Chapter 8: Health Care in the U.S.

Having knowledge of the history of the health care system in the U.S. will assist us in understanding the problems we have today with health care in the U.S. Let's take a look:

The first U.S. health programs/insurance were established in the 1930s.

- Why were they created?
- Who paid for them?
- What were they and what did they cover?

- Health costs had gotten so high most Americans could not afford to receive care for any major health problem
- Individuals paid for coverage along with companies and businesses that provided their employees with health insurance to attract the best employees and keep their existing employees healthy
- Health insurance: Blue Cross (hospital) and Blue Shield (doctors and other medical expenses)

How did early health insurance affect the push for national health insurance?

- Initially, no desire among middle class Americans for national health care because their health costs were taken care of
- Hospitals and doctors were getting paid by BCBS so they didn't want something different
- What was the eventual problem with this system of insurance?

What were some of the shortcomings of the first health insurance programs?

- Too expensive: Individuals were eventually having to pay high deductibles (insurance won't pay until the insured person has paid a certain amount) and co-payments (amount paid each time visit doctor)
- Only the healthy were allowed to enroll (why?) by using actuarial risk ratings—consequently many people were denied health insurance
- Pay was based on "fee-for-service" (very important concept) where doctors/hospitals got paid for each health care service they provided (What is problem with this? What is the alternative?)
(more shortcomings)
- doctors made more money by requesting more tests or prescribing drugs that required the patient to have regular doctor visits
- hospitals made more money by keeping patients in the hospital longer
- Capitation is a system that pays the doctor a set amount for each patient that has her/him as their doctor; What is the MDs incentive with capitation?

Why did the U.S. government get involved by offering a health program to the elderly (Medicare), disabled (Medicare) and poor (Medicaid)?

Poor Americans could not afford health insurance (as well as many middle income)
- retired persons often lacked health insurance; a single major health problem could bankrupt an older couple
- the disabled were often uninsured
- National health care could not get enough votes in Congress (unlike many other countries where national health care was begun)

What major health care programs did the U.S. government establish/support in the 1960's (there are three, one was for low-income)?
1. Medicaid was established to provide health care services to the poor.
What do you know about Medicaid? (Who pays for it? What services does it provide?)

Medicaid—is paid for by a combination of federal and state funding (the percentage that the federal government contributes to the total cost depends on the wealth of the state—the poorer the state the more the federal govt pays).
Medicaid—varies by state in terms of:
- who qualifies (who is considered poor),
- what is covered, and
- how much will be paid (payment rates to MDs & hospitals for specific health services (Texas is one of the stingiest states regarding all three)
Medicaid—is considered a charity to those receiving it (health care is not considered a "right")

2. Medicare was established to provide health care services to the disabled and persons 65+
Its part of a larger program called:
Old Age, Survivors, Disability Insurance (OASDI)
What do you know about Medicare? (Who pays for it? What services does it provide?)
- the individual (or individual’s spouse) must have paid into Social Security for 40 quarters (10 years total) to qualify (disabled—needs fewer quarters to qualify with exact # of quarters based on a complex formula)
- health services paid for by a combination of federal funds and patient contribution.
- Part A covers hospital expenses and is totally covered by federal funds
- Part B covers doctor/medical expenses and can only be obtained if the individual pays a monthly fee (much like paying for health insurance but less expensive)
- considered an “entitlement”—that is, earned

3. Health Maintenance Organizations (HMOs) were given some federal financial support

What are HMOs, what are their goals, and how are their goals accomplished?

- goal to make health care more affordable
- includes large numbers of people (less likely to be rejected), providing preventive care—services to keep them healthy; reducing “unnecessary” care (surgeries, hospitalizations)
- HMOs have their own doctors who are paid a salary and required to implement HMO policies designed to avoid unnecessary care
- While HMOs sound good in theory, what problems have emerged?

Problems with HMOs:
- HMO premiums have become very expensive as HMOs attempt to serve a larger population and medical costs have risen
- HMO members are restricted to using HMO doctors (this allows the HMO to avoid fee-for-service)
- HMOs are criticized for difficulty getting access to medical specialists, problems with emergency care, and excessive red tape when trying to file grievances or appeals

Overall, health care became too expensive. How did hospitals and doctors contribute to this?

- Hospitals could get paid for as long as they kept a patient (so why not keep a patient for 30 days, even though s/he only needed to be there 5 days, if Medicare would pay for it)
- Doctors could order all kinds of tests that, in many cases, they profited from

What was the government’s response to these problems?

(hint: Diagnostically Related Groups or DRGs)
What has occurred as a result of DRGs?

- Hospitals push patients out too soon because they only get paid for so many days by the government.
- There is a high unplanned readmission rate to hospitals because patients were pushed out too soon (or for other non-medical reasons).
- Hospitals are now fined if their readmission rate is higher than other hospitals in their region.

As the U.S. entered the 20th century, the health care system was not available to many Americans, in spite of a control on costs through the DRGs and gov't assistance for the elderly, poor and the disabled.

Why wasn't the health care system available to many Americans (that is, why was there a push for Obama care officially named The Affordable Care Act)?

- Hospital and MD costs rising dramatically.
- 54 million Americans could not afford to purchase health insurance in 2010.
- Companies could not afford to purchase health insurance for their employees.
- Health insurance companies looked for ways to NOT provide health care services (e.g., dropping participants; selectively enrolling only healthy participants; example: Hepatitis).
- Insurance companies declined people who had pre-existing conditions.

What are some of the reasons the U.S. has not adopted a “universal” health care system while ALL other advanced countries have?

- Considered to be a step toward socialism.
- The value of individualism and taking responsibility for oneself held high.
- Distrust of big government.
- Belief that private business does a better job than government at providing services.
- Any kind of government support is viewed as a “handout.”
- Hospitals, insurance, and pharmaceutical companies believe it would reduce profits.

What factors have contributed to the high cost of health care in the U.S.?

1. High administrative costs due to a fragmented health care system.
   - What does this mean? Examples?
     - Health providers must advertise, sell insurance, hire collection agencies, etc.
     - Doctors and hospitals must spend time negotiating with pharmaceutical firms; health insur. companies.
     - Each insurer has its own forms to be completed forcing doctors and hospitals to hire personnel to complete and submit forms.
     - In a universal health system, such as found in other countries, these problems/costs don’t exist—they use a single-payer system with one form to be filled out and far less coding of procedures.

2. Health care professionals have more influence on policymakers than consumers.
   - What does this mean? Examples?
     - Health care professionals include doctors, hospitals, pharmaceutical and health insurance companies, etc.
     - Health care professionals spend more (millions of dollars) on well designed lobbying campaigns.
     - Has allowed them to control “capital development” such as the building of new hospitals, purchasing of health care equipment, etc.
     - Has allowed them to have more control setting the prices paid to health care providers.
3. health care is a business with health providers seeking to make as much profit as possible. Examples:
   -- for-profit health care providers must make a profit, not just "break even" in order to satisfy their shareholders or private owners
   -- pharmaceutical companies control which drugs come to market, how they are advertised, and at what prices (not so in nations that have a universal health care system; the exception within the U.S. is the Veterans Admin Hospital system)
   -- hospitals compete for patients and doctors by offering specialized units, expensive technologies, etc.
   -- doctors can increase the number of procedures they recommend for a patient to increase their income

4. health care providers have a great deal of power to influence future policy
   What does this mean? Examples:
   -- have prevented the U.S. government from adopting universal health care
   -- have made it difficult for even small reforms to be passed and implemented unless health providers benefit financially
   -- health providers are able to "play" the system by billing for the most expensive diagnosis that is plausible for each patient
   -- health providers avoid seeing Medicare and Medicaid insured patients because the U.S. government sets how much it will pay and the providers have decided the amount set is too low

   In Sum
   The cost of individual health care services is much higher in the U.S. than any other country as a result of the many factors noted.

4. the pharmaceutical industry has a tendency to interpret its pharmaceutical research more positively than it sometimes should be, i.e., they manipulate the data (why?)
5. by funding university research, the pharmaceutical industry can keep researchers from reporting results that show a drug to be ineffective or dangerous
6. the industry attributes its high prices to its expenditures on developing new drugs
   -- however this accounts for only 14% of their budgets
   -- 50% of their budgets go to marketing drugs (many other countries don't allow pharmaceutical firms to advertise)
7. Medicalization to create illnesses that need their drugs
The Affordable Care Act (also referred to as "ObamaCare" or ACA) was introduced despite American values against "big government" and despite the power of the health care industry (i.e., hospitals, doctors, insurance and pharmaceutical companies).

What were some of the conditions that led to acceptance of this health care plan? That is, why did the American people support ACA?

1. There were millions of people who could not afford to pay for health care insurance.
2. Many people could not "qualify" for insurance because the insurance companies would not allow someone to purchase their insurance if they might cost the company money. This was indicated by a "pre-existing" condition.
3. Insurance companies were denying people services that they needed.
4. The health care costs were getting to high even for the U.S. Government which was paying for Medicare and Medicaid.

What are the major features of the Affordable Care Act (ACA)?

- People can not be denied health insurance (i.e., those with pre-existing conditions cannot be denied or offered only extremely expensive coverage).
- People can stay on their parents health insurance plan until age 26.
- Companies with more than 50 employees must provide insurance to their employees.
- Many more people had health insurance because the ACA required everyone to sign up for it (the government created "health exchanges" to help people find health insurance).
- The federal government will allow more people to be eligible for Medicaid (raise the income level for eligibility) if the state agrees to pay its percentage.

What are the major problems with the Affordable Care Act?

- People can purchase insurance through "government health exchanges" but there are still high deductibles (e.g., $5,000) and co-payments.
- Those who had insurance found their coverage got more expensive because insurance companies say they need more money to pay for those who can now enroll but are expensive to serve (they were previously denied).
- Still a very expensive system because of the administrative costs (each insurance company has its own patient forms to be completed instead of having a single form that all insurance companies would use).
- Still a very expensive system because it is still a "for-profit" system so the focus for health care providers is on making money (satisfying shareholders) perhaps more so than on helping those who are sick.
- Health insurance companies can still deny coverage for something that is not life threatening (i.e., a person has insurance but it won’t cover what the person needs).
In sum, major pluses and minuses of the ACA?

- 10’s of millions of people now have insurance who would not otherwise, BUT, many cannot afford the deductibles and co-pays
- More companies are providing their employees health insurance BUT they are now more likely to reduce employees hours to part-time or less than 40 hours/week to avoid the this government requirement
- People with pre-existing conditions can now get insurance BUT their deductibles may be higher than they can pay and the cost to everyone else has gone up

What policies changes have occurred since ACA was passed?

- The U.S. supreme court allowed the Federal government to require all to buy insurance but the Trump administration changed the ACA so it is not required (How does this affect insurance companies?)
- The U.S. supreme court decided that the Federal government cannot make states participated in an expanded Medicaid program for the poor.

What are the myths related to the U.S. health care system?

- Myth: Americans receive more and better care than do citizens of other nations
  - Americans actually receive fewer days of inpatient hospital care and fewer doctor visits per capita (except for the rich)
- Myth: The high cost of health care is due to malpractice suits
  - Malpractice suits account for 2% of total U.S. health care costs; high cost is more related to health care providers setting rates
- Myth: The sophisticated technologies in the U.S. are causing high health care costs
  - actually only contributes a small amount to total costs compared to other causes

The Trump administration has attempted to remove the ACA but has not been successful.

Medicaid: why it’s worse to be sick in some states than others (11:30 minutes)

https://www.youtube.com/watch?v=sOo_aw-xglHQ

Money driven medicine:
(copy into browser, will take you to UNT media lib where can request it on line)

http://iii.library.unt.edu/search~S67?Xmoney+driven+medicine&searchscope=6&SORT=DZ&Xmoney+driven+medicine&searchscope=6&SORT=DZ&extended=0&SUBKEY=money+driven+medicine/1%2C3%2C3%2CB&frameset&FF=Xmoney+driven+medicine&searchscope=6&SORT=DZ&1%2C0%2C0

Watch first 20:00 minutes—explains how doctors feel about the U.S. system
Film: Sicko (produced in 2007) (1st 30 minutes)
https://vimeo.com/76646445

The Danger of Pesticides
www.mercola.com

Kahoot
https://create.kahoot.it/#login?next=

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