

The American health care system

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The American health care system is a daunting, intimidating, complex web of interconnected private insurers, public programs, complex exceptions and options, and a myriad of arcane, obscure laws and regulations intended to achieve one task: provide as much health care as is necessary to the consumer, while preserving an economic incentive for science and industry to continue to produce the dramatic breakthroughs in chemistry and technology that offer Americans incredible improvements in long-term care for the most heinous diseases and chronic. Therein is the rub: consumers seek coverage and care, at affordable prices, and private industry seeks profitability and protection against the expensive long-term investments in scientific and technological breakthroughs that often take years to reach the market. Standing in the middle of the consumer and the producer is the federal government. Yet, it is a fair bet too many Americans envision the federal government as a single actor, capable of reasoning rationally to well-articulated problems. Indeed, the federal government is a complex structure built around a separate executive and legislative branch, with 50 separate states, each on their own electoral time table, and thus each with a multitude of competing demands on their time and money, and each with their own agenda as to how to address whatever priority and preferences seem to have the highest electoral return at any given moment. Everyone can agree that the costs of health care have skyrocketed in the past thirty years, rising from about 5 percent of the GDP in 1960 to over 16 percent by 2004. Everyone also agrees this cost rise is because of the extraordinary achievements in technology and science (as well as having the highest paid physicians per unit of care in the advanced industrial world). And, everyone can agree a nation as wealthy as the United States ought to have everyone receiving the health care they need. How to get there is a story that has as many authors it seems as there are private insurance companies, public lobbying groups, and physicians in the United States. The system seems to many on the verge of total collapse, for lack of clarity and efficiency, as well as an inability to coherently fashion through the American political system a policy response that comes close to correcting the problem – if one can even agree on the true nature of the problem itself.

The remainder of this note will summarize briefly the key issues that seem to be the core arguments and concerns of economists, politicians and experts as they peer into the system. To do so, I have relied heavily on a widely read and to many, controversial analysis of the health care crisis in the United States offered by Paul Krugman and Robin Wells in their review of recent research and publications in the field. Their analysis and findings have been supplemented by

those of Henry Aaron, one of the most widely regarded experts on health care in the United States, and a variety of other sources for insights into this problem.

To understand the basic problems with the US health care system, one must first be clear how most Americans are insured. From my experience in Europe, it seems that all too many Europeans seem to think in extremes on the issue. They either believe Americans pay everything for their health care as out of pocket expenses, or, Europeans often equally error in the other direction and assume that the US has much the same system of coverage as the typical European has, that is something approaching state-supported health care coverage. The truth lies between these two poles, and it is truly complex and to most Americans, too confusing to sustain much interest past a quick 2-minute report on Fox News occasionally. Until, that is, they must confront their first battle with cancer, or a serious injury that disables them or a family member for some period of time, or until they are diagnosed with a chronic ailment that requires expensive drug treatments. Then the truth hits them like a tsunami, and for many, it literally threatens total and complete bankruptcy if they are not properly prepared. In addition to how coverage is provided, one must understand something of the incentives and structures which are built into the system and serve to reinforce the current commitment to the present overly complex system, and which also make reform so difficult. Third, and finally, one must then consider whether reform itself, of whatever type, is a realistic likelihood in the next several years, and if not, what might happen.

Turning first to the types of coverage, one must understand that medical care to citizens in the United States is paid for through four methods: private expenses (either out of pocket payments per treatment, or private insurance), employer-based insurance (private insurance as a benefit provided by the person's employer and not paid for by the person directly), Medicare (federal supported health care for those over sixty-five and/or severely disabled), and Medicaid (for those who are poor or near-poor and cannot survive on their own means of health care). Medicare covers about 40 million Americans 65 and older; about the same number are covered under the rules and guidelines of Medicaid. Americans pay for about 16 percent of the costs of health care from their own pocket. The eighty-four percent they do not pay for is handled by one of the four types of health care coverage.

For Americans under 65 years of age, fully 63 percent are covered by employer-provided health programs. Private insurance (where the consumer chooses their own private insurer, or simply pays per treatment from her own private funds) is usually limited to those who can afford the high cost of private care. According to the Kaiser Family (cited by Krugman and Wells), one of America's leading health care providers, it costs on average about \$10,000 a year for a family of four to pay for private health insurance coverage. This amounts, according to recent estimates, to about half the average wage earnings of a typical Wal-Mart worker

in the US. The fear of globalization and off-shoring for America's biggest corporations is in large measure fueled by the fear workers have that the relentless pressure to cut costs in companies has led to some of America's largest employers severely reducing or cancelling the medical insurance benefits for workers, leaving these workers exposed to the market of private insurance. Another fear is that private insurers seek to insure those who are least likely to need coverage. Indeed, the rule of thumb in the United States is that 20 percent of those paying premiums (either directly or having their employer negotiate with the insurer and paying for the worker's coverage) claim 80 percent of the expenses for health coverage. Indeed, one percent of the population as late as 2003 was accounting for 22 percent of the medical costs in the United States. Thus, those most in need of medical coverage -- the very ill and the less affluent -- drive the system of costs, along of course, with the huge costs of new technology and improved pharmaceuticals. Absent any universal health care system in the United States, this means that for many Americans who can least afford the expensive costs of coverage, and who are at the lower wage scale and most susceptible to unemployment as a result of the pressures of globalization, the complexity and precarious nature of health care coverage is a real and very serious issue. Indeed, the fears are reaching increasingly into the middle and upper middle class ranges of the American social system, as costs rise and the country ages.

Medicaid can help. Uninsured Americans can turn to Medicaid for help when they are without Medicare options (when they are not severely disabled or over 65 years of age) and have no access to employer insurance and cannot afford private insurance. In the past several years, it has been estimated that 6 million Americans have become uninsured in the private sector, and Medicare has picked these people up. It is a complex system, one of the two major social welfare medical systems in the United States (along with Medicare). However, it is funded through a complicated state and federal system (Medicare is funded entirely by the federal government). The rules for entry into Medicaid and increasingly the ranges of coverage for Medicaid patients varies to an extent from state to state. Medicaid is a political target because of its fragmented and diverse political base (50 states, millions of less wealthy and less well-organized and mobilized Americans, and an image of being a welfare waste within the American pay-as-you go, high risk industrialized social-economic system). Medicaid is under fiscal pressure also because states are much more sensitive to budget cuts and the demands of balanced budgets than is the federal government. Since states share the fiscal responsibility of funding Medicaid, the system is continually a target for budget cuts. The coverage one receives under Medicaid is obviously less than what one would ordinarily expect from employer-based systems or from Medicare (or from expensive private insurance).

There can be little doubt however, that both Medicare and Medicaid are becoming increasingly expensive. The Congressional Budget Office notes that rising technology and science costs associated with medical care in American

has the add on effect of pushing the costs of care up faster, per patient, than the per capita income rate of growth within the US. This means that by 2025, the proportion of the GDP consumed by these programs will grow at three times the rate than we would see if indeed the medical costs did not themselves grow so fast relative to per capita income. This disproportionately impacts Medicaid, relative to Medicare.

As Krugman and Wells note in their analysis, when this pressure is added to the fact that employers are also affected by rising health care coverage for their workers, there is a triple crisis of health care in the US: employers are dropping coverage for their workers, Medicaid is under pressure as an entitlement to assist, and the rising capital account imbalances in the US are putting pressure on the federal government to look for ways to cut medical costs across the board on Medicaid and Medicare.

While many proposals exist to reform and improve the system (provide as much health care as is necessary to the consumer, while preserving an economic incentive for science and industry to continue to produce the dramatic breakthroughs in chemistry and technology that offer Americans incredible improvements in long-term care for the most heinous diseases and chronic), the proposals fall into two broad categories. One proposes to create incentives for consumers (and care providers) to make more rational choices and thereby reduce the persistent growth of health-care costs, opening the way to more people being covered through some form of affordable coverage. The second category simply suggests moving to a universal single-payer (i.e., federal government) system. This would amount to a truly universal health care system for the United States.

The proponents of the former option (rational-choice health care) argue with strong evidence that the federal government and employer based insurance companies are not doing enough to control unnecessary expenses. Many of these treatments and health care options are suspected of being offered by care providers without proper consideration of cost. In recent years, the Bush administration has addressed this concern and has begun to embrace this logic through legislation that offers tax incentives to the most affluent Americans to set up private health savings accounts. In this manner, many people might move from employer-based health care coverage to private insurance paid through tax-free private health care saving accounts. The opponents of such a system argue this will drive those who are affluent, healthy and less likely to need extensive care out of the employment-based pool and thereby leave employers and insurers with the most costly and less affluent portion of the population. Profits would not be as easily captured in this system.

For those proposing a universal one-payer system, the gains will be felt through reduced administrative costs (since private carriers spend so much to enforce cost-effective systems, and to screen out the most expensive and high risk

people from their system); less fragmentation (which generates redundancies and waste in the system as a result of so many intermediaries in the market, not to mention the costs of confusion borne by the consumer); and lower cost at higher levels of care. The latter is to be achieved by the scale of economies that accrue to the single-payer. The single-payer, i.e., the federal government, in a universal system would in theory be able to negotiate better drug plans for the consumer and have a more consistent clientele leading to administrative cost reductions in time.

As to efficiency arguments, one must wonder if indeed opponents of the present complex system of primarily private care do not have a point about waste within the system. For instance, in 2002, according to the latest data from the UN Development Report, the United States had an infant mortality rate of 7, compared to 4 for Germany, France and Germany, and 5 for Canada and the UK. The typical American male (per cohort) had a 79.1 percent chance of surviving to the age of 65, while his Canadian neighbor to the north had an 85 percent probability of surviving until 65. A typical Italian male had an 84.6 percent probability, a male from the UK an 83.6 percent probability, a German an 82.3 percent probability, and a French male an 80.9 percent probability. Yet, on a per capita basis in 2002, the US spent \$5,274 on health care, while in Canada the corresponding figure was \$2,931, in Germany \$2,817, in France \$2,736, in Italy \$2,166 and in the UK \$2,160. Of course, one cannot know if these comparisons would worsen, rather than improve, if the current American system was totally revamped. What evidence exists does not suggest it would, but those data are far less comprehensive and systematic.

What are the realistic chances that any meaningful medical coverage reforms will be enacted by Congress anytime soon? Slim to none is the answer. One problem is simply the fiscal mess the country finds itself in right now. Second, as already mentioned, the political matrix within the US federal system makes a coherent reform program highly unlikely. The last time significant and comprehensive reform was attempted, at the beginning the Clinton Presidency in 1993, it proved to be much more than even its most ardent supporters could sustain. And finally, there are far too many special interests that are comfortable with the system as it presently stands. According to The Center for Responsive Politics, in 1990 the pharmaceutical industry spent \$3,235 billion on lobbying Congress. By 2006, that figure had grown to nearly \$14 billion after reaching a peak during the election cycle year of 2000 at nearly \$27 billion. Obviously, they are not lobbying for a universal health care system, but for protecting the profit margins and interest of the pharmaceutical industry, which itself seeks understandably to get as much return as possible on their investment. Democrats receive about 30 percent of these funds, so one should not expect a Democratic Congress to be too ambitious in the pursuit of ways to cut into pharmaceutical profits through federal programs designed to offer cheaper drugs to consumers in a single-payer system of health coverage. Until the baby-boomers start feeling the pinch of cardiac and cancer treatments – something they are already experiencing but are

almost surely to do in much greater numbers in the next decade or so – nothing can realistically be expected to repair the fragmented, expensive, illogical, and largely outdated system of health care to the worlds' wealthiest nation. The reality is Americans may simply prefer a bewildering array of employer-based or private health care options. In this case, perhaps, the market will render its own verdict. Insurers, care providers and consumers have three choices. They can find, through a painful period of discovery, just how much they are willing to sustain the current system, or, secondly, they can work for slight modifications of it, or finally they may simply make the big plunge to a single-payer system. In any event, by most reasonable estimates, we are at least 10 - 15 years from these tough decisions, and as we all know, no politician acts today on a costly reform that can wait realistically until a decade has passed.

Sources drawn upon in this note:

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