# Identifying and Addressing Deficiencies in United States Healthcare

by

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## Introduction and Status of the System

The United States is currently facing a healthcare crisis. There are systemic issues of cost, access and quality, and many would agree that it is imperative that these issues are addressed. The United States spends significantly more on healthcare than other industrialized nations; both on a per capita level and as a percentage of GDP -- in fact spending more than 13% of GDP on healthcare expenses in 2000 (Shi and Singh, 2008). Additionally, there remains a key difference between the healthcare system in the United States and healthcare systems in most other developed nations. The United States is unique among its peers in that its healthcare system is not universal; that is to say that the system does not cover all of its citizens (Shi and Singh, 2008). It is, however, necessary to recognize that there are several unique factors in the United States -- historical, systemic and cultural -- that differentiate the country from others around the world. The system of private insurance that is in place worked well for a long time, and it continues to work well for a significant percentage of the populous (Poplin, 2008). These issues of cost, access and quality are not, though, limited to the uninsured. The entire populous suffers from the lack of insurance for all. Further, as time passes and problems increase, it is more important than ever to address these issues. Subsequently, it is important that the United States find legislative ways to address the aforementioned healthcare crisis presently.

The healthcare crisis in the United States has reached a transitive point. The increases in healthcare costs have far outpaced inflation (measured as CPI) and GDP growth (Sood et al, 2009; Shi and Singh, 2008). Economic resources are of a limited quantity and this point has been exasperated during the current recession and with rising unemployment rates. These factors, among others, have led to an increase in the number of uninsured individuals (Kail et al, 2009; McWilliams, 2009). The United States also has a growing immigrant population, and many of these immigrants are receiving substandard health coverage and care (Gresenz et al, 2009). Another healthcare population concern in the United States is that of the "baby boomers," or the soon-to-be elderly population. The result of this convergence is that there are more citizens in the United States who will be requiring more healthcare. However, the resources with which to provide this care are limited. Despite efforts that have been made to reform the system, healthcare in the United States is on an unsustainable path given these factors and requires some form of further reform (Sood et al, 2009; Poplin, 2008).

The struggles of the U.S. healthcare system can thus be defined as threefold. The first issue is cost. As emphasized above, the United States is spending significantly more than other developed nations on healthcare (Lancaster et al, 2009; Shi and Singh, 2008). The second issue is quality. Despite spending more, the United States lags other developed nations by many significant measures. As a whole, the World Health Organization ranked the United States healthcare system as 37th in the world during a recent study and the Commonwealth Fund ranked the US system last among a select group of reviewed nations (Davis et al, 2007; WHO, 2000). It is also important to note that the United States ranks below average in important measures such as infant

mortality, life expectancy and maternal death rates (Lancaster et al, 2009; Davis et al, 2007). The third measure of the system is access. As established, the United States operates as the lone developed national lacking universal coverage. Hence, it is not surprising that many U.S. residents do not receive appropriate care because of a lack of adequate medical coverage and insurance; this fact being particularly pronounced among "invisible" populations such as immigrants, illegal aliens, the indigent and the poor (Gresenz et al, 2009; Poplin, 2008; Davis et al, 2007). It is important to note, however, that all of the above measures of the U.S. healthcare system view the system in aggregate, taking into account the full population.

When viewed in its entirety the United States system underperforms on many measures compared to its peers. It must be noted, however, the healthcare in the United States is extremely inequitable. During its review of six similar nations, the Commonwealth Fund declared the United States a clear last in terms of healthcare equity (Davis et al, 2007). While cost, access and quality are attacked systemically, a plurality of Americans still receives a satisfactory and above-average level of care (Poplin, 2008). The United States actually excels far and above the level of some of its contemporaries in some measures. With regard to quality, the United States is a leader in research and development and also provides some of the most advanced treatment available for certain diseases such as cancer (Dove et al, 2009; Shi and Singh, 2008). The adequately insured individuals in the United States have been able to avoid some of the charges of care rationing and long wait times for treatment levied against other systems -- whether fairly or unfairly (Oliver, 2009). While cost is a systemic issue, for some individuals insured through their employers or through Medicare in the United

States, the bulk of that cost burden is shifted elsewhere; making this less of a concern on an individual basis (Shi and Singh, 2008). It is important to note that, despite the systemic struggles of the system in its entirety, the U.S. healthcare system does not fail on all accounts for all individuals.

During the Clinton presidency an attempt was made unsuccessfully to entirely reform the system and provide universality led by then first lady Hillary Clinton and Sen. Edward Kennedy among other (Kail et al, 2009; Poplin, 2008). While these attempts were only made a little over a decade ago, an environmental change has allowed the reintroduction of certain ideas with renewed vigor. The election of Barack Obama and a Democratic congress has afforded a political opportunity for reform (Bybee, 2009). Further, a post financial collapse, post bail-out society with an increase in public scrutiny of corporate culture has made the insurance companies a vulnerable target (Bybee, 2009; Poplin, 2008). The zeitgeist has thus accepted the idea of reform as a necessary evil and ethical requirement; with, for example, 90% of New Yorkers suggesting that the government should do more to cover the uninsured and a majority of those polled even offering that they would be willing to pay more in order to reduce the number of uninsured (Fenichel, 2009; Lang, 2009). With a public and political climate so open to reform, an opportunity has been presented that needs to be seized if meaningful change is to happen in the system.

## Critique of Non-Universality and Consequences of the Uninsured

An underlying factor in many of these criticisms of the healthcare system in the United States is the lack of universality. A defensible argument can be made that the

presence of a large quotient of uninsured individuals results in a reduction of the systemic measures of cost, quality and access. This argument can be structured in two ways, though both are equally important in examining where and how the U.S. healthcare system is lacking. The first, when looking at each of the three aforementioned factors, is what the level of cost, quality and access is for both those individuals who are insured and those who are not. Secondly, and equally important when constructing a plan for reform, is what effect the uninsured have on the levels of cost, access and quality for those that do have insurance. Examining each of the measures provides the initial basis from with we can construct solutions.

*Cost*. Cost is the primary prohibitive factor that prevents many uninsured American from receiving adequate and appropriate healthcare. There are currently over 46 million Americans who are uninsured, and many millions more that are underinsured (Dove et al, 2009; McWilliams, 2009). For Americans who do not have access to employer-based healthcare and who are not eligible for public programs, private market insurance is often unattainable. The estimated cost of providing healthcare for a family of four is $15,600, and this cost can be much higher when pre-existing conditions or other health problems are a factor (Dove et al, 2009; Shi and Singh, 2009). At these levels, healthcare is priced out of the range of affordability for many low income households. It also must be noted, though, that cost is not a sole factor in preventing insurance coverage among uninsured individuals. There exist many individuals who willfully choose not to purchase insurance because they either do not have the need for or perceived value of healthcare (McWilliams, 2009).

Law in the United States provides that emergency care can be received by anyone regardless of insurance, financial or citizenship status; that is to say, anyone can walk in and be admitted to the emergency room and receive treatment. After receiving such treatment, however, an uninsured patient can expect to receive a bill from the hospital that they likely can not afford; this being particularly pronounced as insurance companies have negotiated agreements with healthcare providers allowing them to only pay pennies on the dollar compared to what the average patient would pay on their own (Fenichel, 2009; Shi and Singh; 2008). Additional issues arise in the continuation of the initial care that is received. For example, if surgery were needed, there is only a limited number of doctors and clinics providing service to uninsured patients for which there is often long waits. Furthermore, for the poorest of patients even an inexpensive medication or treatment could prove cost prohibitive (Fenichel, 2009; McWilliams, 2009). While there is no level of healthcare or health coverage that can guarantee health, a reasonable inference can be made that when there is not adequate coverage and care that overall health is likely to suffer.

This raises an interesting dilemma. When the uninsured received treatment that they are unable to pay for, there is a corresponding cost that must be shifted somewhere. The systemic cost burden of the uninsured and underinsured is being passed along to insured populations (McWilliams, 2009). While this cost to the providers has risen, the cost of providing care and the bureaucratic costs in administering care have also increased exponentially (McWilliams, 2009; Shi and Singh, 2008). The result is that these increases for the providers are passed along to the insurers who are then passing along the increases to the insured (Coustasse et al, 2009). Americans are

spending more out of their pockets than ever before on healthcare, and more than half of Americans are spending more today on healthcare than they were at the start of the decade despite being covered by insurance (Bybee, 2009; Tanne, 2009). According to Families USA, workers are spending 87% more on out-of-pocket expenses than they were in 2000. Additionally, more than half of bankruptcies in the United States are caused by medical expenses, and in over three-quarters of those cases the individuals were insured. (Bybee, 2009).

Controlling healthcare costs for the entire population requires efficient usage of limited resources. However, funneling the uninsured, underinsured, poor and immigrant populations into costly treatment avenues (e.g., emergency rooms) places an undue burden on the system as a whole (Coustasse et al, 2009). Individual Americans are not only suffering directly from the healthcare cost increases, but also indirectly. Much of the healthcare cost in the United States is covered by employers, and they too are bearing the burden of premium increases. It is not easy -- and sometimes impossible because of unions or other contracts -- for employers to reduce wages to offset premium increases; subsequently, the rapid increases in healthcare costs forces employer's total compensation costs higher relative to increases in GDP (Sood et al, 2009). If healthcare costs continue to rise, there is a reasonable concern that they could stifle economic growth. A study done by the Health Research and Educational Trust estimated that for a hypothetical 10% increase in excess healthcare costs, that there would be an estimated net loss of over 120,000 jobs. The study further showed that industries where more workers were provided with health insurance were more adversely affected (Sood et al, 2009). Summarily, disproportionate increases in health

care costs have been shown to have an adverse affect on economic conditions; both on an individual and macro level. While the inequitable distribution of insurance is only one part in this, it is nonetheless a very significant contributing factor.

*Access*. The inequitable distribution of health coverage in the United States leads to an inequitable distribution of services. The United States offers some of the most advanced care and some of the most expert specialists available anywhere in the world (Dove et al, 2009; Shi and Singh, 2008). The services are not, however, available universally. Further, certain segments of the population are unable to receive even the most basic levels of primary care. As the number of uninsured individuals grows, more patients than ever are reliant on uncompensated care and charitable care provided by states, hospitals, clinics or other organizations; though with more individuals requiring this care and budgets being strapped, there are less resources than ever available with which to provide this it (Geletko et al, 2009). Finding a means with which to provide access to these individuals and pay for it has been described as one of the biggest healthcare challenges in the United States (Palkon and Baranczyk, 2009). In Florida, for example, the value of donated healthcare services soared over an astonishing 1500% between fiscal year 1992/1993 and fiscal year 2006/2007 (Geletko et al, 2009).

Not surprisingly, studies have demonstrated that in the United States, uninsured individuals have less access to primary care and recommended care and receive an overall lower quality of care when compared to insured individuals (McWilliams, 2009). Many providers are unwilling to offer primary services to uninsured or underinsured patients; thereby the only means for which there is access to the healthcare system is emergency facilities and specialty clinics - whose availability and number are limited

(Coustasse, 2009). In medicine, the quality and continuity of treatment is essential in managing and preventing illness. Since the uninsured are less likely to receive this ongoing care, they are more likely to develop more significant illness requiring more invasive, intensive and costly treatment - for which they have a legal entitlement (Glied, 2009).

As with the costs related to the uninsured and underinsured, these access issues create a trickle down effect for the rest of the population. Since the uninsured and underinsured are forced to seek the bulk of their treatment through emergency facilities, a backlog of patients are created in emergency rooms that would not otherwise be there. This leads to hospitals and healthcare providers being forced to allocate more resources in this direction and away from other areas. As a systemic result, too little evidence based preventative and primary care is received and too much of the more expensive, less effective discretionary care is administered (Dove et al, 2009; Shi and Singh, 2008). The number of uninsured and underinsured and the resulting uncompensated care provided, creates both a financial and resource bottleneck in the United States' system leading to the unavailability of care or wait times to receive care. Subsequently, this factors in to the United States ranking very low comparatively on measures of healthcare access (Coustasse et al, 2009; Davis et al, 2009).

*Quality*. The plight of quality of healthcare in the United State has followed a similar trajectory to access and cost. As demonstrated, the overall quality of care in the United States is subpar relative to other peer nations (Davis et al, 2007). Given the fact that many uninsured or underinsured individuals do not have the fiscal resources to pay for care, it is not surprising that they receive a lower quality of overall health outcomes

(Glied, 2009). In looking at the overall quality of the system, it is nearly impossible to separate the healthcare coverage issues with the net effect on quality; having such a large uninsured quotient receiving substandard care will undoubtedly bring down the average from those who are receiving standard care (Davis et al, 2007). While the argument has been made that given the breadth of resources in the United States that the healthcare system should be able to produce the results of the highest quality in the world, the effectiveness of the system in actually doing that has been called in question (Palkon and Baranczyk, 2009; Glied, 2009).

As has been detailed, concerns about insurance coverage are not limited to a select, isolated portion of the population. Certain segments of the population, in particular the poverty stricken, do have a higher instance of being uninsured; however, a broad spectrum of Americans are affected. The number of uninsured Americans is estimated to be above 15%, with over 30% of Americans thought to have been uninsured over a rolling four year period (Glied, 2009). In addition to financial pressures, the loss of insurance can be caused by a change of employment, a revocation of employer sponsored health insurance or because of the choice of the insured. As a result, all socioeconomic groups are likely to contain some level of uninsured individuals. As the insured and uninsured are intertwined populations, the quality of treatment of the two groups cannot be separated (Glied, 2009; McWilliams, 2009).

The result is a shift in medical service that ultimately affects all patients whether insured or uninsured. For understandable reasons, doctors and healthcare providers are forced to alter their focus to who they treat, as well as on what treatments they provide (Fenichel, 2009). A logical deduction would follow that doctors are only likely to

provide the most advanced, and likely most expensive treatments, where there is negotiated payment in advance with the insurance companies (Coustasse et al, 2009). Some insurance plans, even for those who are fully insured, will not cover certain recommended treatments, rendering them unavailable to patients. Where optimal treatment is not received, health is likely to decline. Not only will insurance affect health here, but health will subsequently affect insurance status -- when health declines it often becomes more expensive and more difficult for someone to obtain health insurance (McWilliams, 2009; Shi and Singh, 2008).

The resulting focus, from both health providers and patients, is subsequently centered somewhere other than concerns about the best possible care and general health; there is the worry of if and how treatment can be paid for. This combined with the large number of people who transition in and out of coverage periods leads to uneven care. Patients will seek and receive more care when they have access to it, and less when they do not. This gap is especially troublesome with chronic conditions, where consistent treatment is necessary for the most effective treatment (Fenichel, 2009). Further, studies have shown that where there is not equitable cost sharing among all patients, there is a net overall increase in the utilization in care (both appropriate and inappropriate) which actually results in no increase in overall health (McWilliams, 2009).

The lack of an equitable system of health coverage results in an equitable system of healthcare being unattainable. Some individuals will receive too little care, and their health will suffer. Others will receive too much care, and their health will not increase despite the increased attention and cost. This blend of care makes it nearly

impossible to measure quality and tell what is working and what is not. Where there is inequitable care, it is difficult to measure whether the successes and failures of a particular facility are due to the ultimate quality of care, or whether their due to the quality of individual patient coverage (Glied, 2009). Summarily, despite the fact that a number of Americans receive excellent care, the quality of care for the population as a whole suffers relative to other nations on account of a sizable uninsured and underinsured population.

## Alternative Approaches and the American Perspective

The United States lags other developed nations in the delivery of cost effective, high quality care to the full population despite advantages in financial and intellectual resources. Subsequently, it is worth examining how other nations have approached these same challenges and why the United States has taken a uniquely different approach. Many modern healthcare challenges are global in their scope; aging populations, poverty, financial constraints and other issues present healthcare challenges in many developed nations (Shi and Singh, 2008; Davis et al, 2007). Nations other than the United States have linked their efforts to improve healthcare quality with efforts to improve healthcare access (Glied, 2009).

While other nations have taken various approaches, the underlying theme in their systems in universality (Oliver, 2009). Some countries such as Canada use a single payer model, where the government acts as an insurer and health delivery remains private. In Great Britain, the government controls both the coverage and delivery of health care. Some countries, such as Germany, use a blend of non-profit and private

insurance organizations along with government and employer subsidies to achieve universality. Another option to achieve universality is to use mandates, such as in Sweden, where every citizen is require to purchase healthcare.

There is no “one size fits all” option that works everywhere. Each nation has tailored its healthcare to fit with its needs and socio-political climate. There are advantages and disadvantages to each. Partially or fully socialized systems such as Canada and Britain’s rank high on equity and efficiency; where systems such as Germany’s rank high on general health and access (Davis et al, 2007). Single payer systems, again like Canada, have been uniquely effective in addressing many of the specific problems that plague the United States; they have shown an ability to reduce administrative costs and improve equity in access (Oliver, 2009; Davis et al, 2007).

That said, the single payer model has long been a point of contention in the United States. An alternative to single payer, the 1993 Clinton plan which sought to achieve universality by ensuring everyone access to private insurance; however, also met widespread opposition (Poplin, 2008). Despite this, an expansion of government intervention is offered by many as a solution to the healthcare problems in the United States. Americans retain their unique disposition though, and continue to question the benefits of such change.

Americans hold many differences compared to their worldwide counterparts. Americans are more likely to hold a negative or skeptical view of government and authority than are their foreign counterparts (Vladeck, 2002). Health delivery systems outside the United States are generally funded through taxation rather than through private contributions, and Americans tend to view additional taxation as a detractor to

private market growth and expansion (Oliver, 2009). Additionally, there exists a large and powerful private insurance market in the United States that is generally not compatible with many public insurance or health care delivery models (White, 2009). Despite these counterweights, there is still significant political desire to effect some level of reform (Bybee 2009; Poplin, 2008). That said, strong opposition and fractured political affiliations make achieving a total restructuring of the system difficult (Poplin, 2008; Vladeck, 2002).

## Actions to Improve Healthcare Delivery in the United States

Immediate wholesale and systemic change in the United States is unlikely. There is not the political or public willpower necessary to make it happen, and the current healthcare insurance and delivery systems are well entrenched. That said, there are measures that can be taken to achieve significant improvements without demolishing healthcare in the United States as it exists today. There are many proponents of taking an approach focused on small, incremental changes; however, these solutions are unlikely to provide lasting and sustainable changes in U.S. healthcare (Lancaster et al, 2009; Bybee, 2009; Poplin, 2008, Vladeck, 2002). As it is said, you cannot clear a canyon with a series of short jumps.

Improvement in U.S. healthcare can be achieved through a pluralistic program; that is, by delivering healthcare through a blend of public and private insurance options. There are concerns that such a system would create a tiered level of delivery and exacerbate the inequality of healthcare. Steps taken to regulate and monitor insurance and delivery can, however, be taken to alleviate these concerns (Lancaster et al, 2009;

White, 2009). The goal of improving the system can be achieved through a number of steps focused on the following two systemic changes; first, expanding a public, government led, insurance option and, second, regulating the private insurance industry. While such a plan is likely to draw the ire of private insurers, if they are able to continue to deliver a competitive product, they will continue to exist successfully (Lancaster et al, 2009; Anderson and Waters, 2007). The result should be a patient-centric system providing high quality care to more residents without the dramatic annual increases in cost.

The first, and arguably most important, step to be taken is to seek and attain universal access. For healthcare to work most efficiently and effectively in the United States, health coverage needs to be made available to all citizens. The first step in doing this is to regulate the primary source of health insurance in the United States. Most Americans receive their coverage through private insurers and the insurers have the ability to cover whomever they please. This often leads to “unhealthy” individuals being unable to obtain coverage in the private market, because the higher payout they would require make them unprofitable for the insurance companies (White, 2009). HIPAA law already lays out pre-existing condition requirements with regard to insurance that is offered through employer plans (US Dept. of Labor, 2009). These same protections need to be implemented in the private market place.

Regulation is needed to require insurance companies to cover individuals, without disqualification based on pre-existing conditions. As previously examined, a cycle exists where not only is a lack of insurance a cause of health problems, but health problems can also cause a lack of insurance (McWilliams, 2009). Further, in order to

allow premiums to remain affordable, it should be required that premiums are set based on a community rating -- where all individuals pay the same rate for the same coverage -- rather than a rate based on pre-existing conditions and health screenings (White, 2009; Poplin, 2008). The result of these steps will be to allow those who wish to purchase insurance, access to do so in the existing private system.

Despite efforts to eliminate under insurance on the basis of pre-existing conditions, there will still be those individuals who will not be best covered by the private market. In order to address the gap in coverage, there should be a comprehensive public option subsequently referred to as Medicare Part E as defined by the Brookings Institution (Anderson and Waters, 2007). Part E will allow for comprehensive coverage for all individuals. Part E, as it has been proposed by the Brookings Institution, would make available affordable coverage to individuals and businesses that currently have difficulty obtaining coverage in the private market for a variety of reasons (Anderson and Waters, 2007).

Medicare Part E also serves a secondary purpose. A very real concern exists that as insurance regulations become more restrictive and the act of insuring becomes more expensive, the insurers will pass these increases on to their customers. As aforementioned, there should continue to be a robust private insurance market, though it has been demonstrated that private competition alone has not been effective in lowering premium costs (White, 2009; Poplin 2008). As with the current Medicare system, an expansion to Part E could include premiums and payouts scaled to actuary determined break-even levels and subsidized for those beneath a certain income level relative to the poverty scale (Anderson and Waters, 2007). While the private insurers

are not likely to be enamored with this idea, studies have shown that there can be an effective co-existence of public and private options (White, 2009; Anderson and Waters, 2007). This system should be established in such a way to allow private citizens or employer to purchase into the plan, as they would with private insurers. For the indigent and unable subsidies can be provided, thus ensuring access for all citizens (Anderson and Waters, 2007).

Summary

Due to a variety of challenges the United States is facing a healthcare crisis that is increasing exponentially and needs to be addressed. Despite delivering some of the most advanced treatment in the world, the United States lags other developed nations in its attempt to provide access to cost effective care of the highest quality to all of its residents. The United States has sought to provide health coverage to its citizens through a primarily private delivery model, supplemented with public insurance for the neediest citizens (the poor, elderly, veterans, etc...). As this system has not effectively controlled costs or provided universal coverage, other nations have moved to a variety of other systems to provide health coverage for their citizens. No system has proven perfect, and each has needed to adapt to the unique aspects of its particular nation. There are many defining factors about the United States that differentiate it from other nations.

Subsequently, despite outside successes it is not feasible to scrap the insurance system in the United States as it exists. There is not the public will for it, and there is not the political capital available to make it happen. That said, the system in the United

States can still be improved to make it work for all Americans, while controlling costs and ensuring quality care for everyone. This starts with reforming the insurance industry so that it works for patients first, and protects the insured. Further, rules can be implemented to ensure that more Americans have access to this private insurance market. As there are still those citizens that will likely fall through the cracks, the private insurance market needs to be complemented with a strong alternative government option. Providing an alternative option that the public, whether individuals or employers, can buy into as opposed to the private market will offer a competitive benchmark for the private market. The majority of citizens will purchase the most cost effective, highest quality product that is available to them. The existence of a competitive public option will encourage the private market to offer that product, and can provide a fall back for the citizens for which it does not.

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