System (NHS) was established in 1948 to provide free health care for all residents of the United Kingdom, designed to be free at the point of need, meaning that every time a resident needs to go to the doctor or receive inpatient hospital treatment, it is provided free of charge. This system is funded by federal taxation and run by the Department of Health. In addition there are also private healthcare providers, in which people pay either by insurance or out of pocket at the time of use (BBC, 2005).

The basic concepts are the following (Light, 2003):

- Health care should be “free at the point of service.” No copayments are needed for services.
- Health care is funded through income taxes. The UK people believe that income taxes are more equitable and cost effective than insurance-based health care as in the United States.
- A strong primary healthcare base should be established for the NHS. Every UK resident should be able to choose a physician or healthcare service. The system also provides general practitioners (physicians) incentives to practice in underserved areas.
- Reduction in the inequalities of health care is made. Areas that have greater health problems and are poorer are now getting more funding.
- Bonuses are given to general practitioners who reach population-based targets for health prevention.
- All subspecialists are paid on the same salary scale.
- Basic prescription drugs are price controlled while research for new drugs is rewarded. The government works out an agreement with the private pharmaceutical companies to create price controls for drugs.
During the last few years the private sector has funded some of the buildings and structures within the National Healthcare System, and in addition some local communities are currently making some of their own healthcare decisions. Since 1997 a change in philosophy toward healthcare management has moved toward more partnerships and comprehensive planning. The New Labor government has emphasized cooperation with the competition of the private healthcare systems, better management, and improved organization (Muller, 2002). There are differences in the healthcare system within each country in the United Kingdom. There is a secretary of state for health, who must answer to the UK parliament. The Department of Health is responsible for local planning, regulation, inspection, and policy development. There are also 28 strategic health authorities who manage the health care of their region and are considered the link between the Department of Health and the National Healthcare System (BBC, 2005).

Healthcare services are divided into primary and secondary and are managed by the local NHS organizations called trusts. Primary care is delivered by local general practitioners, surgeons, dentists, and opticians, who are generally called primary trusts. The primary trusts decide the amount and quality of services provided by hospitals. They receive about 75% of the overall NHS budget. In addition they also control hospital funding. The hospitals and specialized services, such as mental health, are managed by organizations called acute trusts. The primary trusts are often outsourced to private companies. Usually the outpatient services such as surgery and ophthalmology generally have long waiting lists. Private health care has similar services, and patients who use this system of care generally pay by private health insurance. Insurance premiums are either paid by employers or individuals who pay out of pocket by themselves. There are over 300 private hospitals in the United Kingdom (BBC, 2005).

The UK healthcare system is currently far from ideal. Light (2003) comments about the current situation of the UK’s NHS, reporting that the current system is no longer sustainable and no longer affordable. If services were limited to only emergency and welfare service it would have been economically feasible. Specialty care services will be united with primary care services. Muller (2002) states that the system is failing to meet expectations because of underfunding and the fact that it is centrally controlled.

Stevens (2004) reports that the National Health Service of England has a healthcare system with outdated old buildings and inadequate equipment. Health professionals consist of 2 physicians per 1000 people as compared to 2.8 in the United States and 3.3 in France and Germany. Long waits exist for routine surgery. In 2003, the UK taxes increased and policy makers began to pay more attention to improving the healthcare system. Recently some issues were identified, and the following changes were made as a result (Stevens, 2004):

- Increase the supply of physicians and nurses. The supply of physicians and nurses was increased by 55%.
Modernize the infrastructure. Hospitals were rebuilt and record keeping, prescriptions, and scheduling went to an electronic system.

Increased in-service learning help for doctors, nurses, and other health professionals to make great improvements in the new knowledge and technology of healthcare delivery.

National standards were made in types of care given to patients. Goals were set to improve health statistics for specific illnesses such as reductions in rates of heart and cancer disease, access to care for all residents, and reductions in infant mortality rates.

For the first time doctors were subject to mandatory relicensing every five years. Quality assurance is used to upgrade standards of care.

Healthcare providers are individually rated by performance and the results are published as public information.

Financial bonuses are given to healthcare providers who are doing an excellent job.

Healthcare funding now goes to primary care trusts directly, which purchases some managed care for patient care.

Patients are given a choice of any provider, which may be public, private, or not for profit.

The NHS will be using the diagnosis related group (DRGs) system for keeping pricing for services more regulated.

The NHS will be accountable to local citizens for its budget, spending, and services.

**Health Issues**

Within the United Kingdom the major health issues are cancer, coronary heart disease, stroke, accidents, and mental illness. New health problems are HIV/AIDS and Creutzfeldt-Jacob disease (Sproston and Primastea, 2003).

Cardiovascular disease (CVD) and stroke are some of the biggest causes of death or disability per year. Life expectancy is 80 years for women and 75 years for men. A goal was set to reduce CVD and stroke death rates for people under 75 by two fifths by the year 2010. In a study conducted by the UK government, 13.6% of males and 13% of females reported a CVD or stroke diagnosis. Incidence increased as household income decreased (poorer people had greater incidence). Stroke is the single largest cause of severe disability and the third most common cause of death in the United Kingdom. Each year 11,000 die of stroke in England and Wales. Most people diagnosed with CVD or stroke took aspirin and lipid-reducing medications (Sproston & Primastea, 2003; Youman, Wilson, Harrarf, & Kalra, 2003).
Diabetes (types 1 and 2) was reported by people over 35 years at the rate of 4.3% for men and 3.4% for women. Incidence also increased as household income decreased (poorer people had greater incidence) (Sproston & Primatesta, 2003).

Hypertension (high blood pressure) was diagnosed in those people with a systolic blood pressure of 140 mm Hg or greater and a diastolic blood pressure of 90 mm Hg or more. The prevalence was 31.7% of men and 29.5% of women. Less than half the informants of the study were on treatment medications. Treatment rates were 46.3% for women and 36.8% for men. Uncontrolled hypertension is the greatest cause of stroke (Sproston & Primatesta, 2003). Lloyd, Schmieder, and Marchant (2003) report that in the United Kingdom about 5.7 million adults, which is 12% of the population over 16 years, have a blood pressure above 160 mm Hg/95 mm Hg. In addition, 10.3 million (21%) have a blood pressure of 140 mm Hg/90 mm Hg. An estimated 58,000 cardiovascular problems occur in these patients because of hypertension, which would not exist if their blood pressure were within normal limits. They concluded that failure to control blood pressure contributes to huge monetary costs to the NHS for treating cardiovascular problems.

Cancer causes problems for one in four people, with the most common form (one third) being lung cancer. Eighty to ninety percent of all lung cancers are from smoking. For women, 20% of cancer is due to breast cancer. England has one of the worst rates of breast cancer in all of Western Europe. Cancer in the United Kingdom is one of the three leading causes of death for all ages, except for preschool children. Cancer causes about 62,000 deaths per year (Sproston & Primatesta, 2003).

Smoking was identified as the single greatest preventable cause of illness and premature death in the United Kingdom. In the United Kingdom the overall smoking rates for all ages are 27% of men and 24% of women. These rates are higher for younger adults and lower for those 75 years or more. In 2004 the Public Service Agreement (PSA) set an objective of reducing adult smoking rates to 21% or less by 2010. Cigarette smoking increases as household income decreases (Sproston & Primatesta, 2003).

Alcohol consumption was reported by 42% of men and 26% of women, who stated that they consumed alcohol at least three days a week. The statistics on alcohol (2004) revealed that in 2002, 47% of men drank more than four units of alcohol at least one day in the previous week, and 22% of women drank at least three units of alcohol one day in the past week. Total expenditure on alcohol was 5.7% of family income in 2003 (Sproston & Primatesta, 2003).

Overweight and obesity were diagnosed for 65.4% of men and 55.5% of women in the United Kingdom. Overweight is defined as 25 kg/m² and obese as over 30 kg/m². Obesity rates were higher in lower-income households (Sproston & Primatesta, 2003).

Accidents account for 10,000 deaths per year in England. England has lower death rates from car accidents than anywhere else in Europe, but rates of death of children from pedestrian accidents are one of the highest in Europe. Road accidents are higher in rural areas than larger cities. Older adults are at risk for death and disability from falls.
Osteoporosis affects more women and contributes to the number of broken bones, especially wrists and hips (Sproston & Primastea, 2003).

Infant and Child Health

The infant mortality rate for the United Kingdom is 6 per 100,000 live births (Youman et al., 2003). Child poverty in the United Kingdom is about 19.4%, as measured by children who are living in households with less than 50% of median income. This compares with 22.4% in the United States, but other developed European countries, such as Sweden, Norway, or Belgium have rates less than 5%. The United Kingdom has experienced high levels of unemployment in the past 20 years. Socioeconomic status (SES) is among the most important health determinants during a person’s lifetime. Poverty and low SES are associated with higher infant and childhood mortality rates, chronic childhood illnesses, and many acute illnesses. In addition there is a close relationship with birth weight and mental health problems (Spencer, 2003). National statistics (2004) reports that children's dental health is much improved. The 2003 Children’s Dental Health Survey found that among 15-year-olds, cavity rates have fallen from 42% in 1983, to 30% in 1993, and to 13% in 2003 (National Statistics, 2004).

Herbal Supplements by Adults

The use of herbal extracts in the United Kingdom especially by older adults has been increasing. A recent survey found that 15% of those older than 65 years used over-the-counter herbal medicine during the last 12 months. The herbs are used to treat existing health problems, prevent illness, and promote general health. Older adults should report the use of herbs to their doctors. Doctors should have good information about potential herb and drug interactions (Canter & Ernst, 2004).

Israel

Israel was created as a nation in May 1948, in the area known as Palestine, which had been ruled by the British from 1920 to 1948 through a charter from the League of Nations. The creation of the nation of Israel resulted as the culmination of the Zionist Movement that began in the 1800s in Europe. Immigrants came mostly from Eastern Europe. After World War II and the Holocaust, larger numbers migrated to Israel. In addition, others came from Arab countries in Asia and Africa.

The country of Israel has a population of 6,433,000 people. Its 2003 GDP per capita was $20,780, and life expectancy was 78 years for males and 82 years for females. The population consists of 80% Jews, who speak Hebrew; 15% Muslims, who speak Arabic (Sunni); and the remainder are Christians and Druze. In the early 1990s a large number of immigrants came from the former USSR, increasing the population by 14%. This immigration doubled the number of physicians as well as the total healthcare needs of the
country. The Arab population has a large number of children (40% under the age of 15) and a small portion of elderly (5.1% are older than 65 years). The Jewish population has 27% of its children younger than 15, and 11.1% of its adults older than 65. The country's older adult population is 9.5% of the total population, which is larger than any country in the European community or the United States. (Infoplease, 2005; Israel Ministry of Foreign Affairs, 2003).

Israel's system of government is a parliamentary democracy, with the highest authority of law run by the Parliament, called the Knesset. The Knesset has 120 members elected by the citizens every 4 years. The executive power is in the cabinet, headed by the prime minister. The head of state is the president, who is elected for a 5-year term. This person has mostly ceremonial duties and minimal authority. Unemployment is 8% for all residents, with a higher rate for the Arab minority population (Israel Ministry of Foreign Affairs, 2002).

Israel has a high rate of literacy (95%). There is free education for all children ages 5–15 years, and postprimary education is also free, lasting another 6 years (Infoplease, 2005; Israel Ministry of Foreign Affairs, 2003). Israel is one of the most highly educated countries in the world with the highest numbers of engineers, scientists, and PhDs per capita (135 per 10,000) (Israel Ministry of Foreign Affairs, 2003).

The agricultural economy is citrus fruits, vegetables, cotton, beef, poultry, and dairy products. Industry consists of high-tech products such as aviation, communications, and electronics, as well as wood and paper products, foods, beverages, tobacco, and diamond cutting. The cell phone and voice mail was originally developed in Israel by the Motorola Company (Infoplease, 2005; Israel Ministry of Foreign Affairs, 2003).

There are international disputes about the Israeli land. The West Bank and Gaza Strip are Israeli occupied, subject to the Israeli-Palestinian Interim agreement. Permanent status is to be determined by further negotiation. The Golan Heights is Israeli occupied, and Lebanon claims the Shab’a Farms of the Golan Heights. The capital is Jerusalem, but the United States and most other countries have embassies in Tel Aviv (Infoplease, 2005).

Culture

Although Israel has residents who differ greatly in racial and ethnic backgrounds, it is still possible to describe the Israeli culture. Israeli cultural values reflect that the family is central to Israeli life with great emphasis on children. Married children often live near their parents and care for their elderly parents. The father is considered the head of the household, but women also have input into family decision making (Israel Ministry of Foreign Affairs, 2002).

The predominant religion is Jewish. Jewish people believe that when death occurs, the body must be buried within 24 hours. Traditionally the body is in a white shroud and the casket is made of wood. Traditional Jewish diets consist of kosher food. The rules of kosher food dictate that only animals with cloven hooves who chew their cud may be
eaten. Slaughtering and preparation of meat must be done in a certain way. Only fish with scales may be eaten, and no shellfish are allowed. Milk and meat may not be eaten in the same meal (Israel Ministry of Foreign Affairs, 2002).

Arab culture is the second most common culture of Israel. An Arab is defined as anyone who was born in an Arab-speaking country and speaks the Arabic language, and shares the beliefs and values of the Arabic culture. Arabs are either Muslim or Christian. Most Arabs value Western medicine and also have other strong beliefs, such as in the evil eye. Arab women are less likely to work outside their homes, due to the cultural practice of staying at home to care for the house and raise the children. When an Arab girl has her first menstrual period (menarche) she is considered a woman. She is not expected to socialize with boys and the family may put greater restrictions as to when she may leave the house and with whom. For the Muslim girl, she may start wearing the head scarf or hijab (Israel Ministry of Foreign Affairs, 2002).

Health Statistics

Israel has been a pioneer in modern public health and is one of the world’s healthiest countries. Israel has absorbed numerous Holocaust survivors who had severe health problems and many immigrants diagnosed with TB, malnutrition, cancer, and heart disease. Many immigrants from the Ukraine and Belorussia were exposed to radiation from the Chernobyl nuclear plant meltdown in 1987 (Israel Ministry of Foreign Affairs, 2002).

Healthy life expectancy at birth is 70.5 years for males and 72.3 years for females for the year 2002. The infant mortality is 5.4 per 1000 live births, higher for Arabs, and lower for Jews and Christians (Looking at Israel Health, 2003). The difference in infant mortality rates among Jews and Arabs is caused by consanguineous marriages among Arabs that produce more congenital abnormalities and also by the lower Arab use of prenatal care services. Arab child mortality is 7 per 1000 children. The fertility rate is 2.9, with a rate of 2.6 for Jews, and 4.6 for Moslems. Total fertility rate is higher in Israel than in all countries in Europe. Total expenditure for health care is $1890 per person, or 9.1% of the GDP (WHO, 2003).

Israel has a highly developed healthcare system with a comprehensive scope of services and high technology, which make it one of the most progressive in the world. The Israeli government has an active role in financing and setting up the network of services. Israel has a high level of immunizations (90%), compared to the European community; it ranks second in immunization rates for polio, sixth for diphtheria, and seventh for measles. Israel’s life expectancy is higher for Jews and women than for Arabs and men. In comparison to European nations it has a very low rate of diseases and deaths due to alcoholism (Israel Ministry of Foreign Affairs, 2002). In 2002 Israel began giving smallpox vaccines to its healthcare workers, police officers, and others who may be in contact with people with smallpox. The HIV/AIDS prevalence rate is .1% for adults ages 15–49 years. About 1.5 to 4.9 per 1000 residents are living with HIV/AIDS (UNICEF, 2003).
Healthcare System

The ministry of health is responsible for licensing, supervising, and planning all health services in Israel. The government has a network of hospitals that represent about 50% of the total hospital beds in the country. These hospitals were developed by the government’s general sick fund, which are presently called General Health Services (GHS). In 1994 the National Health Insurance (NHI) Law was passed to provide health care (health insurance and access) to all residents of Israel. Almost all services are available on a basis of need, rather than the ability to pay. There are four different sick funds available to residents who may choose one they wish. One problem is that the ministry of health does not provide incentives for quality assurance for the sick funds (Israel Ministry of Foreign Affairs, 2002).

Emergency care is available through Magen David Adom (Red Shield of David), a mobile ambulance service, similar to the Red Cross or Red Crescent in other countries. There are 354 general and specialized hospitals as well as a network of outpatient clinics, mother–child health centers, convalescent homes, rehabilitation centers, and school health programs, which include dental care (Israel Ministry of Foreign Affairs, 2003).

Israeli health researchers have made significant contributions in cancer, immunology, cardiology, brain, orthopedic, plastic surgery, and the treatment of burns. Israeli medical technological developments include computerized tomography, pacemakers, and lasers (Israel Ministry of Foreign Affairs, 2003).

Not all of Israel’s residents and neighbors are happy with the system of accessing health care. The Palestinians believe that the new Israeli wall blocks some access to health care. The 10,000 chronically ill Palestinians and 100,000 pregnant women could face great hardships and be put at some risk. Yunis al Khatib, who heads the Palestinian Red Crescent Society, said that Palestinians living in 22 enclaves have been denied access to health care (Aljazeera.net, 2005).

Health Issues

The leading causes of death in Israel are heart disease, cancer, stroke, and injury. One quarter of the population is overweight, and this increases with age. Smoking levels are high, with 33% of males and 25% of females smoking (Israel Ministry of Foreign Affairs, 2002). HIV/AIDS in Israel dropped from a rate of .96 per 1000 in 1990 to .47 per 100,000 in 1996, due mainly to education. Human organ transplants have been performed in Israel since 1964, including kidney, liver, and heart. A national organ transplant center was established in 1993 (Israel Ministry of Foreign Affairs, 2002).

Financing Health Care

National healthcare spending has been steadily increasing. The National Health Insurance (NHI) Law was passed in 1995. Every employer must pay a health tax to finance a portion of his or her employees’ health insurance. This health insurance has a capitation...
formula that puts limits on healthcare spending per person, depending on age, rather than ability to pay. Because care for the older adult is much more costly than younger residents, the sick funds receive 3.5 times more money per person for those 75 years and older than for younger residents. In addition, more money is funded for each person with a diagnosis of thalassemia, Gauche’s disease, end-stage renal disease, multiple sclerosis, and HIV/AIDS. The national funds come from several resources, such as the taxable income from wages, the national budget, and some from out of pocket funds from consumers, which are from copayments. Dental services are not covered by national health insurance. Private physician fees and medications are not covered. The rate of out-of-pocket fees for medical care is among the highest in the European community. Health care covered by the National Health Insurance for all Israeli residents include the following (Israel Ministry of Foreign Affairs, 2002):

- Medical diagnosis and treatment
- Preventive medicine and health education
- Hospitalization (general, maternity, psychiatric, and chronic)
- Surgery and transplants (if medical treatment is not available, treatment abroad will be covered)
- Preventive dental care for children
- First aid and transportation to a hospital or clinic
- Medical services at the workplace
- Medical treatment for drug and alcohol abuse
- Medical equipment and appliances
- Obstetrics and fertility treatment
- Treatment of injuries caused by violence
- Medication, ordered by a health provider from the ministry of health
- Treatment for chronic illnesses
- Physical therapy, occupational therapy, and other therapies

Healthcare Resources

There are 26,000 physicians in Israel, most of whom are salaried employees of hospitals and sick funds. The ratio of physicians to residents is 4.6 to 1000 residents, which is among the highest in the world. One reason is the immigration of many physicians from the former Soviet Union. Primary and secondary health care is provided by sick funds. Mental health, chronic, and long-term care are covered by government funds, but no dental care is provided free of charge. Sick funds resemble the health maintenance organization (HMO) delivery system in the United States. Every permanent resident of Israel is eligible for membership in one of four types of sick funds, and may change from one
type to another once a year. Sick funds must accept anyone regardless of gender, age, or health status (Israel Ministry of Foreign Affairs, 2002).

Reproductive Health
Modern contraception is available and legal. Most who use contraception, use the IUD. Sterilization is seldom used. Abortion is legal under certain circumstances. The Israeli Family Planning Association is run from Tel Aviv. It provides counseling for adults and teens and provides HIV/AIDS educational programs. It has specific training for working with Russian-speaking and Ethiopian immigrants (International Planned Parenthood Federation, n.d.). An estimated 68% of reproductive age adults use contraception of some type (UNICEF, 2003).

Violence and Health Care
A consequence of the daily terror situation in Israel is that residents must address the daily anxiety, stress, and fear directly relating to safety and security. Others must deal with post-traumatic stress syndrome, and for healthcare providers, compassion fatigue. Compassion fatigue relates to the trauma of those who provide care for the victims of trauma (Wiener, 2005). Wiener (2005) also states that since the beginning of the Intifada and until 2003, trauma and deaths have resulted from the Israeli–Palestinian conflict. More than 275 security persons and greater than 650 civilians have been killed by terrorism. In addition, 1700 security persons and over 4400 civilians have been injured by terrorism. These incidences take their toll in psychiatric disorders such as anxiety, stress, depression, and post-traumatic stress disorders.

A study by Aharonson-Daniel, Waisman, Dannon, and Peleg (2003) indicated that a relatively high number of children have been affected by terror-related injuries. They reported that besides the physical damage, the incidents have often dramatically upset the sense of safety, security, and well-being of surviving children. In Israel millions of children use a bus to get to and from school, and many terrorist explosions have occurred on buses or at bus stations. Often whole families are injured at one time. Powell (2004) also describes an organization called Physicians for Human Rights (PHR) representing Israeli and Palestinian physicians who work to promote peace through dialogue. They work with mobile medical clinics to bring health care to Palestinians who can not access care, which includes prisoners in Israeli jails. Under the Geneva Convention the Israeli government is still responsible for the health of Palestinian territories.

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