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A Comparative Analysis of Health Care Access and Utilization: Nordic Countries VS. USA

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Abstract
The purpose of this study is to examine healthcare access and utilization to explain the differences in health care outcomes between the Nordic countries and the US to inform public policy. The study uses desktop research methodology using information from publicly available statistics in both the Nordic countries and the U.S. In all 300 articles, journal publications, and websites post about the subject matter were included in this study. The economic data used in the study derive from national sources in the Nordic countries, OECD (Organization for Economic Cooperation and Development) health database, and European Union Eurostat. The healthcare systems in the Nordic countries are publicly financed through taxation and are universal, whereby every person obtains access to the health services they need, when they need them, and without facing healthcare costs that force them into financial hardship. The healthcare system in the U.S. is not universal; it is profit-driven (in terms of private medical services and health insurance programs in the marketplace), and when provided by public institutions, are managed at astronomical rising costs. A significant number of U.S. adults has medical debts. Citizens of the Nordic countries have a better access to, and higher utilization levels of, health care than their U.S. counterparts. Public health policy recommendations would include creation of more social inclusion policies at all levels of government to ensure effective access to, and utilization of, health care for all citizens in the U.S. The U.S. needs to increase its spending on social programs that decrease healthcare costs.
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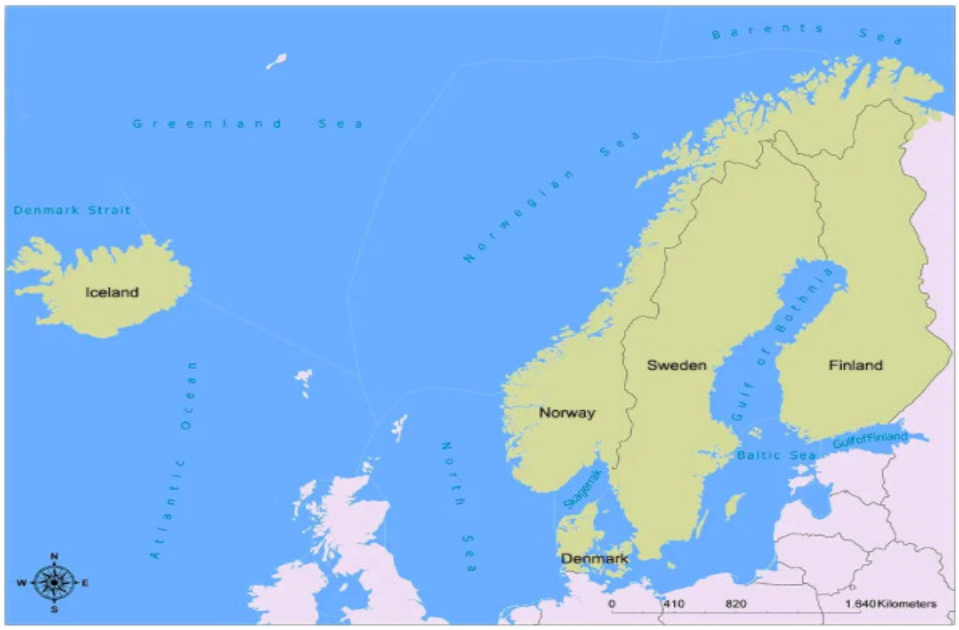
INTRODUCTION

The Nordic countries are a geographical and cultural region in Northern Europe and the North Atlantic (see Figure 1). It includes the sovereign states of Denmark, Finland, Iceland, Norway and Sweden; the autonomous territories of the Faroe Islands and Greenland; and the autonomous region of Aland. They are situated to the north of Western Europe, with Finland and Norway being adjacent and contiguous to present-day Russia. In terms of geographical size, the region is approximately 1.3 million square kilometers with a total population of 27.3 million (2018 estimate) and a population density of 21 persons per square kilometer.

Figure 1: A Map of Nordic Countries



Nordic Countries

The US is situated in North America, sandwiched by Canada to the north and Mexico to the south (see Figure 2). It has a total geographical size of 3,796.742 sq. miles (or 9.833,520 km^2), a total population of 331,449,281 (2020 US Census), and a population density of 87/sq. mile (or 33.6/km^2). It is the third populous country in the world. The US geographical size is approximately 7.4 times, its population is 12.1 times, its GDP 12.53times, that of the Nordic countries combined, respectively.

Figure 2: A Political Map of USA

Source: map of usa - Bing images

According to the World Bank the combined Gross Domestic Product (GDP) of the Nordic countries (excluding Aland) in 2021 was US$1,834.8 billion US dollars compared with that of the US which was US$22.996.10 billion, US dollars, that is, 12.53 times that of the Nordic countries, combined. The GDP value of the United States, ranked number 1, represents 17.2 percent of the world economy. These statistics show significant contrasts between the United States and the Nordic countries (see Table 1 for more details).

Table 1: Statistics Showing Significant Contrasts Between the United States and the Nordic countries

	GDP 2021	
Country	Ranking	Millions of US$
USA	1	22,996,100
Sweden	22	627,438
Norway	27	482,437
Denmark	34	397,104
Finland	44	299,155
Iceland	109	25,459
Faroe Islands	171	3,241
Aland	***	***
Total Nordic Countries		1,834,834

*NB: *** Info not available*
Source:
World Bank Development Indicators Database
World Bank, 1 July 2022

The Nordic region is linguistically heterogeneous, with three unrelated language groups; the common linguistic heritage is one of the factors making up the Nordic identity (Markkola, 2015). In contrast, the United States is English speaking. Although homogeneously linguistic, an increasing number of the Hispanic population

speak Spanish. The population is diverse, Caucasian Whites, African Americans, Native Americans, and Hispanic Whites, make up the racial and ethnic groups.

The above information sets the background of this study.

Access to healthcare is a key topic of debate worldwide. Countries are facing a range of healthcare challenges, from rising numbers of patients with multiple chronic diseases amid population ageing to providing access to new and innovative treatments that are also cost-effective. Healthcare systems must reconcile these challenges against a backdrop of already stretched budgets. As a result, the ability of populations to access the healthcare they need is increasingly under the spotlight (The Economist Intelligence Unit, 2017) .

In 2016 The Economist Intelligence Unit developed the Global Access to Healthcare Index which examined access to specific kinds of care, including child and maternal health services, care for patients with infectious diseases and non-communicable diseases (NCDs), access to medicines, and the extent to which there are inequities in access (accessibility domain). The index also measures the conditions that allow for good access to effective and relevant healthcare services, such as policy, institutions and infrastructure (healthcare systems domain).

The index finds that performance in the accessibility domain is generally stronger than in the healthcare systems domain, suggesting that much more needs to be done to develop and extend coverage, the geographical reach of infrastructure, equity of access, and efficiency to improve the sustainability of health systems (The Economist Intelligence Unit, 2017) .

Access to healthcare and utilization of health care in any country are two sides of the same coin. Access to health care is a precursor to health care utilization. Healthcare access means whether individuals have health insurance coverage and a usual source of care (Carabello et al., 2020; and Krumholz et al., 2021). According to Krumholz et al. (2021), coverage includes private health insurance, Medicare, Medicaid, military plan, other government or state-sponsored health plan. Health care utilization, on the other hand, means individuals have a regular source of care. In between these two vital components of healthcare, is affordability, which implies that individuals do not forego or delay medical care because of cost or are able to pay for needed prescription medicines (Krumholz et al., 2021).

However, the very concept, as well as, the understanding and implementation of healthcare accessibility and utilization has changed across most of the advanced countries, with the exception of the United States (Feldstein, 2012). A far cry is the uncertainty of how much progress has been made in the last two decades towards attaining the goal of universal access to health care, especially for minority ethnic populations in the U.S. (Krumholz et al., 2021).

LITERATURE REVIEW

Healthcare Access

Access to healthcare is a system, whereby every person would obtain access to the health services they need, when they need them, without facing healthcare costs that force them into financial hardship. It is a key topic of debate worldwide. Certainly, access to healthcare poses a challenge to many countries as they face increasing healthcare challenges. The COVID-19 pandemic has exacerbated the challenge and brought it to the forefront. With aging populations, and rising numbers of patients with multiple chronic diseases, the need to provide access to healthcare is increasingly under the spotlight in most countries.

In 2016, London-based The Economist Intelligence Unit developed the Global Access to Healthcare Index, which is to be utilized to measure how healthcare systems across 60 countries are working to offer solutions to the most pressing healthcare needs of their populations. The index provides a total of 23 sub-indicators within two domains to evaluate whether citizens in each country have access to the appropriate health services (The Economist Intelligence Unit, 2017). The first domain is the accessibility index, which examines access to specific kinds of care, including child and maternal health services, care for patients with infectious diseases and non-communicable diseases, access to medicines, and the extent to which inequities in access exist. The second domain focuses on healthcare systems which measures the conditions that allow for good access to effective and relevant healthcare services, such as policy, institutions and infrastructure (The Economist Intelligence Unit, 2017).

At the individual level, access to healthcare is assessed by ascertaining whether individuals have health insurance coverage and a usual source of care (Caraballo et al., 2020; Krumholz et al., 2021). A usual source of care is a usual place an individual goes to whenever he or she is sick or needed health advice, (Krumholz et al., 2021).

While universal coverage is the ultimate goal for most countries in the economically advanced world, it does not mean universal access, even though extending universal health coverage (UHC) can be a crucial part of improving access. There is an important distinction to be made between the ability to access healthcare services and its successful delivery to a wide population. A right to healthcare may be guaranteed in law but not actually available in reality, especially in remote or underdeveloped regions. It may be accessible but not affordable.

According to Yates (2021), there is a need to be careful in allowing countries to say that they are providing access and see if they really are providing the services.

Finally, according to The Economist Intelligence Unit, in its 2016 study, asserted that "it is not enough to provide access to care: people must have access to the care that is relevant and right for them," (p. 29). But the goal is achievable provided: a) the extent to which inequities in access (accessibility domain) are eliminated, and b) the conditions that allow for good access to effective healthcare services, such as policy, institutions, and infrastructure (healthcare systems domain) exist and are sustained. U.S. policymakers should endeavor to adhere to these two principles.

Healthcare Utilization

The US primary care system is almost entirely private and increasingly corporate. The primary care delivery system is extremely pluralistic with little central coordination at either the federal or state level (Weiner, 1988). The majority of Americans obtain primary care from independent office physicians.

About 18% of Americans have medical debt that has been turned over to a third party for collection, according to a report published in July 2021 in the medical journal JAMA. That figure does not account for medical debt that is carried on credit cards or all medical bills owed to providers. Research shows that people with medical debt are less likely to seek needed care and that medical debt can damage people's credit and make it more difficult for them to secure employment. According to Holpuch (2022), many local governments and city councils, such as in Ohio and Illinois, have adopted a new strategy to address the high cost of health care. They are partnering with RIP Medical Debt, a nonprofit that aims to abolish medical debt by buying it from hospitals, health systems and collections agencies at a steep discount.

According to Holpuch & Dickerson (2022), Cook County plans to spend $12 million on medical debt relief and expects to erase debt for the first batch of beneficiaries by early January. In Lucas County, Ohio, and its largest city, Toledo, up to $240 million in medical debt could be paid off at a cost of $1.6 million. New Orleans is looking to spend $1.3 million to clear $130 million in medical debt. The $1 million in Pittsburgh's budget could wipe out $115 million in debt, officials said.

To be eligible for debt relief through RIP Medical Debt, people must have a household income up to 400% of the federal poverty level, or about $111,000 for a family of four, or have medical debts that exceed 5% of their annual income.

Wesley Yin, an associate professor of economics at UCLA, said medical debt relief could be a "game changer" for some people, but governments should also be addressing the causes of medical debt, including high costs and limited access to good health insurance.

A growing body of evidence connects medical debt with health outcomes through effects that we already know influence health. Medical debt-specific research and existing research on the drivers of health draw a clear link between these factors and poorer health outcomes. Even when poor health itself contributes to medical debt, debt-related issues can exacerbate the situation and worsen existing health disparities. Like all other drivers of health, the effects of medical debt are closely interrelated and mutually influential (e.g. the health effects of medical debt may intensify economic stability issues by leading to lower productivity).

Socio-economic differences between the Nordic countries and the U.S. and the prevalent high-level of general welfare system in the Nordic countries, demographic differences, etc. may help to explain the observed differences in accessibility and utilization of healthcare between the Nordic countries and the United States? The partisan political system in the U.S. does not encourage the implementation of social programs that would decrease health care costs and make medical services affordable to all, but especially those below the Federal Poverty Level.

According to a number of scholars (e.g. Feagin & Bennefield, 2014), socio-economic factors play a significant role in the abilities of citizens to obtain health insurance, and thus, access to health care, and utilization. People with high socio-economic status utilize superior resources for better health, while individuals with low status are unable to afford such resources (Feagin & Bennefield, 2014).

METHODOLOGY

This study is based on desktop research and information from publicly available statistics in both the Nordic countries and the U.S. The study used this research methodology because it enables the researcher to review existing research for information relevant to the project's needs. This method is very much appropriate because it assist the researcher to do the following: (a) to identify specific or useful qualitative or quantitative data relevant to project needs; (b) to develop an understanding of current policy and business needs; (c) to identify gaps in existing data requiring further research; and (d) to understand how a project may contribute back to a larger body of knowledge. The review captures articles, journal publications, and websites post about the subject matter. In all 300 articles, journal publications, and websites post about the subject matter were included in this study. The economic data used in the study derive from national sources in the Nordic countries, OECD (Organization for Economic Cooperation and Development) health database, and European Union Eurostat.

RESULTS AND DISCUSSION

Discussion and Analysis of Healthcare Utilization in Nordic Countries

According to a publication on the Healthcare Systems in Nordic Countries in Health Management, 2016, the Nordic countries healthcare systems are taxation based, and therefore locally administrated, with every citizen having equal access to healthcare services. The entire resident population of the Nordic region is covered by publicly financed comprehensive access to high quality health care at minimal or no direct patient cost (Einhorn, 2019).

In Sweden, for example, the healthcare system is mainly government funded, universal for all citizens and decentralized, although private health care also exists. The health care system in Sweden is financed primarily through taxes levied by counties and municipalities.

Approximately 75-85% cost of universal healthcare (Einhorn, 2019) is paid by tax revenues at the local and national levels. co-payments and cost-sharing exist for adult patients in respect of prescription drugs. patient payments are capped at modest levels especially for low-income and chronic conditions.

Health outcomes stack up well in the Nordic countries with Iceland, Sweden, and Norway among the best and Finland and Denmark about average for Western Europe. All have life expectancies two to three years longer than the United States (Einhom, 2019).

Dental care services are free for children but can be a major expenditure for adults. Private insurance is available for dental care.

The basic structure of universal healthcare has remained the same in the Nordic countries for decades. Patients choose their primary care physicians who are the gatekeepers to specialized and hospital care (Einhom, 2019). Emergency care is hospital-based with various on-call systems to allow rapid access.

General practitioners are self-employed; they have service contracts with the local health services. They are compensated through a combination of capitation (patients registered on the physician's list) and fees for services. Group practices and clinics are becoming popular and common.

Like in most countries of the world, especially the U.S., healthcare costs have in recent years increased in the Nordic countries. The overall economic burden, as a share of the Gross Domestic Product, has been relatively stable over the past decade ranging from 8.5 percent in Iceland to 10.9 percent in Sweden (Einhom, 2019).

The economic growth of the Nordic countries will play a decisive part in the future development of the health care sector, because the economic development sets a limit to the resources to be allocated to the health care sector (Stig & Lütz, 2013). The higher the economic growth is in the entire economy, the larger the possibility of prioritizing publicly financed activities. The demographic development, as the number of elderly people is increasing, is an important factor to the economic development.

Discussion and Analysis of Healthcare Utilization in United States of America

In a clear contrast, access to healthcare in the U.S is based on: 1) private insurance which includes coverage provided through an employer or union, coverage purchased directly from insurance companies, or TRICARE, and 2) public health insurance coverage which includes Medicaid, Medicare, CHAMPVA, and care provided by the department of Veterans Affairs and the military.

Employer or union insurance coverage refers to health insurance provided to employees by an employer or by an association to its members is called group coverage. Health insurance an insured bought on his/her own—not through an employer or association—is called individual coverage.

TRICARE is the Department of Defense's health benefits program for the military community. The TRICARE Supplement Insurance wraps around the TRICARE coverage so that in most cases, the insured obtains 100% reimbursement for TRICARE covered services, which includes medical and pharmacy. In addition, TRICARE Supplement Insurance affords the insured the ability to seek care from any TRICARE authorized civilian facility or provider. TRICARE Supplemental Plan covers 100% of Doctors Visits, Pharmacy, and Hospital Co-pays, 100% out-of-pocket costs for covered services, 100% excess charges to the legal limit up to 15% above the TRICARE rates, etc.

In terms of public health insurance coverage, the Affordable Care Act signed into law by President Barack Obama on March 23, 2010, marked a historic achievement in terms of enhancing access to healthcare by including : 1) requirements that everyone buy health insurance (i.e., individual mandate, minimum essential coverage); 2) rules that prevent insurers from denying coverage or raising premiums based on preexisting conditions (guaranteed issue); and 3) subsidies to make health insurance affordable (i.e., advanced premium tax credits, cost sharing reductions) (Hardy, 2020). These three mechanisms were described by Gruber (2011) as "three-legged stool," three fundamental provisions, designed to fix the broken non-employer insurance market in the United States and to expand health insurance coverage as a result.

Under the ACA, various States have numerous roles and responsibilities to play, which include implementing new health insurance requirements to expanding their Medicaid programs. As it turned out, it became obvious, that too many Americans, unlike their Nordic countries' counterparts, were either uninsured or

underinsured. Furthermore, U.S. healthcare spending was high and unsustainable, and private insurance coverage was expensive, thereby driving up copays, and resulting in reduced benefits. According to the American College of Physicians (ACP), although the Patient Protection and Affordable Care Act of 2010 (ACA) led to historic reductions in the number of uninsured persons, yet nearly 30 million remain uninsured, millions more are underinsured. African Americans and other minority category groups accounted for a disproportionate share of the uninsured and underinsured.

Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government. According to Medicaid.gov, total enrollment in the program was 83.5 million people as of August 2022.

Table 2: Number and Percentage of People by Health Insurance Coverage Type in U.S. 2018 - 2020

Number and Percentage of People by Health Insurance Coverage Type: 2018 to 2020									
	2018			**2019**			**2020**		
Coverage Type	Number	Margin of error (+/-)	Percent	Number	Margin of error (+/-)	Percent	Number	Margin of error (+/-)	Percent
Total ……	323,668	133	X	324,550	132	X	325,638	153	X
Any health plan ……	296,206	641	91.5	298,438	688	92.0	297,680	638	91.4
Any private plan ……	217,780	1,222	67.3	220,848	1,121	68.0	216,532	1,166	66.5
Employment-based ..	178,350	1,283	55.1	183,005	1,142	56.4	177,175	1,070	54.4
Direct-purchase …….	34,846	647	10.8	33,170	776	10.2	34,041	653	10.5
Marketplace Coverage	10,743	428	3.3	9,716	417	3.0	10,804	439	3.3
TRICARE	8,537	508	2.6	8,534	522	2.6	9,183	579	2.8
Any public plan ……	111,330	962	34.4	110,687	967	34.1	113,337	923	34.8
Medicare ……	57,720	401	17.8	58,779	409	18.1	59,844	393	18.4
Medicaid ……	57,819	891	17.9	55,851	927	17.2	57,921	893	17.8
VA or CHAMPVA ….	3,217	182	1.0	3,221	188	1.0	2,979	175	0.9
Uninsured ……	27,462	630	8.5	26,111	657	8.0	27,957	612	8.6

Source: U.S. Census Bureau Current Population Reports, P60-274, published September 2021 (Table 1).

From the Table 2 above, the following key take-aways on health insurance can be made: 1) the percentage of people with health insurance coverage for all or part of 2020 was 91.4; 2) in 2020, 8.6 percent of people, or 28.0 million, did not have health insurance at any point during the year; and 3) in 2020, private health insurance coverage continued to be more prevalent than public coverage at 66.5 percent and 34.8 percent, respectively.

Of the subtypes of health insurance coverage, employment-based insurance was the most common, covering 54.4 percent of the population for some or all of the calendar year, followed by Medicare (18.4 percent), Medicaid (17.8 percent), direct-purchase coverage (10.5 percent), TRICARE (2.8 percent), and Department of Veterans Affairs (VA) or Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) coverage (0.9 percent), 4) Between 2018 and 2020, the evidence was that the rate of private health insurance coverage decreased by 0.8 percentage points to 66.5 percent, driven by a 0.7 percentage-point decline in employment-based coverage to 54.4 percent; 5) Between 2018 and 2020, the rate of public health insurance coverage increased by 0.4 percentage points to 34.8 percent, and 6) In 2020, 87.0 percent of full-time, year-round workers had private insurance coverage, up from 85.1 percent in 2018. In contrast, those who worked less than full-time, year-round were less likely to be covered by private insurance in 2020 than in 2018 (68.5 percent in 2018 and 66.7 percent in 2020).

Thus, access to, and utilization of, health care services is driven significantly by the ability to obtain health care insurance in the United States. In contrast, no such comparable statistics exist in the Nordic countries, where universal health care is guaranteed to their resident populations. Their ability to pay for health care services is out of the equation. In the United States citizens who cannot afford health insurance go to the Emergency Rooms (ER) of hospitals to get medical services as a last resort. In the Nordic countries, patients choose their primary care physicians (subject to availability), and these doctors serve as 'gate-keepers' to specialized and hospital care. Emergency care is hospital-based with various 'on-call' systems to allow rapid access (Nordic.info). All municipalities in Norway, for example, offer an out-of-hours medical service for immediate medical assistance 24 hours a day.

In a comprehensive study of the health consequences of uninsurance, *Care without Coverage: Too Little, Too Late*, the Institute of Medicine (IOM) in 2002 found that uninsured adults in the United States have less access to recommended care, receive poorer quality of care, and experience worse health outcomes than insured adults do (IOM, 2002). Derived from a systematic review of a large body of research, the foregoing findings led to the conclusion that, in fact, providing health insurance coverage to uninsured adults, would likely improve their health status and reduce their risk of premature death. Since this report was published, the number of Americans with health insurance rose to 46 million in 2007, including 37 million, or 19.6 percent, of the nonelderly adult population (DeNavas-Walt, Proctor, & Smith, 2008). If health insurance coverage indeed improves health, then the benefits of policies to expand coverage could be substantial.

There is no universal health insurance in the United States due to historical-cultural and political-structural factors (Vladeck, 2002). Among the historical-cultural factors are Americans generally have a negative attitude about government, the absence of a traditional aristocracy, syllogism, the absence of a successful labor party, and the persistent historical issue of race in American politics, all of which combine to prevent a unified platform to achieving universal health insurance. These are reinforced by political-structural factors such as constitutional limitations that prevent the distribution of needed resources from the wealthy to the poor, the diverse nature of the United States, and the power of money in U.S. politics.

Discussion and Comparative Analysis of Healthcare Accessibility and Utilization between the Nordic Countries and U.S.

Whereas the dominant themes in the U.S. healthcare system is its rising costs, and racial and ethnic inequalities amongst its populations, resulting in worse access to effective health care, especially for minority ethnic groups (Waidmann & Rajan, 2000), the Nordic countries manifest a high level of access to high quality health care for all their resident populations. No one is left out on grounds of inability to pay because the healthcare system in each of the Nordic countries is publicly financed through taxation. Access, treatment and public health are the three key dimensions in healthcare policy in the Nordic countries (Einhorn, 2019).

This study found the following significant differences in access to health care and utilization between the Nordic countries and the U.S.

1) Access to, and utilization of, health care services is driven significantly by the ability to obtain health insurance in the United States. In contrast, the Nordic countries have universal health care guaranteed to their resident populations, and therefore access to health care is equally guaranteed.
2) Nationwide healthcare systems take many forms, and access to healthcare varies across countries, municipalities, and individuals and is primarily influenced by socio-economic factors, especially in the U.S. Access to healthcare in the Nordic countries is seen as a fundamental human right by the resident populations; it is an aspiration, at best, in the United States and its attainment remains a mirage.
3) The US spends more than the Nordic countries (indeed, any other country in the world) on providing medical services, yet access to healthcare lags. For example, spending on pharmaceutical is much higher in the U.S. than any other country on earth. According to The National Health Expenditure Accounts (NHEA), Centers for Medicare & Medicaid Services, U.S. health care spending grew 2.7 percent in 2021, reaching $4.3 trillion or $12,914 per person. As a share of the nation's Gross Domestic Product, health spending accounted for 18.3 percent. According to Eurostat, the Nordic countries' share of Gross Domestic Product in 2020 was: Norway, 10.5%, Sweden, 11.4%, Denmark, 10.5%, Finland, 9.6%, and Iceland, 9.6%. The higher U.S. spending on healthcare has not necessarily translated to a better health care, compared with the Nordic countries.
4) The Nordic countries are more egalitarian than the United States, despite the economic superiority of the United States. The Nordic model, which combines elements of capitalism and socialism, partly explains this higher egalitarian status. Important features of the Nordic model include the public provision of social services, investment in services associated with human capital, and a strong social safety net. Society-wide risk sharing is a cardinal component of the Nordic model. The Nordic countries are today among the richest countries in the world measured by GDP per capita (Fellman. 2019). The Nordic economies are marked by large public sectors, extensive and generous welfare systems, a high level of taxation and considerable state involvement. The existing universal health care system is an integral part of the generous welfare systems.
5) The US spends more than the Nordic countries (indeed, any other country in the world) on providing medical services due to prices, appear to be the main driver of the cost difference between the United States and the Nordic countries.
6) Although there are some patient fees in Nordic countries, but they pale, beside medical treatment costs, in the United States.
7) Medical debt is nonexistent among the resident population of the Nordic countries. However, it is an observed feature of the U.S. healthcare system.
8) A major difference between the US primary care system and those of the Nordic countries, (especially

Denmark, Finland and Sweden) is one of control and governance. Whereas the US primary care system is almost entirely private and increasingly corporate, the publicly sponsored Nordic systems are socialized (Weiner, 1988). In the US, the primary care delivery system is extremely pluralistic with little central coordination at either the federal or state level. The majority of Americans obtain primary care from independent office physicians.

CONCLUSION AND POLICY RECOMMENDATIONS

People who lack quality healthcare are often left with a poorer quality of life and lower life expectancy (the overall mortality level of a population). Countries, such as the Nordic countries, with efficient and effective accessibility to health care systems have overall better health outcomes than the U.S. where access to, and utilization of, health care systems lag. Bearing this in mind, some of the policy suggestions, from the U.S. perspective, would include:

- Creation of more social inclusion policies to ensure accessibility and utilization of health care for all citizens in the U.S. The US needs to increase its spending on social programs that decrease healthcare costs.
- The U.S. should enact laws and regulations that will promote and increase access to health care in the country to lower health insurance premiums and rising costs of healthcare management. One often referred to example of US healthcare spending is pharmaceutical, especially innovative medicines.
- Good primary care is a vital building block for good access. The level of development of a country's primary-care system is not only indicative of the political commitment of its leaders to providing healthcare but is also a foundation for any sustainable healthcare system. Moreover, experts are increasingly viewing primary care as one of the best investment governments can make at a time of strained public finances. The U.S. government and Congress should pay attention and pass legislation to improving primary health care.
- Medical debt is nonexistent among the resident population of the Nordic countries. However, it is an observed feature of the U.S. healthcare system. And although some states and city councils have come up with programs to write off medical debts for some of their residents, a national policy aimed at eliminating medical debts is needed. It should not be the norm in the first place before write-offs are implemented.

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