it is possible to achieve excellence by focusing not on competition but on cooperation, and not on choice but on equity. The basic principles and policies that Finland has adopted are not complicated, and could be implemented almost anywhere. The principle of creating a level playing field that supports every individual—call it the schoolmaster's version of the Nordic theory of love—led Finland to commit to supplying an equally good education to everyone, free of financial considerations. In the end it was the commitment to educational equity that resulted in excellence, not the other way around, and this commitment has placed Finland in an admirable position as it faces the future—a challenge that America, too, must face.

The United States already possesses all the resources and knowledge it needs to improve its schools. The best American schools continue to infuse students with traits that people in other countries envy: energy, creativity, self-confidence, and entrepreneurial spirit. Combining the best of Finnish and American approaches would bring the United States into the twenty-first century and create an education system truly designed for the future. It would allow America to benefit from all its talent, and it would free children and their parents both from worry and unhealthy dependencies. Schools are not the only places that teach us what we need to know in life, but they are the beginning. That beginning needs to be open to all.

FIVE

HEALTHY BODY, HEALTHY MIND

HOW UNIVERSAL HEALTH CARE COULD SET YOU FREE

WELCOME TO BURKINA FASO

It was a sunny Saturday in late April in New York City. The weather was unusually warm, and Trevor and I were planning to head out to the park to enjoy the first taste of summer after a cold winter. But first I sat down and went through the day's mail. An official-looking envelope had arrived for me from Finland. Perhaps it should have worried me, but it didn't.

By then I'd been living in the United States for just under four months. Trevor and I weren't yet engaged, so I didn't know that I would eventually become a permanent resident of the United States. I was still paying taxes to Finland, and I was still enrolled in Finland's national health-insurance program. In addition I'd taken out a reasonably priced Finnish travel insurance plan to cover me for any emergencies in the United States. It seemed like a good situation for the time being.

When I tore open the envelope from Finland, everything changed. The letter inside, from a Finnish government agency, informed me that because I was now residing outside Finland, my benefits as a Finnish citizen were being suspended. As I stared at the letter, a tight knot formed in my stomach. My new life in America had already been taking its toll on me in anxiety, but the causes for my unease hadn't been entirely clear, even to me. Now I had a reason to worry that was crystal clear. My access to Finland's national health program had been cut off, and in the same moment, the supplementary travel plan I'd purchased had been invalidated, too. Essentially I had just lost my health insurance.

Relax, Americans would tell me. When I mentioned my new lack of health coverage to American acquaintances, several explained that they themselves had lived without health insurance for years—some because they couldn't afford it, but others just because they didn't think it was necessary. "You just have to go to your local free clinic," they advised me, and "you'll be taken care of."

Needless to say, that wasn't really the way it was supposed to work. People in the United States who do not have health insurance are supposed to pay for all of their treatment themselves: doctors, ambulances, hospitals, drugs, tests. Charity clinics might help, but they are no substitute for having health insurance. As a result, what tends to happen in practice is that Americans who lack insurance forgo some of the most important medical visits a person can make, like screenings for diseases such as breast cancer or prostate cancer. When sick, they also tend to put off going to the doctor unless they experience unbearable pain, at which point the illness may have progressed so far that they're already in serious trouble and require far

more invasive and expensive treatment. I certainly didn't want to end up in that situation myself.

I started to harbor serious fears about ending up deeply in debt if I went to a doctor without insurance. Sitting at my kitchen table in Brooklyn reading the newspaper some mornings, I'd run across stories like the one about an uninsured young woman about my age who'd experienced sudden digestive discomfort, ended up in the hospital for a couple of days, and been stuck with a bill of over seventeen thousand dollars. I heard stories of people who elected to have a painful tooth yanked out, instead of getting it treated, because simply removing it was cheaper. Millions of uninsured Americans don't even take their prescribed medicines, or take only part of the prescribed dose, or self-medicate with random leftover drugs they get from their friends, all in order to save money.

Yet many Americans, including politicians who should know better, continue to repeat the reassuring mantra that no American dies for lack of health insurance. It turns out that even this isn't true. Victims of car accidents who lacked health insurance, for example, received less treatment and were significantly more likely to die of their injuries than victims who had health insurance, even when they were taken to emergency rooms, according to one study I read. Other studies estimated that uninsured adults in the United States had a 25 or even 40 percent higher risk of death than insured adults, even after adjusting for various factors such as age, smoking, and obesity.

In addition, one had to ask how many Americans were regularly risking death because they knew that seeking treatment was likely to be financially ruinous. Yes, American emergency rooms are required to take care of anyone in acute pain, or in a condition serious enough to require immediate medical attention,

but they are certainly not required to do so for free, and they're not required to care for people with potentially deadly chronic conditions such as diabetes, which can kill you, too. The notorious bills that uninsured patients receive from hospitals for emergency-room treatment—thousands of dollars for just a few stitches—can be incentive enough to stay home and take your chances, even if you are seriously at risk. Hospitals might ask uninsured patients to pay for treatment in advance, pushing debt collectors on them even as they sit in the waiting room, and can sue them later if they don't pay their bills—and seize up to a quarter of their after-tax wages in payment.

In fact I learned that medical bills were the cause of most personal bankruptcies in the United States, which meant that hundreds of thousands of Americans were losing their property and having their credit scores destroyed every year as the result of being uninsured or underinsured for health care. In America the uninsured were reduced to begging for leniency from hospitals, and begging from friends and family for burdensome financial assistance in the face of their staggering medical bills. Many ended up dragging their family members into debt along with them.

I sat in my Brooklyn apartment and imagined with a shudder what a good impression I'd make on my new American boyfriend's parents if I suddenly required emergency surgery without insurance, and needed a quick fifty thousand dollars to cover the bill.

By now I'd developed great affection for many aspects of life in America, and I was impressed by the fantastically high-tech medical technologies that American doctors and hospitals seemed able to deploy routinely to improve health and save lives. The cutting-edge clinical trials and experimental treatments

American patients had access to clearly brought unique benefits, and I knew that American medical schools and research institutions were among the most advanced in the world. All the same, as someone from a Nordic society, I'd also had a hard time explaining to Americans, even to Trevor, what it was like to move from a country with a national health-care system such as Finland's to the United States.

To be sure, health care in the twenty-first century is a huge challenge for every nation, and no country has a perfect system. Today even the countries that score best on global health-care surveys struggle with continuously rising costs, overburdened hospitals, long wait times, and administrative nightmares. But there are several different ways of approaching these problems, and when you've experienced life with a Nordic health-care system, coming to America is a shock.

A few years ago an American journalist named T. R. Reid set out to catalog what the basic approaches to health care were around the globe. Reid identified four basic models that different societies use to manage health care for their citizens. One model is the approach that Finland uses today, along with the other Nordic countries—Sweden, Norway, Denmark, and Iceland, with some variations in implementation. It goes by the name "Beveridge model," after William Beveridge, the economist and social reformer whose 1942 report inspired Britain's National Health Service. The UK continues to use a version of this approach, as do countries like Spain and Italy.

The basic idea of the Beveridge model is simple: Health care is provided and paid for by the government through taxes, just like other public services such as public education. As with public schools, users of public health care pay nothing or small copays when they go to see a doctor, and like teachers, many doctors are full-time salaried employees of national or local

governments. Doctors can also be private providers paid directly by the government. In addition, there may be other private doctors, hospitals, and insurance policies that users can choose, if they are willing to pay for these themselves. Because the government is paying most doctors' salaries, the expenses of the hospitals, and most of the medications, it can negotiate good deals, which in turn keeps costs down. This is also the model that is often presented in the United States as something to be terrified of, and which is frequently labeled with the scary-sounding term "socialized medicine."

The second basic model Reid identified is the "Bismarck model," named for Germany's late nineteenth-century chancellor and used in that country as well as in Japan, Belgium, and Switzerland. There health-care providers such as doctors and hospitals are private, as are the health-insurance companies. Employers and employees share the cost of insurance, and the government picks up the tab for the unemployed. However—and this is a big "but"—the system is not-for-profit; the private insurance providers are essentially regulated charities. They are required by law to cover everyone, and the government controls costs by regulating medical services and fees.

The third basic model is the "National Health Insurance model," used in Canada and to some extent in Australia. The providers of health care are private, but the national or local government runs a single, unified health-insurance program that all users pay into and that in return pays the bills—which is why it's also often referred to as a "single-payer" system. This arrangement allows the government to negotiate lower prices with doctors and hospitals.

In his book *The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care* Reid points out, however, that most of the world's countries are too poor and disorganized to

offer any of these three models. Instead these countries rely on a fourth model, if it can be called a "model" at all: Patients simply pay for whatever medical care they can afford themselves, with no insurance or government plan to help. This is the ugly reality for many in countries such as Cambodia, India, and Burkina Faso, to name a few. The results of this system are, as Reid writes, predictably straightforward and brutal: "The rich get medical care; the poor stay sick and die."

The American health-care system occupies its own peculiar niche, because it's a hodgepodge of all four models. According to the U.S. Census Bureau, in 2014, 55 percent of Americans had employer-sponsored health insurance, 37 percent were covered by some form of government health-care program, 15 percent paid for private insurance themselves, and 10.4 percent (or 33 million people) had no health insurance at all.

Most Americans under the age of sixty-five live in a mercenary version of Germany. Employers negotiate health insurance for their employees from private insurance companies, and the employer and employee share the cost. The insurer, in return, is supposed to pay for treatment provided by private doctors and hospitals. Unlike in Germany, however, the insurance companies and medical providers in America are largely for-profit businesses, with every incentive to charge as much as they can and give out as little as possible. Moreover, the United States government does not pick up the insurance tab for the unemployed, and does not regulate prices of medical services to manage costs.

For those over the age of sixty-five, meanwhile, the United States is a confusing and inadequate version of Canada. The government runs its own health insurance program—Medicare—and pays most or part of the bills. Then there's Medicaid, for the very poor. The federal government and the states fund health

care for particularly impoverished citizens, especially children, pregnant women, the disabled, and the elderly, but the eligibility requirements and exact provisions vary from state to state. You might conclude—especially if you come from a nation that has one of the first three models mentioned above—that Medicaid in the United States is rather like a national healthcare system. However, you have to remember that in America "poor" actually means "extremely destitute." Many adults in the U.S. who are struggling financially are nowhere near poor enough to qualify for Medicaid, and many states do not offer Medicaid to childless adults at all.

American military veterans, meanwhile, actually live in an increasingly underfunded version of Britain or a Nordic country. The government pays the salaries of doctors and the costs of facilities, which belong to the Veterans Health Administration. But because of America's prolonged military campaigns in the Middle East since 2001, the VA as a whole has been flooded by an enormous influx of veterans that has been straining the system. The federal government has been trying to improve the service by adjusting funding and reforming management.

Finally, for uninsured Americans, who are usually either young, self-employed, unemployed, or working part-time or for small businesses that don't offer health insurance (or only offer insurance that is prohibitively expensive), the United States is not that different from Cambodia or Burkina Faso. The uninsured have to pay out-of-pocket to get medical care. If they can't, they get emergency care, but a bill will follow, causing many to rack up debt, lose their credit ratings, or end up in personal bankruptcy. For small or chronic conditions that aren't life threatening, they must either find a charity clinic, pay up, or keep suffering.

On that sunny April day in New York City, when I opened that letter from Finland, I joined the ranks of this last group of Americans. Now, when I looked down from our apartment to the bustling street below, I no longer saw Brooklyn. All I saw was Burkina Faso.

It's hard to exaggerate how fundamentally the loss of health insurance destroyed my sense of personal security and well-being. In most other modern industrialized societies, including Finland, health care is considered a basic human right. I couldn't wrap my head around the thought that in my new home country, it was really considered okay for people not to get care, or if they did, to be forced into bankruptcy as a result. I went from incredulous to frustrated, to scared, to weepy, to angry, and back again. It didn't matter that for the time being I was perfectly healthy. Each irritation in my throat meant pneumonia, and every twinge of my knee or elbow signified surgery. A lump on my neck meant cancer. And everything meant insurmountable bills.

Considering that millions of people around the world lived without health insurance for their entire lives, it was true that I was fortunate. If things got really bad, I could always move back to Finland. In addition I had some savings, and Trevor and I did both have families who might be able to help us out, at least a bit, if things got rough. By American standards I was still relatively privileged. But by Nordic standards, and by the standards of most other advanced nations, I was in fact in actual danger of becoming destitute.

And so it was that I joined the ranks of the haggard, overworked Americans who spend countless hours of their lives researching their options, trying to find a less-bad health-

insurance arrangement from among many confusing, expensive, and downright terrible alternatives. And I soon discovered that I couldn't do it alone.

UNHEALTHY DEPENDENCIES

When I first moved to the United States, I struggled to understand what Americans meant when they discussed whether or not a job came with "benefits." I envisioned subsidized gym memberships or lunch vouchers, and wondered what all the fuss was about. After I learned that buying health insurance on your own was so expensive that mostly it had to be bought through a group of some kind—an employer, a union, a professional association—and that employer-sponsored health insurance usually covered that employee's entire family as well, I started to understand: Securing a job with benefits, or at least this one benefit, could literally mean the difference between normal life and bankruptcy, or even life and death.

It also struck me as peculiarly un-American that private businesses would be saddled with such a profound social duty. It sounded so, well, socialist. Wasn't the purpose of a business to make profits, not to arrange the medical treatment of its employees? Meanwhile American citizens were dutifully paying their taxes—so wasn't it the purpose of their government to provide essential social services in return for those taxes? And wasn't it completely twisted that when people lost their jobs, they lost their health insurance as well, right when they might need it the most?

From the perspective of any society that claims to value and support the autonomy of the individual, the fact that at least half of all Americans depend on their employer for what is perhaps

life's most essential social service makes no sense. It severely curtails one's freedom. People cannot choose what kind of work life they want without weighing the financial and medical risks for themselves and their families of becoming, say, an entrepreneur rather than a salaried employee, or of pursuing their dream rather than taking a mind-numbing desk job. Not to mention that if you succeed in establishing a small business, and you're fortunate enough to grow, you're then burdened once more when you have to shoulder the administrative and financial burdens of health insurance for your employees. Entrepreneurs in the Nordic countries don't have to worry about their own health insurance at all. They already have it, they always will, and they can choose to follow their dreams at least free of that particular worry. Business owners in the Nordic countries can offer their employees extra health coverage at a private clinic as a perk, and many do, but this is nothing that even remotely approaches the administrative and financial burdens with which American businesses struggle on a daily basis.

Relying on employers to arrange health insurance makes no sense in other ways as well. Every time an American considers changing jobs, he or she faces a complete upheaval of his or her health-care situation, and often the frightening prospect of a gap in coverage. A typical example: One of my acquaintances in the United States changed jobs and found himself uninsured for three months. The insurance from the new employer didn't kick in immediately, and the so-called COBRA insurance meant to bridge such gaps was too expensive for him and his wife without the substantial employer contribution they'd been getting. So for ninety days they just lived their lives unprotected, hoping for the best. Americans go on churning in and out of various health-insurance plans as their jobs, finances, location, and eligibility change, but doing so is exhausting, bewildering,

and an inefficient use of everyone's time, energy, and money. Worse, insurance companies know that many of their customers will leave them for another plan at some point. As a result insurers have little incentive to cover preventive care that could save costs in the long run. For private insurers offering plans through employers, the best strategy is to pay as little as possible now—people's future health be damned.

Later in life, Americans have their personal freedom and independence curtailed in yet another way, again courtesy of their health-care system. A survey of working Americans revealed that more than half the respondents reported that they planned to work longer than they would like to, just so they could continue receiving health insurance through their employer.

In any Nordic country these kinds of curbs on personal freedom would be considered totally unacceptable. Nordic people believe that everyone should work, just as Americans do—the level of workforce participation in the Nordic countries easily matches or exceeds that in the United States. But it would be unbelievable in a Nordic country that your career choices should be dictated by health care. This is especially true in today's twenty-first-century economy, in which people increasingly work on short-term projects, as part-time employees, or as self-employed freelancers. In our hypermodern world, which requires a nimble society with a flexible, healthy workforce, separating health care from the nature of an individual's employment is smart.

And what about ObamaCare, the much-discussed, -defended, and -maligned Patient Protection and Affordable Care Act that took effect in the beginning of 2014—didn't it solve many of these problems? It did attempt to address some of them, at least in theory. The new law required practically every citizen and legal resident to buy private insurance, or otherwise pay a tax penalty. It helps people with low incomes lacking affordable employer-provided insurance by giving them tax credits to pay for insurance. It makes it easier for individuals to buy insurance directly through online Web sites—the infamous "exchanges" that suffered so many problems when they were rolled out—thus enabling freelancers, the unemployed, and owners and employees of small businesses to get insurance. It is, in fact, created with people like Trevor and me in mind. In practice, however, it still has many problems, as I quickly discovered.

Once Trevor and I got married, I got my American "Green Card," the coveted residence permit that would allow me to work freely for American employers. In theory this would allow me to get a job with employer-sponsored health insurance. In addition I'd now have the option of joining Trevor's health plan for freelancers, as his official spouse. I started hunting for a job but my résumé, which consisted mostly of editing and writing articles in Finnish, along with the worst economic recession in the United States since the 1930s, did not exactly have employers in New York rushing to hire me. Trevor and I sat down and pored over our finances, and the latest health-insurance plans offered by the Freelancers Union. We were making money, but our sad conclusion was that the health plans for freelancers that included a spouse were much too expensive for us. We were stuck.

And thus I experienced, firsthand, another type of unhealthy dependency that the American health-care system pushes people into: not just unhealthy dependencies on employers, but unhealthy dependencies among family members. Since my prospects of finding a decent job were so slim, I now did what many Americans do: I told my spouse that he'd better get a job that provided us both with health coverage.

By then I'd already encountered quite a few American couples who lived with such arrangements. Although one spouse might want to change careers or become self-employed, nevertheless they'd agreed that he or she would stick with the job they had. The main reason, of course, was that the entire family relied on the health insurance that went with that job. Having grown up with the Nordic theory of love, with its basic principle that healthy relationships between people are built on the true independence of each individual, financial and otherwise, such arrangements felt to me dangerously conducive to resentment. When one person has to put part of their own potential or dream on hold, or quash it altogether, while their spouse and children rely on that person's sacrifice, everyone is being subtly held emotional hostage. It is just this sort of arrangement, and the tarnishing of otherwise loving relationships, that the Nordic theory of love is intended to avoid.

For many Americans arrangements like these do not appear problematic on the surface. The family is seen as a unit that works to the benefit of all its members, and if one person in the family is happy in a job that provides health insurance, there doesn't seem to be any problem at all. And even if that one person would prefer to become self-employed, or make other decisions that would complicate the family's access to health care, isn't it only right that they put their family first? Making sacrifices is part of being in a relationship and having a family. Certainly on a basic level that's just as true in Nordic countries as anywhere else.

Yet such dependencies in relationships are a slippery slope. Sacrifices and resentments can accumulate silently, even subconsciously, and undermine the interactions of people who otherwise love one another. The goal of the Nordic theory of love is to prevent this corrosion of relationships, and to do so by creating social arrangements that allow everyone to give love as freely as possible, without strings attached. Calculations of who owes whom what, or who makes what sacrifices, should not be part of the emotional equation. That way the family becomes a team with each individual contributing to the whole from a position of independence and personal strength. Today our modern expectations—in the Nordic countries as well as in much of the United States—are that individuals should have this basic independence, while still being part of families and communities. But the outdated American approach to health care undermines that ideal, and this seemed especially tragic to me because it was so unnecessary.

Despite all of my qualms, however, if I wanted to stay in the United States and have health insurance, I had no choice but to become dependent on Trevor. In the process Trevor would have to make career choices and sacrifices that he might not otherwise have made, complicating our relationship with potential resentments, and deepening my psychological dependence on him. Fortunately Trevor did manage to land a teaching job that offered health benefits for both of us. I was relieved—until he came home from a meeting with his new employer and told me what it would cost.

Having heard so much about "employer-sponsored health plans," somehow I'd assumed that they would be cheap, or even practically free, for employees—wasn't that why it was called a "benefit"? I hadn't yet understood that a wide range of plans and costs existed, and that one had to be savvy enough to navigate them. I also hadn't yet realized the extent to which Trevor's new profession of teaching wasn't the highly respected profession in the United States that it was in Finland.

Later I would research the average costs of employer-sponsored plans in the United States. According to a report by the Kaiser Family Foundation, the total average annual premiums for employer-sponsored health insurance in 2015—in other words, the combined amount paid by the employee *and* the employer for the insurance—came to $6,251 for single coverage and $17,545 for family coverage. If you looked only at the amount that just the employee had to pay, from his or her own salary, the average annual share was $1,071 for single coverage and $4,955 for family coverage. But I also learned it is not unheard of for families to pay up to $15,000 of their own money every year, even for employer-sponsored health insurance.

In addition to premiums, of course, most employer-based plans have an annual deductible that requires patients to pay a certain amount of their costs themselves first (on average, $1,318 for single coverage). The majority of American workers also have to shell out copayments for office visits with physicians, as well as part of the cost of their prescription drugs. Gradually I came to realize that when an American says how much they pay for their insurance each month, it tells you nothing until they clarify their deductibles, copays, coinsurances, the extent of the coverage, and all the other terms I had never heard of before in my life. Mostly, the bigger the employer, the better the deal for employees.

Trevor's new employer was, unfortunately, not big, and teaching in America, especially at a small institution, could provide some awfully small "benefits." With Trevor's new salaried job, our only option for health insurance was a family plan—there was no spouse-only option—that would cost $790 a month for the two of us. And that was after the employer had kicked in around half of the total cost. Granted, our payments would be a bit less than the freelancer's plans we'd been looking at, but this

was not at all what I'd been expecting. In fact, it was more than double the national average for a family plan at the time, and we didn't even have kids.

I did my best to take this latest blow with grace. But nine and a half thousand dollars a year sounded like an enormous sum, and there were copays on top of it. This was another of those moments when I felt I really wasn't cut out for life in America. Tears started to stream down my face. Trevor watched me silently for a while, and then softly asked, "Have I told you lately that I'm insanely in love with you?"

We hugged each other tightly. Two lovers, tortured by the American health-care system. I almost laughed through my tears. So this was the drama of romance, American-style. Life had been so different for me before.

WHO'S THE BEST?

Living my life in Finland, I'd received my primary medical care from a variety of sources. When I was a kid I'd visited either the school nurse, a public clinic, a public hospital that specialized in treating children, or sometimes a private doctor paid for by my parents. In college I used a publicly funded student health center. Later, when I was a working adult, I usually just went to my local public clinic. Occasionally I saw the private doctor offered to me for minor illnesses by my employer. And at other times I chose to see a private dermatologist or gynecologist outside either the public system or my employer's plan.

So what would all this cost me? When I went to the public clinic, I might owe a copay of some twenty dollars for the first few visits of the year. Once I'd reached a cap, there was hardly anything more to pay out of pocket. In 2016, the combined

annual out-of-pocket maximum for most services—public clinics, emergency rooms, tests, operations—for every person in Finland was about $750, no matter what kind of treatment you'd received or how expensive it was. If I'd had to take prescription drugs, my out-of-pocket copays for those would also have been capped; in 2016 the annual maximum was about $660. And if I'd been poor, Finland's social services program would have helped me with the copays, too. Many medications for serious long-term illnesses such as diabetes, multiple sclerosis, or cancer are covered at special rates, with the patient paying less than five dollars per prescription.

Meanwhile, if I went to see a doctor who'd been made available through my employer, the visit was simply free. On the other hand, if I went to a private doctor outside my employer's plan, I paid most of the bill myself, although the government generally subsidized these visits as well.

I usually made my choice about where to go for primary care based on little more than which location was most practical and could give me an appointment fastest. I didn't really worry about differences in the quality of care, because there isn't much difference between the private and public primary care physicians in Finland, apart from the question of who pays the bill. Many doctors split their time working for both the public and private sector. Municipalities sometimes buy services from private providers, while employers sometimes buy services from public clinics. Private clinics can often offer an appointment faster, while public clinics are cheaper or free.

Should something serious turn out to be wrong with you, though, all these primary care providers will send you to one address: the public hospital. Private clinics and hospitals in Finland mainly offer care for conditions that are not life threatening, in

such specialties as ophthalmology—say, cataracts—gynecology, dermatology, and dental care, or surgery for sports injuries. The more involved and expensive care for more life-threatening issues, such as cancer treatments or cardiac operations, is almost completely the domain of the public sector. When it comes to the big stuff, the country simply takes care of you, at negligible cost to you. Period.

Finns and some other Nordic citizens have legitimate grievances with the current state of their health care. In the public hospital system, if you require nonemergency or elective surgery, the waits can be long. For example, in 2014 the average wait for cataract surgery was only about thirty days in the Netherlands, but almost three times that in Finland (the same wait existed in Portugal). The average wait for a hip replacement was about forty days in the Netherlands, but 116 days in Finland.

Americans might assume that long waits for these sorts of surgeries are the inevitable result of having a health-care system run by the government. But that's not the case. A study in 2014 by the Commonwealth Fund, a private foundation specializing in health-care research, ranked Britain, which also uses the Beveridge model, as fourth in the world in access to specialists, right after the United States. Britain has also shortened its wait times dramatically from the past—all it took was for the government to commit the right additional resources. So for Finland this is a solvable problem, and the Finnish government has already taken steps to address it. Patients in the Netherlands, Germany, and France, all of which have national health-care systems of one kind or another, have faster access to nonemergency and elective surgery than do patients in the United States.

Even so, the next thing I can imagine an American saying

about all this is: America has the best doctors and the most advanced medical treatments in the world. Americans are willing to put up with their system because no public health care can compete with that. Right?

It's hard to make any unequivocal statements about the quality of care between health-care systems in wealthy nations, but two things can be said for sure. One: Wealthy people tend to get more care than the poor almost everywhere. And two: Of all the developed nations, the country that has the most severe extremes of this sort of inequality is the United States.

Everyone agrees that the United States is home to some of the world's best medical schools, highest-skilled doctors, most productive research institutes, best-equipped hospitals, and most innovative treatments. If you have the money in the United States, you absolutely can get world-class care. But here's the thing that somehow escapes American awareness in this discussion: *Everyone* else in *all* the other wealthy industrialized countries—absolutely including all the ones that have universal national health-care systems—is also getting world-class care. And they get it whether or not they have a fancy insurance plan and a huge reserve of personal wealth.

In addition to conducting surveys on education, the OECD—the joint organization of wealthy nations—studies health care in different countries. According to its research, the United States as a whole does not actually outshine other countries in the quality of care. The United States has shorter life expectancy, higher infant mortality, and fewer physicians relative to the population than most other developed countries, including the Nordic nations. When we look at outcomes in some dramatic illnesses, such as cancer, the United States does have some of the best survival rates in the world—right after or

ahead of the Nordic countries. The rankings vary marginally here and there, but overall the United States and the Nordic nations achieve very similar results in how long patients live after a cancer diagnosis.

However, there is a particularly important respect in which the United States has performed considerably worse than the Nordic nations. A Commonwealth Fund study from 2011 concluded that in comparison with fifteen other industrialized countries, Americans under the age of seventy-five were the most likely to die of conditions that are at least partially preventable or treatable. These include bacterial infections, diabetes, heart disease, stroke, or complications of common surgical procedures. As many as 91,000 fewer Americans would die prematurely if the United States could achieve the rate of the leading country, which was France—a nation with a strong national health-care system using a variation of the Bismarck model, with public and private providers and regulated, nonprofit insurance plans. Sweden, Norway, Finland, and Denmark all performed better in this regard than did the United States. When the Commonwealth Fund compared American health care with ten other nations on criteria such as quality, access, efficiency, equity, and healthy lives, the United States ranked dead last.

American patients skip care because of costs more often than do patients in other countries, and American doctors are more embroiled in what the Commonwealth Fund calls "administrative hassles." So despite America's strengths in the kind of high-tech and dramatic emergency hospital care that you see on TV—I have been addicted to the show *Grey's Anatomy* for years—American health care also has severe weaknesses. The American cardiologist-turned-author Sandeep Jauhar summarized the state of health care in the United States in an interview about his book *Doctored: The Disillusionment of an*

American Physician on National Public Radio. "American medicine," Jauhar told NPR listeners, "is the best in the world when it comes to providing high-tech care. If you have an esoteric disease, you want to be in the United States. God forbid you have Ebola, our academic medical centers are second to none. But if you have run-of-the-mill chronic diseases like congestive heart failure or diabetes, the system is not designed to find you the best possible care. And that's what has to change."

And compared with Nordic citizens, Americans are losing their freedom and independence in yet another way: financially. When it comes to health-care costs, the U.S. system means that Americans are getting robbed.

THE PRICE WE PAY

One fine spring day in New York City I was having coffee with an American friend whose wife had given birth in the previous year. He mentioned they had recently received a number of unexpected bills from the doctors involved and from the hospital, six months after the fact, related to the delivery. The bills ran into the thousands of dollars. He and his wife had insurance, and he hadn't been aware that these bills would be coming, but he assured me it wasn't a huge problem. He'd called the hospital, and the collections office had agreed to lower the amounts based on the couples' earnings. Now they were paying fifty dollars a month toward the remaining bill of a thousand dollars or so. He also mentioned that overall, he felt his insurance had been good. A few years back he'd had surgery on the same plan. The cost of the surgery had been more than ten thousand dollars, but his share had been only around fifteen hundred dollars.

I had just returned from a trip to Finland, and I was speechless. It wasn't that I hadn't heard a story like his many times before. One friend in New York had to pay $950 for the extraction of a wisdom tooth, since she didn't have dental insurance. Another acquaintance's wife went to the emergency room to have a glass fragment removed from her foot. The hospital took X-rays that revealed nothing, and the doctor told her to see a specialist. Then they sent her a bill for $1,244. One friend with an affordable corporate insurance plan, including dental, found that none of the doctors who specialized in fixing the particular problem she had with her jaw took any insurance, so she had to pay $1,600 out of pocket. What rendered me speechless was not the bills and costs themselves, although I did find them outrageous, but the fact that my American friends didn't seem to realize there was anything strange about all this.

For sure, many Americans with good jobs and high-end insurance don't end up paying much extra for their care. But even for many middle-class Americans, underinsurance that results in extra medical bills is a terrible problem. A Harvard study surveyed people who were being forced to declare personal bankruptcy as the result of an illness. The majority of them turned out to be middle aged, middle class, and college educated, and they'd had health insurance at least at some point during their ordeal. Their financial troubles resulted from a combination of copays, prescription drug costs, and bills from doctors and hospitals rising into the tens of thousands of dollars, as well as from lost income during their illness. Even when Americans have health insurance, they mortgage their homes and borrow money to pay medical bills.

ObamaCare was partly intended to solve some of these problems. For example, the Affordable Care Act put limits on copays for preventive services, and it capped annual out-of-pocket maximums for most policies. In 2016, these caps were

$6,850 for an individual, and $13,700 for a family plan. That's still a lot of money. And ObamaCare didn't solve the problem of insurance companies sticking patients with humongous bills for services that the insurers decide they're simply going to refuse to cover, not to mention costs for out-of-network treatment that is often impossible to avoid. All this would be utterly unheard of in Finland.

Americans tend to assume, of course, that people in Nordic countries are also getting a rotten deal. Nordics, after all, have to fork out so much in taxes over the years to pay for their public health-care system.

Before I discuss the very interesting question of taxes—which I'll get to in the next chapter—here are the comparative statistics specifically on health-care spending. Regardless of how health care is paid for—through taxes or private insurance or direct payments from patients—each country spends a certain amount on health care for every citizen. Finland's per-person spending is, along with Iceland's, about average among the OECD countries. How about the United States? The quality of the medical care in the United States is, as we've seen, pretty much identical to, or in some areas slightly worse than, Nordic medical care. Yet Americans are paying, per person, two and a half times what citizens of Finland and Iceland pay. In fact the United States now spends more on health care than any other country in the world by a wide margin.

How come?

In 2013 the normal delivery of a baby in the United States cost on average $10,000—four times as much as in Spain. An MRI fetched more than $1,000, compared with $140 in Switzerland. American bypass surgery cost $75,350, or almost five times as much as in the Netherlands. The average cost of a hospital day

in the United States was more than $4,000, as opposed to $480 in Spain. How is it possible that Americans end up paying so vastly much more for exactly the same services?

Several American investigative journalists have set out to answer exactly this question, and their discoveries have been stunning. To begin with, American hospitals routinely charge such high prices for even the smallest items that the practice could be called fraudulent—if it weren't perfectly legal. Steven Brill's extensive report "Bitter Pill: Why Medical Bills Are Killing Us" in *Time* detailed hospital billings of $1.50 for a generic painkiller that you can buy a hundred of on Amazon for $1.49, $18.00 for an individual diabetes-test strip that Amazon sold in boxes of fifty for $27.85, or 55 cents each, and $13,702.00 for an injection of a cancer drug that costs the hospital less than $4,000.00

A series of articles in the *New York Times* by Elisabeth Rosenthal, tagged, "Paying till it hurts," also showed how Americans are systematically charged more for drugs, scans, and procedures than are patients in other developed countries. "Americans pay, on average, about four times as much for a hip replacement as patients in Switzerland or France and more than three times as much for a Caesarean section as those in New Zealand or Britain," Rosenthal revealed. "The average price for Nasonex, a common nasal spray for allergies, is $108 in the United States compared with $21 in Spain." Drawing on a report by the Commonwealth Fund, Rosenthal went on to compare hospital stays in the United States with those in other developed countries. She found that while hospital stays in the United States were no longer than those in other countries, they nevertheless cost three times as much.

There are a variety of reasons for the high cost of health care in the United States, and a lot of them are related to the fact that

it's an old-fashioned, free-for-all of private arrangements, rather than a modernized, rationalized, national system with clear regulations. American insurance companies negotiate prices down as much as they can, but often their bargaining power is limited. There are only so many hospitals in most areas, and those hospitals have also been consolidating to create more powerful private entities. By buying up doctors' practices and forming in-house labs, hospitals have managed to form near monopolies, increasing their leverage against insurers, which allows them to charge more.

In addition American hospitals treat many health issues with heavy-handed and expensive methods, whereas their European counterparts will often choose a less intrusive solution that's just as effective. When it comes to delivering babies, for example, the American rate for C-sections is much higher than in other developed countries, and needless to say, each American C-section costs more than it does elsewhere. Pharmaceutical companies, for their part, keep gouging Americans with higher drug prices than they charge elsewhere in the world. American insurance companies, hospitals, and doctors also all spend extraordinary amounts of money on administration, because the complexity of America's private system has created multiple layers and separate areas of management as well as various middlemen. Not to mention the huge sums that American healthcare companies and providers spend on advertising to drum up more business.

A lot of these drivers of excessive cost simply don't exist in other countries. There are far fewer bills, forms, and disputed claims when care is provided by a public hospital, or paid for by a single public insurance provider, nor is there any need to advertise. As the *New York Times* has noted, many of the typical professions that soak up consumer dollars in the American health-care industry—medical coders, claims adjusters, and care navigators, to name a few—are unnecessary and unheard of in other countries.

Then there are American doctors. They order more tests than do doctors in other countries, and Americans are charged more for those tests, as well as for their medical devices and drugs. American doctors also take a much bigger cut of all these charges for themselves than do their European counterparts, and they often have extensive financial arrangements with laboratories, device makers, and drug companies that can skew their incentives and entice them to choose a more expensive form of care, beyond what is medically necessary.

I have family members in Finland who are doctors and dentists. They earn a comfortable income, but their homes are normal homes in ordinary suburbs or in apartment buildings, and no one is driving Porsches. Based on an OECD report, Finnish doctors who are general practitioners earn twice the average Finnish salary, which is pretty darn good. Specialists in Finland do even better: They earn two and a half times the average salary. But for American doctors the earnings premium is dramatically higher. In the United States general practitioners earn three and a half times the average American salary. American specialists take home five and a half times the average.

American doctors do work longer hours than Finnish doctors, but this doesn't wholly explain the higher earnings, since doctors in Canada and France work similar hours but make less. One of the biggest justifications American doctors tend to give for their high salaries is that they have to pay off the debt for their very expensive educations themselves. It's true that this is not an expense doctors trained in Finland have to worry about,

since medical school in Finland—if you can get in—is free. Another justification for the high incomes of doctors in the United States is the expensive malpractice insurance they're forced to buy. In Finland such costs are negligible.

In all fairness, though, it is not the doctors who earn the most in American medicine. That dubious honor goes to the real bosses of American health-care profits: hospital administrators and insurance company executives.

Who pays the price for all this? The average American.

Not long ago a man in the United States known as "Steve H." needed a neurostimulator implanted in his back. He had health insurance, and he went to an American hospital for the one-day surgery. The tale of Steve H.'s operation, which is both remarkable and totally commonplace, was one of the stories reported by Steven Brill in *Time*. The operation went well, but afterward Steve H. received a bill, despite having insurance. The bill included, as Brill puts it, "all the usual and customary overcharges." For example, among the many itemized entries was "STRAP OR TABLE 8X27 IN," for $31. Brill explains: "That's the strap used to hold Steve H. onto the operating table. Just below that was 'BLNKT WARM UPPER BDY 42268' for $32. That's a blanket used to keep surgery patients warm. It is, of course, reusable, and it's available new on eBay for $13. Four lines down there's 'GOWN SURG ULTRA XLG 95121' for $39, which is the gown the surgeon wore. Thirty of them can be bought online for $180. Neither Medicare nor any large insurance company would pay a hospital separately for those straps or the surgeon's gown; that's all supposed to come with the facility fee paid to the hospital, which in this case was $6,289." The total for Steve H.'s one-day operation came to $86,951. Steve H.'s insurance only agreed to pay out $45,000. The total amount that Steve H. himself now owed the hospital to pay for all those inflated charges was still $40,000. And that didn't even include the doctors' bills.

Compare this with the case of an acquaintance of mine in Finland. He had been suffering from numbness, pain in his back, and a burning sensation in his hand. After a few weeks of waiting to see if the pain would go away, he saw a doctor and learned that he would need surgery. He had the option to have the surgery in a private hospital, but he elected to use a public hospital that was part of Helsinki University. Afterward he spent a few hours in the ICU, followed by an overnight stay in the regular wing of the hospital. He was home the next day, and then got six weeks of paid sick leave. He, too, received a bill for the operation. His reaction to the bill was strong enough that he decided to post it on Facebook: "Just received a bill from the hospital. MRI pictures of the neck and the following neurosurgeon's appointment €29. Removal of two prolapsed vertebral discs by the most experienced neurosurgeon on neck problems in Finland + one night stay in the hospital €69.60. Total cost €98.60."

Forty thousand dollars, versus ninety-nine euros, which comes to about $105. My acquaintance was very happy with his care. Especially with the price.

How do Nordic countries keep costs so low? Many Americans believe they know the reason: death panels.

DEATH PANELS

What many Americans fear most about public health care is the idea that in countries with public health-care systems, the government unfairly—and maybe even secretly—limits the

medical treatment that people can receive. This fear was infamously given voice by former Alaska governor and vice presidential candidate Sarah Palin. Health-care reform in the United States, Palin claimed, would lead to "death panels" of bureaucrats who would decide which people were "worthy of medical care." Palin's claim was quickly debunked. America's new Affordable Care Act—ObamaCare—included no provisions that would cause any individual to be judged worthy or unworthy of medical treatment. Later the fact-checking outfit PolitiFact actually named Palin's false claim the number-one "Lie of the Year."

Nevertheless many Americans continued to believe that Palin's statement was true, the assumption being that part of the way that Finland and the other Nordic countries reduce the medical bills of their citizens is in fact by having something like what Palin was describing—if not "death panels," at least committees of government number crunchers who rule out lifesaving procedures that are too expensive. This is simply not the case. As in the United States, in the Nordic countries there are no committees that pass judgment on whether or not a patient will get care. Such decisions are left up to individual doctors in consultation with patients. That said, doctors and patients in Nordic countries do face limitations, of course, exactly the same limitations faced by doctors and patients in the United States in dealing with private insurance companies—namely, whether or not certain treatments or drugs are covered. The difference is that in Finland and the other Nordic countries, the process for deciding which treatments and drugs are covered is reasonable, transparent, and accountable to citizens. That goes for pricing, too. Nothing could be further from the American way of doing things.

Absurd as it might seem, in the United States it is nearly impossible for anyone—consumers and experts alike—to actually find out in advance what a medical test or procedure is going to cost. When I finally got my first American health-insurance plan through Trevor's new job, I read the thick benefits book the insurance company sent, but I could understand little of it. The terminology was confusing, the rules more so.

Asking around, I discovered that my bewilderment was not at all unusual. In medical matters big and small in America, patients will mostly discover the price of their care only after the fact, even if they are stuck paying for it themselves. When a group of researchers from Iowa University telephoned more than a hundred American hospitals—two from each state, as well as Washington, DC—to request the lowest complete price, including hospital and physician fees, for a hypothetical hip replacement for a sixty-two-year-old grandmother, only one in ten hospitals was able to provide the full price, and even then the prices ranged from $11,000 to $125,000.

Patients aren't the only ones entangled in America's confounding, chaotic, and outdated patchwork of medical and insurance providers, and losing their precious time and resources trying to manage costs and plan their care. Increasingly, so are doctors.

An American acquaintance of mine who works as a genetic counselor described the problem of medical pricing in the United States from her perspective. Since each patient has a different insurance plan, a doctor often has no idea what a test or treatment is going to cost the patient, and the doctor can't spend all day on the phone calling everyone's insurance companies. Even when they try to figure it out, she said, often they can't. "I stood around for ten minutes on Friday with a cardiologist

and a cardiology fellow debating whether or not to send a genetic test on an inpatient or wait until they were an outpatient," she wrote once in a Facebook post. "We were trying to figure out how to keep the family from getting a huge bill, but to answer that question would have required knowing if they had met their deductible for the year, if they had met their out-of-pocket maximum for the year, and what percentage of the testing their insurance would cover if they hadn't. There is NO WAY we could answer those questions on a Friday night—plus it's a really lousy use of our time."

Nonetheless many American doctors do spend countless hours calling insurance companies to get prior authorization for expensive drugs that the insurance companies would prefer not to cover. A Commonwealth Fund report found that more than half of American doctors report that the time they have to spend trying to secure drug or treatment coverage for their patients is a major problem—a bigger percentage than in any of the other ten countries that were surveyed.

As a patient, if you don't know what a treatment is going to cost you, sometimes it may not matter all that much, especially if your employer has done a good job at picking the plans they offer. But sometimes it does matter. One friend's doctor had recommended what the doctor described as a routine heart test for my friend's new baby, just to make sure everything was fine. The parents agreed—who wouldn't?—thinking "routine" meant covered. Only later did they discover that their insurance did not cover the exam, and a bill of a thousand dollars followed.

Many Americans have come to believe that the reason you can't really know what anything is going to cost is simple. With for-profit hospitals loading their bills with "all the usual and customary overcharges," as Steven Brill put it, what for-profit insurance companies do is first deny every claim they can, and

then wait to see whether, and how much, you're going to fight back.

Let's be frank: This sort of behavior has no place in a modern civilized nation, not when we're talking about providing citizens with a service as essential as health care. Health care in the United States has regressed to such a Wild West state of affairs that patients, who in most cases are already suffering from an illness or other health problem as it is, also must additionally endure frustration, anxiety, and anger as they are forced to spend vast amounts of time and energy just fighting for the basic right to have their care covered.

No Nordic citizen has to put up with anything like this.

Nordic societies today have all decided that health care in a modern nation should be a fundamental human right, and as such, it makes the most sense to provide health care as a basic social service. Along with just about every other wealthy industrialized nation—except the United States—this means that the Nordic countries regulate the cost of medical services and drugs in a centralized manner, which prevents all of the pricing insanity so commonplace in America.

Take prescription drugs in Finland, for example. In this case there is indeed a "panel," and because it's a very important one, its decisions are open to public scrutiny. The panel consists not of death-dispensing bureaucrats but of medical experts—doctors, professors, and pharmacists—and its job is to review applications from pharmaceutical companies to have new drugs covered by the public system. The panel bases its decisions on studies of the drugs' effectiveness, and determines a maximum wholesale price as well as reimbursement rates for approved drugs. If the drug is approved, the public health-care system will pay much of its cost. In 2013 the committee's negotiations

with pharmaceutical companies ended with 95 percent of applications accepted.

None of that, by the way, prevents patients in Finland from paying out of their own pocket for a drug that the national system doesn't cover. Once a drug has been approved for sale either by the European Union or Finland's agency overseeing medicine—the equivalent of the FDA in the United States—the drug company is free to sell it at any price and anyone can buy it, as long as he or she has a prescription and the money. This is exactly the same as in the United States. The price is restricted only for drugs covered by the public system.

Finland's system for evaluating and regulating the effectiveness of drugs and treatments has several key advantages over the laissez-faire approach in America. The most obvious advantage is that it helps the country control health-care costs by weeding out expensive yet ineffective treatments, or drugs that have a more affordable alternative. The downside is that there are cases where a drug that serves some part of the population is deemed too expensive to be covered.

However, since the decisions are open to public scrutiny, they can be challenged by taxpaying citizens. Compare this with the United States, where calculations over what to cover, and by how much, are most often made by private insurance companies, usually in secret. Reimbursements vary widely, for no reason that patients or even doctors can discern, leaving patients with no recourse, wondering why their plan covers one treatment but not another, and why the patient next to them with different insurance might get access to both. It's ironic that Americans so often dislike the idea of public health care because they think government will force decisions on them. Yet, unlike the private sector, in a democracy it is government services that are the one area that must be transparent, and that

can be openly examined, explained, and questioned. A perfect example is the United States Veterans Administration, whose health-care system has recently been scrutinized, and as a result is now undergoing reforms. While governments make mistakes and might try to obfuscate their failures, it is private providers in the United States that, as we've seen over and over with "all the usual and customary overcharges," can't be trusted.

The fact that the current approach to health care in the United States generally avoids cost calculations up front may sound good at the outset. Naturally people want their doctors to choose the most effective care for them, even if it is expensive. Not considering costs, however, is causing Americans to get less value for their money, because expensive options are used even when cheaper ones would be just as effective. Some Americans have even started to plead with their doctors to take cost into account when making decisions about treatment, because more and more patients are realizing that they are likely to be the ones stuck with the impossibly high bill.

Pleading with one's doctor, however, is itself also becoming an exercise in frustration—and an exercise in suspicion—for many Americans. Out-of-control costs and the many other injustices that have become endemic to medical treatment in the United States are starting to undermine the very bedrock of the American health-care system: trust in one's own doctor.

The recent spread of the anti-vaccination movement is one of the more visible symptoms of this trend. However, I also encountered this mistrust among many of my American acquaintances in a more everyday way. More and more I noticed them voicing their suspicion that their doctors were pushing excessive diagnoses, expensive tests, and invasive operations on them in order to make money, rather than out of medical necessity.

Many had turned to the Internet instead, in search of alternatives such as dietary regimens or other noninvasive treatments. A Harvard study from 2014 showed that while the majority of Americans were satisfied with their most recent physician's visit, trust in the medical profession as a whole in the United States had plummeted since the 1960s. Of twenty-nine countries surveyed, the United States came in twenty-fourth in the proportion of adults who trust doctors.

To doctors this type of suspicious thinking can be frustrating. They've studied for years, maybe decades, to master their trade, they work exceptionally hard, and they aim to heal their patients, not to harm them. But no matter how unfair doctors feel such accusations to be, the suspicions held by growing numbers of Americans are not unwarranted. The United States does, for example, clearly have a more medicalized approach to pregnancy and delivery than many other countries, with unusually high rates of C-sections. Some patients might think this a good thing. But as the OECD has noted, approaches to birthing that rely on midwives instead of obstetricians are just as effective. In fact a review of studies found that births led by midwives resulted in fewer complications than ones led by obstetricians.

Similarly, American doctors order far more tests than do their counterparts elsewhere. They order more MRI tests per capita than any other OECD country. On the surface this, too, could seem like a good thing—more tests, better care. But according to the OECD, evidence suggests instead that Americans simply overuse CT and MRI exams. "Many studies have attempted to assess tangible medical benefits of the substantial increase in CT and MRI examinations in the United States," the OECD notes in a report, "but have found no conclusive evidence of such benefits." American doctors also prescribe

far more antibiotics than Nordic doctors do, despite extensive studies showing that the more antibiotics are prescribed in a community, the more resistant bacterial strains will take root there.

Not that the Nordic countries are entirely immune from some of this. The vast new troves of health information that are becoming available online have created a new trend of patients second-guessing doctors in the Nordic countries just as in the United States. However, in the Nordic countries, patients are not usually suspicious that their doctors might be putting profits ahead of ethics. In a country such as Finland, patients certainly might worry that cuts in health-care budgets could be leading to longer wait times, or to doctors whose schedules are too rushed. But rarely would a Finn have any cause to suspect that a doctor working in the public system could be personally benefiting from a particular care decision. Most doctors are simply salaried employees, and their compensation does not primarily depend on the number of tests or operations they perform. It's hard to overstate what a difference this makes compared with the way the American system is structured, and how much better Finns and other Nordic citizens are served by their health-care system as a result.

Given the growing distrust of doctors in the United States, perhaps it's no wonder that Americans place so much emphasis on being able to find a doctor they like. In fact, perhaps being able to choose one's doctor is one of the few redeeming qualities of the United States approach. Surely Americans would lose that freedom with a public health-care system like Finland's.

Or would they? And what does it even mean to have the freedom to choose who provides your health care, and the freedom to choose how it's provided? Does that freedom actually set you free?

THE RIGHT TO CHOOSE

About a year before I moved to New York, my brother Mikko married his girlfriend, Veera, in a lovely little town in the Finnish countryside. An American family who were close friends of my mother's since her student exchange year in Ohio almost fifty years earlier had come all the way from the United States for the ceremony. In a fragrant orchard at a long table, I sat talking with two sisters from the American family. The possibility of my move to the United States was looming in my mind, and there were so many things I felt I still needed to understand. At some point our conversation turned to going to the doctor, and I asked the sisters how much it mattered to them that they be able to choose their own physician.

"I absolutely want to choose my own doctor," one of them said instantly. She then went on to describe how, when faced with a serious illness, she'd launched into an intensive program of discovery for herself, researching everything she could about the condition online, cataloging possible treatments, calling friends and relatives for advice on securing the best doctor, and advocating strongly for the treatments she felt were most appropriate for her. She wanted to be in control of her own destiny, she told me firmly.

I had never thought of doctors that way. If I were suddenly seriously ill, the last thing I'd want to have to do, on top of dealing with my fear and discomfort, would be charging ahead with the onerous task of researching doctors, treatments, hospitals, and prices. I'd want the doctors to take charge. They were the experts, not me.

Immediately, my own attitude made me feel weak and pathetic compared to this visitor from America. Apparently, I was willing to surrender my life thoughtlessly into the hands

of strangers, without standing up for myself. I admired the way Americans seemed so consistently to take responsibility for themselves, no matter what the situation, without ever expecting anyone else to do it for them. Certainly much of what has made America great has been this attitude of self-determination.

Losing the capacity for self-determination is one of the things that many Americans worry about the most. A few years after that conversation, I ran across an online comment on an American newspaper's Web site, written by a vocal Internet commentator by the name of Guy Thompto. The comment struck me deeply, especially as someone who had grown up, as I had, on the border of the Soviet Union. "Sometimes freedom is taken away in large chunks, such as when the tanks rolled into Eastern Europe," Thompto wrote. But then he went on, and now he was talking about health care: "Sometimes freedom is scrubbed away, one layer at a time—such as when your freedom to freely choose the physician you want, what you are willing to pay, and what coverage you deem necessary for yourself and your family is taken away. People sometimes tell us that taking away these freedoms is for our own good, or sometimes for the good of the less fortunate. . . . We are told that if we disagree, we are greedy—or more often, ignorant."

Had I been coddled by the state back in Finland to such an extent that I'd developed a childish trust in the choices the government had made for me—whether in schools or health clinics? Worse yet, was I such a brainwashed underling that it simply had not occurred to me that I had the right to demand which doctor I saw? How did this fit in with the Nordic ideals of personal autonomy, individualism, and independence, and with the Nordic theory of love? Perhaps I should celebrate the ability to choose my doctor in America, and see what this newfound freedom was all about.

It turned out to be more complicated than I had expected. Soon enough I was lost in the mysterious maze of physicians, clinics, and hospitals throughout New York City, desperately asking friends for recommendations, calling various offices only to learn that they didn't take my insurance or didn't take new patients. Over the next several years, as Trevor's employer changed insurance companies, or Trevor changed jobs, we were frequently forced to leave whatever doctor we'd been using. Every time, we pored over plans, costs, doctor reviews, and paperwork. Choosing a doctor became an exhausting burden that yielded few, if any, benefits. Many Americans may be fortunate enough to have found a good doctor they like, and fortunate enough to live a settled-enough existence that they can build a relationship of trust with that doctor over time. But that is often not the way it goes.

When I lived in Finland, who my doctor was hadn't much mattered to me because all the doctors I encountered in the public health-care system struck me as quite good. However, let's say I had wanted to choose a particular doctor at the public clinic, and to see that same doctor every time. Over the past decade it has become much easier to choose your own doctor even in the public system. Norway and Denmark have already opted for the British model, in which primary care physicians are private providers, but the taxpayers foot the bill for everyone's visits. Patients can choose any doctor they want to sign up with, and doctors get paid partly based on the number of patients on their rosters, and partly on actual visits. Hospital care is still mostly a public service, and a referral from the primary care physician is usually needed for visits to a specialist. That said, many Danes have additional private insurance offered by their employer, which gives them other options. In Sweden patients can also choose their primary care physicians, whether

private or public, and the taxpayer money follows them where they want to go.

In Finland options to see private doctors who are partly subsidized either by the government or by employers have existed for a long time. Today Finns can also choose their public doctors, health clinics, and hospitals freely, with only some limitations—for example, you can switch which public clinic you use no more than once a year, which helps prevent costly administrative churn in the system. Moreover, there has been talk in Finland of moving closer to the Swedish model, which would give Finnish patients even more fully taxpayer-funded options.

After comparing my experiences with doctors in Finland and America, I came to this conclusion: In some ways I got more care in the United States than in Finland. My American insurance typically covered an annual physical exam and all manner of routine tests that had never been performed on me in Finland, since no doctor there had ever considered them necessary. At the same time, having to arrange so many aspects of health care myself, while also having to navigate the ever-changing maze of employers, plans, prices, and the scarcity of openings with good doctors, I was thrown into a state of constant stress—and I wasn't even sick or injured yet. I longed for a different kind of freedom—the freedom of knowing that the Finnish health-care system was always there for me regardless of my employment status. I wanted the freedom of knowing that all the doctors were good and that their goal was whatever was in my best interests, rather than generating profits. I wanted to know that the system would automatically take me in and give me excellent care without my having to exhaust myself with self-advocacy in my moment of weakness and need. That was real freedom. So was the freedom of knowing that none of it would bankrupt me.

AN AMERICAN IN FINLAND

Everywhere in the world people have complaints about their health-care system, and even the best-performing nations still need improvement. The journalist T. R. Reid, as he describes traveling the world studying different approaches to health care, quotes a Princeton policy analyst named Tsung-Mei Cheng. Having observed the difficulties of creating effective health-care systems around the globe, Cheng came up with what she calls her three "Universal Laws of Health Care Systems." They are as follows: "1. No matter how good the health care in a particular country, people will complain about it. 2. No matter how much money is spent on health care, the doctors and hospitals will argue that it is not enough. 3. The last reform always failed."

Many Finns consider the Finnish health-care system a disaster. The health-care perks that salaried Finns get from their employers allow them to visit primary care physicians without any wait. This leaves the unemployed, the self-employed, or retired Finns to face longer waits at public clinics. In addition private care that is subsidized by the public system has ensured that Finns with money can buy their way into immediate elective surgery more quickly than the less well-off. By American standards the prices of private care in Finland are not outrageous, but Finns who can afford them do get better access to care than those who can't.

An American might think that it is only right to reward people for their hard work, and to give people incentives to get a job with benefits, not to mention to earn a salary good enough to be able to pay for better health care if they want to. In Finland today, however, the fact that such trends might be starting to emerge is generally considered a disgrace. While there are

Finns who think a more libertarian and private-sector approach would serve Finland better in health care, as in other areas of life, most Finns believe that their success as a nation in the twenty-first century demands that real equality of opportunity be extended to every member of society no matter what, including in the form of a strong national public health-care system.

To ensure that access to health care in Finland remains equitable, the Finnish government has instituted rules shortening the amount of time patients might have to wait before seeing a doctor. Now all nonemergency cases must be evaluated within three days of a patient contacting a public health clinic, and access to a general practitioner or specialist for nonemergency care must follow no later than ninety days after the initial evaluation. Elective surgery must be scheduled within six months. Needless to say someone who needs emergency care or is suffering from acute pain can always walk into an emergency room anywhere in Finland, for a copay of less than forty-five dollars. In addition the Finnish government is in the process of pushing through changes in health-care administration and funding that would create a more centralized system, in an effort to improve both efficiency and equality.

Still, if you've grown up with the American health-care system, you might wonder why any American would go to all the trouble to think about having a Nordic-style system instead. Maybe the devil you know is better than the devil you don't?

That's what Pamela might well have thought, until she was diagnosed with multiple sclerosis.

The hour-and-a-half drive from Helsinki to Lammi, a Finnish town of about five thousand people, runs on roads winding through farmland and past bright-red barns. On a crisp October day, the fields were covered by a thin layer of frost, and

the low-lying sun shone brightly on the yellows and greens of autumn. When I arrived in Lammi I rang the bell of an apartment at the end of a small row of houses, and a forty-nine-year-old American from Alabama named Pamela opened the door.

Pamela is a chatty brunette with bright eyes and an easy laugh, and much affection for her white-and-black cat, Yoda, as well as her big blue-and-yellow parrot, Sibelius—named after the famous Finnish composer. The pets kept us company while we talked.

The story of how Pamela got to this small town in rural Finland started decades ago in Altamonte Springs, Florida, where she was working her first waitressing job. One night a Finnish student came in with a friend, and soon enough Pamela and the student started dating. They got married and lived in the United States for two decades, with Pamela working an office job in a hospital in Birmingham, Alabama. When her husband was offered a job back home, they moved to Finland. When I met her she had been living in Finland for five years, but now she and her husband were both struggling to find permanent employment. The company her husband had first worked for in Finland had since gone out of business. They were thinking of moving back to the United States, but there was an obstacle—Pamela had recently been diagnosed with multiple sclerosis.

Unlike in the United States, the fact that she and her husband were both currently out of steady work didn't mean they had no health-care coverage. As soon as Pamela was diagnosed she was taken in by Finland's public health-care system. When I met with her the Affordable Care Act was about to take effect back in the States. Encouraged, Pamela had researched options for individual insurance plans offered by the new health exchanges, but she couldn't figure out if she could sign up before

she knew which state they might settle in, or how the tax subsidies would work in her case. With her illness, she couldn't risk being without health insurance for extended periods of time.

In Finland none of that was an issue. Her coverage was close to 100 percent, and it did not depend on employment or where she lived. She paid copays of forty dollars here, twenty dollars there, but the low annual caps that apply to all Finns applied to her as well. She was seeing a neurologist, an ophthalmologist, a urologist, a nurse, and a physical therapist, as well as attending subsidized exercise classes. Getting appointments sometimes took longer than she would have liked, but mostly she was happy with her care. "I've been to see lots of people. I feel like I've been taken care of," Pamela told me. Rummaging through her kitchen drawers, she dug out a cheese slicer with a special handle designed for people who'd lost strength in their fingers. Pamela waved it gleefully in the air. "The occupational therapist gave me this, and a cool knife, and scissors, and a chair to sit on in the shower," she explained, "and I didn't pay for any of it."

Having worked in an American hospital herself, and having had her share of health issues even before the MS diagnosis, Pamela had considerable experience with the health-care system in America. Her stories of the twists and turns she experienced in dealing with American health insurance and hospitals unwind like many an American health-care tale—with so many actors, phases, and hurdles that keeping track is hard even for the protagonist. Based on her experiences, she has deemed Finnish hospital care top-notch. One time in Finland she stayed alone in a hospital room meant for two people, with minimal cost to her. "I was there for five nights, had excellent care, two ambulance rides, X-rays, CAT scans, follow-up visits, and the whole thing ended up costing me three hundred dollars," she related, still

astonished. Similar care she had received in American hospitals had seemed just as good to her, but came—as usual—with a much higher price tag and far more hassle and stress.

When Americans imagine a hospital in a public health-care system, they often envision something out of the former Soviet Union—a barren, gray, old facility with lazy staff, dirty sinks, and lack of adequate equipment. The decor of Finnish hospitals actually did strike Pamela as somewhat sparse and utilitarian, with the chairs lined up in the hallways next to the appointment rooms, instead of having general waiting areas, and without the customary buzz of American hospitals with their volunteers, chapels, and gift shops. Visiting a rather sad-looking gift shop in a Finnish hospital, Pamela immediately envisioned how she could spruce it up, and her American can-do spirit bubbled up: "I thought, I wanna whip you guys into shape!"

Squandered gift-shop opportunities aside, Pamela would like to correct some of the misconceptions about public health care that she feels her fellow Americans have. Finnish hospitals are just as clean and modern as American ones, sometimes even more so. But what about the latest medical innovations? Didn't she think she might get better, more cutting-edge care if she were to move back to the United States? No, Pamela replied, she didn't think she was missing out. And she had something with which to compare her Finnish care—her sister in the United States has MS too. Imagining herself back in the States, Pamela mused: "I'd be getting more cutting-edge care than in Bangladesh, yes, but not more than in Finland."

Later I encountered another American in Finland married to a Finn, and this American was also suffering from MS. Michele's experiences were very similar to Pamela's. But her disease had already progressed so far that she required expensive medications that Pamela did not yet need. In the United States drugs

for MS are much more expensive than in many other countries; when she lived in the United States Michele was paying six hundred dollars in copays every year for one drug she needed, even with her insurance. When I chatted with her, I sitting in Brooklyn and she in Finland, she had just been to a pharmacy to fill a prescription for the same drug. In Finland, she told me, the drug was costing her the equivalent of fourteen dollars a year. (This was before the Finnish government set a new annual deductible for all prescription drugs—fifty-five dollars in 2016.)

Pamela missed her friends and family back in the United States, and reminisced about many aspects of American life that were easier for her—abundant parking, big grocery stores, a bigger house, cities designed for people who have difficulty moving. But as far as she was concerned, the quality of the medical care in both places is fine. For her it is all about being able to *afford* that care.

Pamela's case can be considered somewhat unusual, of course, in the sense that she happened to develop such a serious, long-term condition. But even when people don't, there is one ailment that no one can escape.

AGING WELL

The hope for all of us in the twenty-first century is that we survive to a healthy old age, and lead independent lives, passing our days as we would like and giving our affection and attention to our loved ones without strings attached. The Nordic health-care system helps make this hope a reality, while the American health-care system often shackles people instead into relationships of dependency.

In the United States, Medicare helps those aged sixty-five

or older pay for their health-care needs. But there are some enormous holes in long-term elder care that Medicare doesn't cover—in fact some of the biggest expenses of all: room and board in nursing homes or assisted-living facilities; twenty-four-hour nurse services; home health aides who deliver meals, help bathe the elderly, get groceries, and clean the house. In America the cost for all such services simply falls on the elderly themselves, until they've exhausted most of their assets and are destitute.

To pay for all this yourself, the conventional wisdom in the United States is that you need to have saved at least a million dollars before you can retire. Unfortunately most Americans are nowhere close to meeting the minimums they need. Based on a 2013 estimate, the median financial net worth of an American household headed by someone nearing retirement—aged fifty-five to sixty-four—was, excluding homes and cars, not much over sixty thousand dollars. Meanwhile, in 2013 the median annual cost for a private nursing-home room in the United States was more than eighty thousand dollars. If an American completely runs out of money in old age, Medicaid—the state-run program for the poor—will probably kick in, but it will often require relocation to a nursing facility of questionable quality. Some states have also been cutting their Medicaid funding and changing eligibility requirements, leaving people who once relied on the program to their own devices. Considering all this, perhaps it's no surprise that several studies have identified running out of money in retirement as one of the most pervasive fears among large swaths of the American public, even among the wealthy.

Since many elderly Americans cannot possibly pay for all the services they need, their grown children end up taking care of them—not just helping to pay their bills but literally becoming their nurses and home health aides, as well as their health-care coordinators and advocates. This, of course, is on top of the burdens these grown children are already shouldering—trying to take care of their own kids, managing their own family's health care, and paying their own bills. This requires adults and their elderly parents to negotiate a profound, intensely personal, and often discomfiting new role reversal, in which parents who have grown accustomed to their autonomy become dependent, sometimes painfully so, on their own children. Sometimes these new relationships between older parents and their offspring become a wonderful opportunity for renewed emotional connection. The reality of life in the United States, however, tends to be that younger families with kids are already stretched terribly thin, struggling to make ends meet in terms of both money and time. While they might be more than happy to spend some weekends and holidays with their elderly parents, taking care of them and paying their bills is an entirely different matter.

As I observed the lives of my American acquaintances and relatives, I was dumbfounded to learn that it was perfectly common for people with careers and children to take turns with their own siblings doing elder-care duty. Others were paying thousands of dollars each month to help their parents cope, and some women in the prime of their working years were dropping out of the workforce and giving up their careers in order to care for aging family members.

These sorts of arrangements might not come as a surprise in a traditional society where, for example, daughters-in-law might be expected to cook three meals a day for a three-generation household and wait on their husbands' parents hand and foot. But that's not the society that most people in the modern West aspire to in the twenty-first century.

Nordic families love their aging parents as much as those anywhere in the world. That's exactly why they want their love for the elderly to remain untainted by the sort of resentments

that can arise when aging parents are stuck in relationships of dependency with their own children—relationships that destroy the autonomy, independence, and freedom of everyone involved.

The Nordic countries are among the nations around the world whose populations are aging the fastest. Many aging societies across the globe still expect children to help pay for their elderly parents' care, but the Nordic nations, informed by a view of contemporary life that draws on the Nordic theory of love, are not among them. They believe that it makes more sense in this day and age for society to provide complete elder care as a basic social service. This in turn allows families to enjoy one another's company, unencumbered. It also ensures the dignity and well-being of every individual, regardless of his or her personal wealth—and regardless of the not-insignificant question of whether or not he or she happens to get along with every member of their family. Just as Nordic societies believe that children should not be left at the complete mercy of their parents, they also believe that parents should not be left at the mercy of their children.

Because of this philosophy the Nordic countries have arranged elder care largely the same way they've arranged public health care, as a fundamental government service that is paid for through taxes and that is available to everyone. A chief goal is to help aging citizens remain in their own homes for as long as possible, with municipalities supporting them by providing home health aides, food delivery, housecleaning, and shopping services either for free or at an affordable price. When the elderly do move into nursing homes or assisted living, the cost is partly covered by contributions from each resident's own pension or retirement income—to the extent that such income is available. But there is also a reasonable cap on these contributions, allowing each resident to preserve some financial independence as well. The rest is funded by the public system. As a result the assets of nursing-home residents are not touched, nor will their children be charged. Tellingly, many of my acquaintances in the Nordic countries—including those who see their elderly relatives quite frequently—remain unfamiliar with the details of their care and its costs. Much of it is arranged directly by municipalities, so there's no need for other family members to get involved in managing the logistics.

It must be stated, though, that Nordic elderly care—and Finnish elderly care in particular—has many problems. The quality and costs of such care are debated constantly, and the Nordic media have exposed poor practices in both privately and publicly operated nursing homes. Finnish politicians have begun to suggest that as the population continues to age, wealthy baby boomers can't continue to expect to get their care fully covered. In addition the Finnish eagerness to help the elderly live in their homes as long as possible has lately led to accusations that even those who cannot cope at home anymore are having trouble getting into nursing homes. Despite these issues, international studies have consistently found the Nordic countries, particularly Norway and Sweden, to be some of the best places on earth in which to grow old.

As with Nordic health care more generally, there is a fair amount of choice for the elderly. They can choose to pay for private services themselves, or to live in private assisted-living facilities. And many grown children do spend countless hours helping their aging parents. But instead of paying for and arranging the care from scratch, their burden consists of discussing the best solutions available with their parents and the municipal caretakers. In cases where family members prefer to care for their own relatives, the state will fill in where necessary.

For example, municipalities can provide a home health aide who might take over from the family members on weekends or during a vacation period, to give the main caregiver a break. Municipalities will also often pay a family member a stipend while that person stays home to care for an ailing loved one.

When comparing the American and Nordic approaches to elder care, it might still sound as if the Nordic approach breaks families apart by weakening the bonds between family members. However, research suggests that the opposite is true. Tine Rostgaard, a professor at Aalborg University in Denmark who specializes in Nordic family policies, explained it to me this way: "Because we have such a big public provision in place, you could also say that people dare to go in to give informal care because it's realistic for them. It's not too time consuming, and they don't stand alone with the biggest care tasks."

In other words, Rostgaard continued, having a public system that will take care of the fundamentals, and the most difficult aspects of care, actually frees up family members to provide truly loving care for their aging relatives in ways, and amounts, that are not overly taxing or exhausting. This leaves everyone more satisfied, and prevents resentments from poisoning relationships. Again the Nordic approach improves everyone's quality of life.

ENVISIONING A HEALTHY NATION

When ObamaCare took effect at the beginning of 2014, some people in Europe had the impression that America's health-care system had actually been rebuilt. I was chatting in New York with a friend visiting from Finland, and at the mention of my health-care woes, he brushed me off brightly, with impressive

naïveté: "But now you have ObamaCare!" From the perspective of Europeans, the state of American health care has been such a strange anachronism for so long that it's perfectly reasonable to assume that it should have been fixed by now. But of course it hasn't.

The Affordable Care Act did address some of the problems. It has extended coverage to millions of Americans, required insurance policies to cover more people than before, and put some limits on insured people's expenses. What the law didn't do is make it simple to buy insurance, or address the overall problem of skyrocketing costs. I happened to be one of those frustrated people in America whose deductible and copays shot up after ObamaCare, even as my out-of-pocket maximum went down. And despite the lower out-of-pocket max, ObamaCare did nothing to ease my fears that if I had serious medical expenses, no matter which private insurance company I was stuck with, it would deny half of my claims anyway. As American commentators have pointed out, ObamaCare is a ridiculously complex, inefficient, annoying, and fundamentally compromised way of trying to do something simple—provide health care for all.

Setting aside the political influence of the private health-care industry, are there legitimate reasons why the United States can't accomplish what most every other wealthy industrialized nation has done, and create a true public health-care system?

As far as I can see, there are three main reasons why the United States arranges most of its health care through employers and private insurance companies. First, doing so doesn't require new taxes. Second, it allows people to choose for themselves the insurance plan and doctor they want. And third, many Americans assume that if you allow a number of profit-driven private insurance companies and private health-care providers to compete with one another, it's good for the consumer.

The thing is, Americans are already paying for much of their health care one way or another through taxes. Taxes finance Medicare, Medicaid, and all health care for military veterans through the VA system. The new subsidies created by ObamaCare work through tax credits. And even private employer-sponsored health care is being supported by taxes. Contributions to health-insurance plans by employers and, in most cases, by their employees are tax-free, which in effect means that employees are actually getting a big chunk of their compensation before taxes. This exemption makes employer-sponsored health care one of the biggest tax breaks in the federal tax code—which is to say, it's public spending in the form of tax dollars not collected. And as such it's a terribly inefficient use of tax dollars, because it directs the biggest benefits to those with the highest incomes and the most generous health plans. People with lower incomes and less generous plans, and those who are uninsured altogether, get a much smaller break or none at all. Overall these policies are a hodgepodge of measures created at different times that have ended up treating Americans very differently depending on how they get their coverage.

And when it comes to buying and selling health care, when a buyer in any transaction is desperate—as most of us are when we need medical treatment—the seller has a huge unfair advantage, and this can distort an otherwise rational free market. In holding on to its private, profit-driven model, the United States is way behind the times, and average American citizens are increasingly getting stuck with the enormous price tag for this completely outdated and unconscionably unfair system.

If a society had limitless funds, constantly running expensive tests on everyone and paying doctors and health-industry executives gigantic salaries would not be a problem, as long as the

treatments were justified for medical reasons, and as long as the poor didn't get left behind. After all, that's what most of us think of as good medical care—the more the better. At the same time the issue is more complex than that. Health spending is growing everywhere in the world as populations age, as expectations rise, and as new technologies and drugs generate more tests and treatments for ailments that used to go undetected or untreated. In a sense no matter how much money a country spends, health care will always be a bottomless pit. There is always something more you can do, and indeed, we are doing much more now than just a few decades or even years ago. But that's also precisely why a modern nation in the twenty-first century needs to ensure that its money is spent wisely—that society is paying reasonable amounts for health care that is effective, and that the criteria for doing so are clear and transparent.

If America's reckless spending were actually creating incentives that dramatically increased the quality of care, then perhaps it could be justified. But the experience of the Nordic countries, along with other advanced societies that have national health care, shows that this just isn't the case. The care in the Nordic countries is equally as good as, or even better than, the care in the United States.

Because spending on health care in the United States has been growing much faster than the overall U.S. economy, and much faster than the family income of most Americans, Americans can essentially no longer afford it. This is sadly ironic: Futuristic new technologies and drugs are being introduced constantly, while most Americans are falling backward into a state reminiscent of the distant past, when only the well-off could afford medical treatment. As a Commonwealth Fund report explained in 2015: "In an effort to reduce their own cost of providing

health insurance, employers have increased the amount that workers contribute to their premiums and also to their health care, through higher deductibles and copayments. The result has been a rapid increase in employees' out-of-pocket costs for premiums for plans that provide less financial protection."

In the decade leading up to 2013, employer-sponsored insurance premiums rose three times faster than wages. Employees' premium contributions and deductibles doubled. As a result Americans are being asked to spend a much bigger part of their wages on health care than just a decade ago. The system that is meant to benefit consumers is strangling them, often to within inches of their lives.

Sadly, many Americans only discover this when they get sick.

In 2014 a forty-eight-year-old nurse from Austin, Texas, named Genny was diagnosed with stage III colon cancer. Her doctors immediately signed her up for a complicated course of treatment that ended up requiring her to be hospitalized for nearly two months. She underwent radiation and several surgeries, and after that twelve rounds of chemotherapy. The treatments were painful, and she endured long periods of excruciating discomfort. The threat of death hung over her and traumatized her husband and their young daughter. On top of all this was the nightmare of her health insurance.

When Genny discovered she was sick, she was insured through her husband's employer. The insurance company was a large corporation with a nationwide presence, the coverage had been good, and over the years the family had diligently monitored their health, getting their teeth cleaned every six months and taking their daughter for annual checkups, without ever experiencing any serious problems. Now, as Genny started her

treatments, everything seemed fine at first. The couple paid out-of-pocket copays and other small charges, but the insurance plan covered most of the costs.

After Genny was discharged from her long hospitalization, and after her several surgeries, she needed follow-up care on an ongoing basis. She still had several open wounds that needed to heal, as well as a catheter and an intravenous line, and she was still suffering severe pain. Her husband had already taken time off to care for her, and had to get back to his out-of-town job. No one in her immediate family was available to help her manage all this either. So she contacted a home health-care agency, gave them her insurance information, and started receiving care. Three months later her insurance company informed her that while home care was generally covered, in this case the provider had failed to get a prior authorization, and the company was thus refusing to pay for it.

Around the same time Genny started her chemotherapy. Partway into the months-long treatment, Genny noticed something odd: The forms from her insurance company were now stating that she was responsible for fifteen thousand dollars for each round of chemo. Suddenly—without warning, it seemed—for the past several treatments Genny had been incurring bills from the oncology center that now totaled some sixty thousand dollars.

Stunned, Genny put two and two together. A month into the chemo, her husband's employer had decided to switch everyone to a different plan with the same insurance company. Genny and her husband had received a notification of the change from the employer, but because it was still the same insurance company, and their coverage had always been good, given everything else they were dealing with they hadn't gotten around to checking whether there had been any changes to the

specific doctors in the new plan. As it turned out, the oncologist and infusion center Genny had already been using had been in-network on the old plan, but not on the new one. No one from the oncology center had pointed this out to her, and she hadn't figured it out herself until after she'd already incurred tens of thousands of dollars in fees.

Then Genny's husband was laid off. The couple was left with no income, and now faced losing medical insurance altogether. Her husband's employer had agreed to keep paying the premiums for another six months, but after that they'd be on their own.

When I spoke with Genny, almost a year after the initial diagnosis, she was nearing the end of her chemotherapy, and as far as her health went, I was glad to hear that things were looking up. Her husband had also gotten a new job, and it came with new health insurance, though from a different company. But Genny was still struggling to figure things out with the old insurance company. "Every time I see one of their envelopes in the mailbox my heart seizes," she told me.

By now she had received dozens of statements from the insurance company, filled with inexplicable codes and confusing charges. "Just to give you an idea," Genny told me, "every chemo treatment has fourteen or fifteen separate charges. They're all for the same dates of service but they're different charges that are covered differently. Frequently they'll assign duplicate claim numbers, or they'll assign different claim numbers for the same date of service." When Genny had the strength, she spent countless hours going through the paperwork, and more countless hours on the phone trying to deal with the astronomical charges that had piled up. She shared some of the paperwork with me, and just looking at it seemed enough to make my head explode.

To avoid any breaks in her care, Genny was now paying the

oncology center monthly installments, and charging thousands of dollars' worth of bills to her credit cards. A patient advocacy group was trying to help her reach some sort of agreement with the insurance company. She still had no idea how much she would owe in the end, and she avoided tallying up all the expenses because it was too devastating. "It's frustrating, it's scary," she said, "and it seems completely arbitrary what gets covered and what doesn't. Nobody knows how much anything costs, and none of it makes any sense. As if cancer and unemployment weren't enough."

Some time after I spoke with her, Genny received both good and bad news. In response to her appeals the insurance company had finally agreed to treat her provider as if it were in-network—for certain dates. That meant that at least part of her chemotherapy would be covered after all. But her home care still wouldn't be covered. While this freed Genny from some of the most outrageous bills, she remained exasperated by the whole ordeal—and no wonder! This sort of thing is not supposed to happen to people fortunate enough to be living a modern life in a wealthy nation.

The husband of a close friend of mine in Finland had also been battling colon cancer. His Finnish doctors in the public healthcare system did everything they could to save his life, including a series of complex surgeries, hospitalizations, and chemotherapy over the course of several years. They were blunt with him about his chances, which were not good, but they never stopped trying; at one point he even underwent brain surgery at the hands of Finland's top neurosurgeon, who is a legendary specialist with an international reputation. When needed, the municipality sent health aides to care for him at home, and toward the end of his life also paid for his care at a private nonprofit hospice. Even with all the care he received, his approaching death and the exhaustion of

enduring the operations and chemotherapy were devastating to him, to his wife, and to his two young children.

In his case the family's finances were also a concern. Although my friend—his wife—works, he himself was able to work only intermittently after his diagnosis. After they did the math, however, they realized that they could still cobble together enough income from her earnings, his salary when he could work, and from the cash benefits the Finnish public system sent them to continue to afford the middle-class lifestyle they'd previously paid for with two incomes. Never once did they have to worry about being left with huge medical bills.

Instead they could focus their energy on cherishing every additional day that the treatments brought, and on loving each other while he was still alive.

The experience of Nordic health care suggests that there is actually no good reason the United States can't switch to a similar approach, and offer high-quality care for less cost. Universal public health care could begin in a variety of ways. The federal government or state governments could operate public insurance plans on the new health exchanges. Such "Medicare-for-all" plans could offer a transparent, fair benefit package to anyone who wanted to buy it, and as these plans grew in participation, they could negotiate better and better prices with providers. This idea is not new. In fact, a public option has been proposed in the United States many times, notably during the early stages of the Affordable Care Act. Several polls have indicated that a half or even a majority of Americans are in favor of creating just such an option.

Some states and counties are already taking matters into their own hands. Vermont, for example, has been preparing to move to a Canadian-style single-payer option. The most recent

plan was to create publicly funded insurance that would offer coverage to all residents starting in 2017, but a few years before the deadline Vermont's governor announced he was abandoning the plan for the time being due to cost concerns. Bills to advance similar plans have been introduced in several states, including Massachusetts and Ohio. Some counties in California are continuing efforts to create public plans or expand the functions of existing ones. Having every state create its own system is messier and more complicated than having the federal government offer public health insurance for all, but in Canada, for example, public health insurance is arranged by the provinces. Similarly, a variety of efforts by American states could hasten change and serve as a laboratory for nationwide reform.

What else could the United States do in the short term? The fact that the United States still does not regulate the prices of most medical treatments and drugs, or consider their effectiveness when determining coverage, is starting to look like a major national embarrassment. Today many nations continue to base their health-care systems on private providers and private insurers, but they set rates just as they do for any other public utility—as they would for an electricity company, for example—or they negotiate fees and basic benefit packages with providers and insurers. In Europe, where prices are regulated, American pharmaceutical companies still happily sell products, clearly deeming that business to be worthwhile. Drug companies warn, of course, that if their profits in the United States were curtailed it would reduce their ability to innovate, but the research and development costs of major American drug companies are but a fraction of their vast profits. Drug companies spend much more on advertising than on product development. As it happens, the United States is also one of the few countries that allows advertising of prescription drugs directly

to consumers. As Steven Brill noted in his exposé for *Time*, there is no reason Americans should be subsidizing these companies with higher prices than in the rest of the world.

There are many ways to change the current American system. President Obama asked Congress to let Medicare officials negotiate prices with drug manufacturers, an utterly sensible practice that is, astonishingly, forbidden by current law. Several states have considered bills that would require drug companies to report their costs and justify their prices to public agencies. With costs continuing to skyrocket, the United States actually has no choice but to catch up sooner or later with the rest of the advanced world on cost control, and these measures could be a start.

The benefits of bringing public health care and more regulated health care to America would likely be huge. For employers, universal coverage would level the playing field and make everyone more competitive, at home and abroad. Currently U.S. employers that offer their employees health insurance, like those that offer parental leaves, are at a disadvantage compared with those who don't. They're also at a disadvantage when competing with companies in other countries with public health care. Many American employers have already hinted that they'd be more than happy to drop the burden of providing health insurance and instead offer their employees higher wages, or support for purchasing their own health insurance. ObamaCare forced big employers to keep offering health insurance, whereas a public option would free both employers and employees from the absurdity of health care that's tied to employment.

For doctors a more unified public system with set prices and clearly defined benefit packages would make their work easier. They wouldn't have to spend time figuring out what their patients' different insurance arrangements cover or don't cover, and they could be relieved of much of the paperwork that results from dealing with a multitude of companies and plans. While Nordic doctors complain about having to deal with bureaucracy and not getting paid enough, I've never seen them work the kind of factory line that several of my American primary care physicians and dentists do. Nurses and dental hygienists do most of the work while the doctor or dentist pops his or her head into room after room for a few minutes each, keeping up the pace in order to pay all the administrative assistants needed to handle all the insurance claims.

For individual Americans public health care would bring tremendous improvements in freedom, autonomy, and independence—freedom from employers, freedom from unhealthy dependencies within families, and freedom from countless hours spent arranging health care and figuring out how to pay for it. In a nation that purports to champion freedom, the outdated disaster that is the U.S. health-care system is taking that freedom away. But that's not all. There's another casualty of this system: community.

During a Republican presidential debate in 2011, Representative Ron Paul, a physician as well as a famous libertarian who at the time was running for president, was asked who should foot the bill if a healthy thirty-year-old man with a good job had chosen not to buy health insurance but had suddenly gone into a coma and required six months of intensive care. "That's what freedom is all about," Paul responded, "taking your own risks." The host of the debate, CNN's Wolf Blitzer, sought clarification: Should society really just let the man die? This time it was members of the audience who responded for Paul, shouting out an enthusiastic "Yeah!"

When I first heard about Paul's audience's "just let him die" approach I was outraged. How could any civilized human being think that way? A few years later I understood how. After I had been paying for insurance for a few years while constantly teetering on the brink of personal financial insecurity, I happened upon an article about a self-employed man who could have afforded to pay for health insurance but hadn't, only to find himself later suffering from advanced prostate cancer; ironically, the cancer had not been detected earlier because he had avoided doctors for fear of the costs. He confessed in the article that he had been an idiot, and expressed profound gratitude for the hospital that treated him and forgave most of his bills, which had already reached half a million dollars.

Just like that, I found myself empathizing with Ron Paul's audience. Unpaid medical bills fall either on taxpayers, as government money flows in to subsidize hospitals that provide charity care, or they fall on other individuals, when hospitals raise their prices to cover their losses, and when insurance companies raise their premiums to cover those higher prices. That man had made his choice. Why should I have to bail him out? In Finland I had never felt that way. The current system in the United States, even though we may not notice it, isn't just bad in terms of getting health care; it also literally tears apart the social fabric of the nation.

A health-care system funded through progressive income taxes ensures that everyone contributes according to ability. It also makes health-care decisions part of the nation's democracy and gives people ownership of the system. If the government were to raise taxes significantly to pay for health-care costs without improving care, people would be up in arms. But if a private insurance company raises its prices dramatically every

year, people grumble but mostly can do nothing about it. And in America it happens all the time.

As I interviewed Nordic citizens about their health care, I was struck by how understanding they were of the need to keep costs at bay and to offer care to the neediest cases. Since they felt they were paying for a system that aims to treat patients fairly, they seemed to embrace the need to be responsible in their own demands as well. In the United States the prevailing feeling seems quite the opposite: that insurance companies are the enemies of common people, and thus should be squeezed out of every penny possible. One health-care researcher described a focus group of ordinary Americans in her study as having an "almost vengeful" attitude toward insurance companies, and a clear determination to go for the most expensive care that their insurance would pay for. If you feel the system is treating you unfairly, you feel no need to be fair in return.

It is difficult for Americans to realize what they're missing. Europeans can feel enormously proud of and even patriotic about their health-care systems because they pay for them with their taxes, and they genuinely feel that the system has been created by them and for them. If the system is not working, they are fierce in their criticism and their demands for change. Success in creating an excellent public health-care system is on a par with any other great national achievement, whether winning Olympic gold medals or landing a man on the moon. Such pride is within reach—especially since public health care actually seems to be what a majority of Americans, particularly the younger generations, want for themselves. According to the Pew Research Center, more than half of millennials believe it is the federal government's responsibility to make sure all Americans have health coverage. There is no reason a country as great

as the United States cannot achieve this. Even Burkina Faso has since passed a tentative law on univeral health coverage.

These differences between nations remind me of an Internet meme that made fun of the premise of the hugely popular American TV show *Breaking Bad*. The story begins when the main character, a high school chemistry teacher named Walter White, discovers that he has cancer, but that his insurance won't pay for his treatment. Needing one hundred thousand dollars for his care, Walt hatches a plan to make money—by cooking crystal meth. The joke making the rounds online depicted how the TV show would go in a country with universal health care. Walt and his Canadian doctor are pictured as the doctor delivers the news:

"You have cancer. Treatment starts next week."

The end.

SIX

OF US, BY US, AND FOR US

GO AHEAD: ASK WHAT YOUR COUNTRY CAN DO FOR YOU

WELFARE OR WELL-BEING?

Before I arrived in the United States I had never heard of "big government." I know—someone from one of those "socialist" European countries where government arranges everything from child care to education to health care who doesn't know what big government is?! But it gets even weirder. I'd also never heard of the "welfare state," a term that makes most Americans recoil in horror. A welfare state, I learned, is in the business of producing "welfare queens," people who survive in a state of unhealthy dependency, living off other people's work and never bothering to do any themselves. According to Mitt Romney, who was caught on camera in an unguarded moment during the 2012 presidential campaign, the [illegible]ion of the American population that apparently fit this description was a staggering 47 percent. Another symbol of all this deprivation often seemed