

Rising Healthcare Costs in the United States:
Contributing Factors and Potential Solutions

HONORS THESIS

Presented to the Honors Committee of

Texas State University-San Marcos

In Partial Fulfillment of

the Requirements

For Graduation in the University Honors Program

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San Marcos, Texas

December 2008

Abstract

United States healthcare costs have been spiraling out of control for the last few decades. With no universal healthcare system in effect, more than forty seven million Americans lack health insurance and cannot afford even the most basic care. This thesis addresses the factors contributing to the rising cost of healthcare, the global context in which the U.S. ranks regarding system costs and outcome, and potential policy solutions to cap the cost and provide more affordable care.

One of the many domestic concerns facing the United States today is health care policy. The concept of policy is ambiguous, so it must be defined before the issue of health care can be addressed. The definition of the word policy is derived from the Greek root meaning "citizenship" and is described as a set of "principles that govern actions toward given ends."¹ Health care policy refers to "health-related decisions made by legislators" and "rules designed to implement legislation or to operate government and its various health-related programs."² Examples of existing health care policies today include Medicare, Medicaid, and the State Children's Health Insurance Program. Each policy that is enacted has been put in place to target specific members of the population, whether it is the elderly, those with limited income or to insure children. There is no all-inclusive program that provides universal health care benefits to all Americans, and the multi-faceted problems of health care policy only continue to deteriorate.

The United States spends a higher percentage of its gross domestic product (GDP) on health care than any other major industrialized country,³ and, yet, nearly forty seven million Americans remain uninsured.⁴ With rising health care costs continuing unabated, the quality of care deteriorating, and the United States spending more and more of its budget

¹ Charlene Harrington and Carroll Estes, *Health Policy: Crisis and Reform in the U.S. Health Care Delivery System*, 5th ed. (Boston: Jones and Bartlett Publishers, 2008), 5.

² Ibid., 6.

³ *Health Care Costs*. Fact Sheet. AHRQ Publication No. 02-P033, September 2002. Agency for Healthcare Research and Quality, Rockville, MD. <<http://www.ahrq.gov/news/costsfact.htm>> (30 September 2008).

⁴ Dr. Norman Chenven, *Economics of Healthcare* (presented at Women Vote - Austin Chapter, Austin, TX, 15 September 2008).

on health care than almost anything else, the country only continues to further lag behind other industrialized nations not in only health care benefits awarded, but life expectancy and fiscal competitiveness in the world markets.

This thesis will ask the question of whether the system as it stands is effective and economically sustainable. The ever-increasing causation for the cost of health care will first be addressed. The thesis will address how the cost of healthcare and lack of benefits affect the United States in relation to other OECD (Organization for Economic Development and Cooperation) countries next. Health care as a market commodity and the necessity for organizational change will next be analyzed. Finally, potential incremental and large-scale solutions, along with existing policy proposals that have either been enacted in a select few states or attempted and failed will be examined.

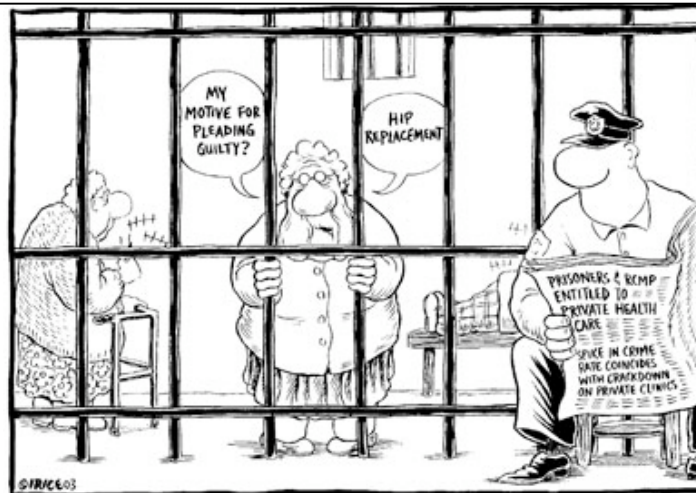
The purpose of this paper is not to come up with the right answer because, as it stands, one does not exist, but rather, to address what is not working in the system. The flaws are easy to identify at face-value, but the broader scope of the problem and complexity of the issue exists within the health status of the American people and the budgetary impact on the United States' GDP. The ultimate questions that must be faced are whether health care is a fundamental right or a market commodity; and how is the issue of inadequate health care policy and regulation in the United States solved?

Chapter 1 will address the factors driving up health care costs.

Chapter 1: What factors are driving the cost of health care?

Sometimes a picture is worth a thousand words...

Figure 1: Shortcomings of Health Care Economics



Source: *Health Frontiers News*, Issue 1, May 2006

The above cartoon illustrates how the struggle to afford health care leads people to desperate measures. The elderly woman in the image cannot pay for her necessary hip replacement, so she admits to a crime she is innocent of so that the state will pay for her medical needs.

Health care policy can be dated back to as early as the 1840s in the United States when some of the first drug safety laws were enacted.⁵ As health care became more advanced and more services were offered, the price naturally began to rise. The 1960s mark the turning point for policy makers to begin to notice a substantial rise in costs for service and a decrease in affordability. Quality of and access to care were naturally concerns for legislators; however, these issues were put on the back burner because the management of costs took center stage.⁶

Prior to the 1920s, healthcare was considered to be a private endeavor in which the government was minimally involved. The Shepard-Towner Act on Maternity and Infancy which was passed in 1921 marked a turning point in the United States when the federal government began providing aid to states for individual health services.⁷ The Social Security Act of 1935 was the first social insurance system in the United States which relieved some of the cost burden of medical care. After the end of the Great Depression and World War II, the Hill-Burton Construction Act (1946) "served as a prototype for federal involvement in healthcare."⁸

In 1973, health maintenance organizations were introduced by President Nixon and Congress as a less expensive alternative to insurance programs, and states were required to mandate rationing programs as of

⁵ Robert I. Field, *Health Care Regulation in America: Complexity, Confrontation, and Compromise* (New York: Oxford University Press, 2007), 5.

⁶ *Ibid.*, 7.

⁷ Litman, 22-23.

⁸ *Ibid.*, 23.

1976 in an attempt to control costs. Other policies passed in attempt to control costs included Medicare in 1965 to pressure hospitals to reduce fees and increase benefits.⁹ This system was originally based on the actual cost of care being replaced by predetermined set amounts based on a patient's preliminary diagnosis; so, the patient received benefits only required for initial diagnosis, not subsequent problems that may not have been readily apparent.

By the 1990s, health care costs skyrocketed out of control. In 2006, economists estimated that over two trillion dollars were spent on medical care, approximately \$6,830 per person.¹⁰ Between 2001 and 2006, insurance premiums soared by seventy three percent, but wages only increased by fifteen percent. Approximately 266,000 companies stopped offering health insurance during that time period, resulting in only about sixty percent of Americans receiving benefits from their employers (down from sixty nine percent in 2000).¹¹ The number of uninsured Americans has steadily climbed in the last three decades, which is primarily due to the fact that per-capita health care spending has increased faster than income; at the current rate, over fifty six million Americans will be without benefits by 2013.¹²

⁹ Ibid.

¹⁰ Marcia Clemmitt, "Rising Health Costs," in *Issues for Debate in American Public Policy: Selections from CQ Researcher*, 8th Edition, ed. Stephen Pazdan (Washington D.C.: CQ Press, 2008), 73.

¹¹ Ibid., 74.

¹² Ibid., 75.

Before the issue of accessibility and affordability of health care can be addressed, the question of why the costs so rapidly increased must first be asked. Improved technology and development of pharmaceuticals, increased administrative costs, a change in the demographics and life style choices are among some of the key contributors. Others include an increased consumer demand, health care labor pressures and medical liability issues. These contributory factors to increased health costs have been outlined below, beginning with the largest element, technology.

Technology and Pharmaceuticals

Health care technology and scientific discoveries have revolutionized the health care industry. Innovations have resulted in vaccines, antibiotics, sophisticated heart disease care, surgical advances and procedures, medical devices (such as CT scanners and implantable defibrillators), and cancer treatment. Few areas of medicine have remained unaffected by some degree of new medical technology. Unfortunately, overutilization and misuse of new technology has led to excessive spending and even higher costs for patients. New and increased use of technology accounts for between forty and fifty percent of annual health care cost increases.¹³ Some types of technology are a wasted cost because it costs more for the new equipment and training of caregivers than it would to use previous protocols.

¹³ Daniel Callahan, *Health Care Costs and Medical Technology*, The Hastings Center (2008) <<http://www.thehastingscenter.org/Publications/BriefingBook/Detail.aspx?id=2178>> (30 September 2008).

A common misconception around forty percent of Americans maintain is that medical technology will always save their lives; death is just another disease to cure.¹⁴ Consumer demand for better health is affected by increased public awareness of medical technology through the media, the internet and direct-to-consumer advertising.¹⁵ Even Congress does not consider the cost of technologies and treatments when they determine which services Medicare will cover. If it is the latest technology, it automatically is superior and will be more effective.

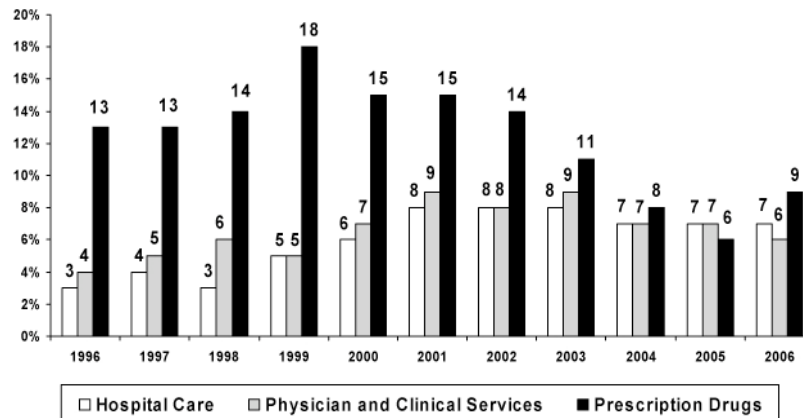
Growth in health care costs is primarily attributed to medical technology spending, which exceeds over \$200 billion annually.¹⁶ There are three primary cost drivers when it comes to the increase in technological costs. First, when patients who do not pay directly for their health care receive services, they place unrealistic demands on their physician to run unnecessary diagnostics and treatment. Second, new technology might be adopted because of its "clinical

¹⁴ Ibid.

¹⁵ *How Changes in Medical Technology Affect Health Care Costs*, The Henry J. Kaiser Family Foundation, provided by the Healthcare Marketplace Project (8 March 2007) <<http://www.kff.org/insurance/snapshot/chcm030807oth.cfm>> (30 September 2008).

¹⁶ Charles Beever, Heather Bums, and Melanie Karbe, *U.S. Health Care's Technology Cost Crisis*, Strategy + Business: ENews (Booz & Company, 31 March 2004) <<http://www.strategy-business.com/press/enewsarticle/enews033104>> (30 September 2008).

Figure 2: Average Annual Percentage Change in Selected National Health Expenditures, 1996-2006



Source: Kaiser Family Foundation calculations using National Health Expenditure historical data for MMedicare and Medicaid services.
<http://www.cms.hhs.gov/NationalHealthExpendData/>.

superiority" to existing technology, but it does not necessarily offer the highest value for a patient. Finally, no market mechanism is in place to determine the value of medical technology, so cost-effectiveness is out the window.¹⁷ The proportion of expenditures from 1996 to 2006 can be observed in the chart above, where prescription drugs consistently ranked higher than hospital care or physician and clinical services. An interesting trend to note is the decreasing disparity among the percentages allocated to each service after 2002.

Aside from technological innovations, new drugs are developed every day, often creating new ailments at the same time. With the production of new pharmaceuticals, a new wave of marketing and information has become available to patients. Where diagnosis and prescription determination used to be at the discretion of the physician, patients are now demanding

¹⁷ Ibid.

advertised medications. Through the internet, television and other media sources, patients have become a more equal partner with their physicians in deciding their treatments.¹⁸

In the past, prescription drugs have averaged approximately ten percent of the total national personal health care spending. Since 1995, costs have been increasing in "double-digit percentages."¹⁹ The primary drivers of increasing pharmaceutical costs include increased utilization, evolving products to newer and higher priced drugs, and manufacturer cost increase due to inflation. The average retail prescription price has rapidly increased two to three times faster than general inflation in the last few years. Prescription drug spending jumped from twelve percent in 1996 to twenty percent in 2003.²⁰ Though the proportion of the United States population using prescription drugs remained constant between 1996 and 2003, spending more than doubled from \$424 to \$950 per person.²¹ Underlying factors contributing to the swift price increase include research and development, spending on direct-to-consumer advertising and decreased customer out-of-pocket expenses.²²

¹⁸ Field, 130.

¹⁹ *Health Care Costs: Why do they increase? What Can We Do?*, Agency for Healthcare Research and Quality, <<http://www.ahrq.gov/news/ulp/costs/ulpcosts1.htm>> (30 September 2008).

²⁰ Samuel H. Zuvekas and Joel W. Cohen, *Prescription Drugs and the Changing Concentration of Health Care Expenditures*, *Health Affairs, The Policy Journal of the Health Sphere*, vol. 26, no. 1, (2007) <<http://content.healthaffairs.org/cgi/content/abstract/26/1/249>>, 429-257, (30 September 2008).

²¹ Ibid.

²² *Health Care Costs: Why do they increase? What Can We Do?*

Around 80,000 strokes occur annually, which can be attributed to atrial fibrillation (irregular heartbeat); in states where anticoagulation drugs have been prescribed regularly, 1,285 strokes were prevented.²³ Middle ear infections account for the most frequent cause of prescribing antibiotics to children. In Colorado, low-cost antibiotics attributed to twenty one percent of expenditures. The Agency for Healthcare Research and Study (AHRQ) found that low cost antibiotics were equally as effective as high cost antibiotics, and nearly \$400,000 of Medicaid for Colorado could have been saved.²⁴ Preventive medicine or more cost-effective use of treatment could help lower the cost of healthcare.

New medical developments greatly affect the increase in cost and medical spending. Development of new treatments for previously untreatable conditions, clinical advances, new procedures and clinical progress and advances all alter the cost of existing treatments. In some cases, the burden of treatment, such as anesthetics and surgical recovery of a patient may decrease. Other treatments, such as vaccinations, may cost more initially, but prevent more investments in the future.²⁵

The question of whether this supplemental treatment is more beneficial must be asked. How often is the treatment used? Do the benefits outweigh the cost? Are some of the uses of technology even necessary?

²³ AHRQ Health Care Cost Fact Sheet, 2.

²⁴ Ibid., 3.

²⁵ *How Changes in Medical Technology Affect Health Care Costs*, 2.

Since the burden of cost-effectiveness lies with the medical insurers and employers who provide health care plans and not the manufacturers or health care providers, the significant impact of medical technology and treatment on health care costs is finally beginning to be recognized.

While technological innovations are the primary cost drivers of health care, there are a number of other factors. The next section of this chapter will turn to the administrative costs of bureaucracy.

Bureaucracy

One out of every eleven Americans is employed by the health care industry.²⁶ The sheer number of medical employees can be illustrated by the growth from 1970 to 1998, where the number of people within administrative positions, such as claims processors, billing clerks or business managers increased by twenty four times.²⁷ During that time, the amount of doctors and health care professionals only increased by two and half times.

The administrative costs of health care often account for more of the cost burden than the medical treatment itself. For instance, in the last five years insurance premiums soared by seventy three percent, even though wages only increased by fifteen percent.²⁸ The regulatory complexity of the healthcare system is so bogged down with paperwork and bureaucracy, that

²⁶ Chenven.

²⁷ Marcia Clemmitt, "Rising Health Costs," 85.

²⁸ Marcia Clemmitt, "Rising Health Costs," 74.

doctors must devote more than twenty five percent of their time to administrative work.²⁹ Aside from the cost and time burden that administrative work has, the defragmentation of the medical system alone is enough to keep healthcare professionals in a bureaucratic quagmire.

Between doctors, nurses, specialists, nursing homes, hospitals, insurance companies, government assistance programs, and other providers, coordination of patient treatment among these various service-providers is nearly impossible.³⁰ Healthcare professionals across the industry have pushed for an information technology system which would improve the quality of care and safety for patients by creating a uniform database so that mis-communication and administrative time costs could be cut down; and the health of the patient could be the focus. While still expensive, the cost burden that falls on the consumers and providers of health care could be diminished, if only by a small margin, because less time would be devoted to paper pushing and more to the health care itself.³¹

Aside from administrative costs, the changing demographics and consumer life style choices of Americans greatly impact the cost of health care. This will be discussed in the next section of this chapter.

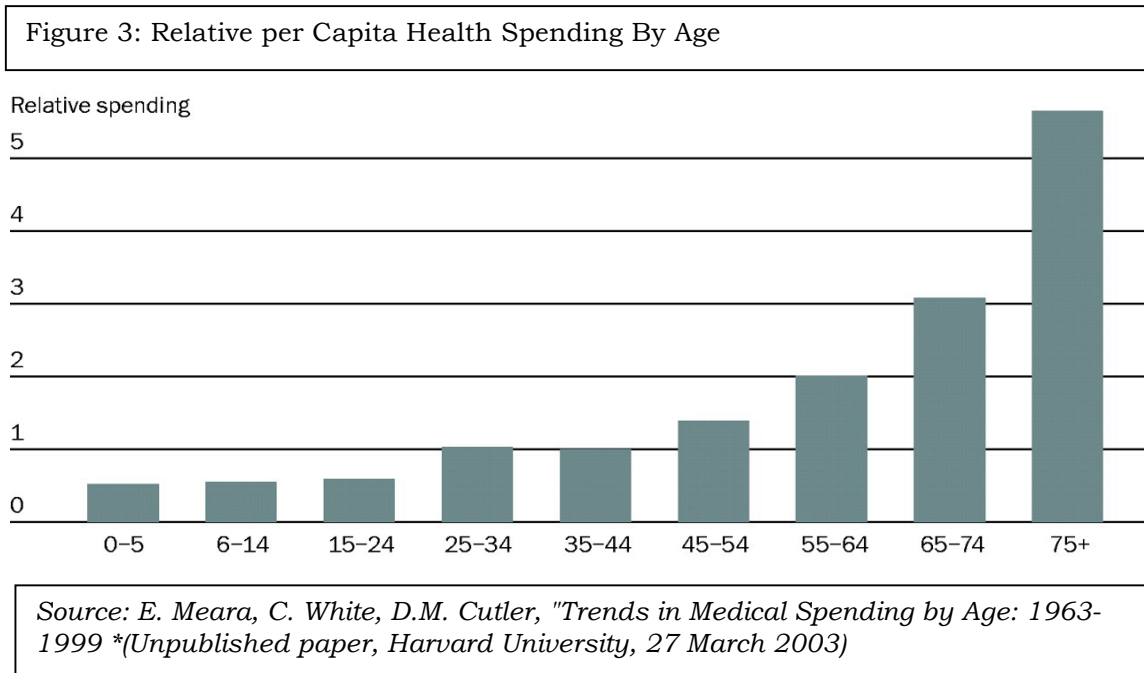
²⁹ Chenven.

³⁰ Ibid.

³¹ Ibid.

Changing Demographics and Consumer Life Style Choices

The burden of increasing cost does not fall only on the provider-side of health care. The changing demographics of United States citizens have also had a great impact on the increased cost. Baby-boomers, or those born between 1946 and 1964, total seventy eight million Americans.³² Average per capita spending for people aged over sixty five was more than three times that of those aged thirty four to forty four in 1999.³³ More resources



are spent on end-of-life care and for the shortest amount of time than any other part of a patient's life. As the baby-boomer population of the country continues to age, so does their cost of health care.

Figure 3 illustrates the relative cost of health care as the population increases. The graph above is broken down by age groups and displays

³² Ibid.

³³ Uwe E. Reinhardt, Health Affairs Policy Journal of Health Sphere, 1.

relative spending per person. Cost appears to increase dramatically beginning around ages fifty five to sixty four and peaks beyond age seventy five.

Life style choices of the American people also have a tremendous impact on the health care industry. Sixty five percent of Americans are overweight, and it is estimated that by 2050, one third of people over forty will have diabetes.³⁴ Between poor diets, lack of exercise, high blood pressure, stress, depression, smoking and drinking, Americans are driving the cost of medical care due to the sheer fact that they do not take care of their bodies, and it costs more to maintain them.

*I hate the men who would prolong their lives
By foods and drinks and charms of magic art
Perverting nature's course to keep off death
They ought, when they no longer serve the land
To quit this life, and clear the way for youth.*

-Euripides 500 B.C.³⁵

It is an ethical question that many health care providers face: when should the utilization of valuable resources and incessant spending on such a small percentage of the population be halted? Between \$100,000 and \$200,000 is spent on a mere two percent of the population.³⁶ The rationing

³⁴ Ibid.

³⁵ Claire Andre and Manuel Velasquez, Aged-Based Health Care Rationing, Santa Clara University

³⁶ Chenven.

of life-extending medical resources is an idea that is controversial and not widely accepted; however, it is one which advocates argue benefit society in an age where access to health care is extremely limited.³⁷

A similar question of providing resources to those who diminish their bodies by abuse and lack of preventative care and strain the system further can be correlated with the argument above. That is not to say that rationing is a realistic or ethical solution, but it should be noted that utilitarian principles guide this notion that perhaps draining the cost of health care resources by such a small percentage of the population is not any fairer.

One can discern there is no single factor related to the driving force of health care costs. Beyond the mentioned variables above are a few other key contributors to cost increases.

Other Factors Driving the Cost of Healthcare

Insurance premiums for employee-based health insurance increased 6.1 percent in 2007.³⁸ Ironically, premiums, which have fluctuated with the market over the last twenty years, dipped "precipitously" in the 1990s when talks of universal coverage emerged in Congress.³⁹ Today, insurance companies charge a hidden tax on policy. Insurers negotiate with hospitals on price and out-of-pocket premiums the patients must pay result in

³⁷ Claire Andre.

³⁸ National Coalition on Healthcare.

³⁹ Marcia Clemmitt, "Rising Health Costs," 82.

assisting the entire cost burden.⁴⁰ As costs of insurance programs continue to rise, the percent of employers offering plans decreases, as does the purchase of individual insurance packages. Flaws within the insurance system also exist for those with preexisting conditions. If a patient has a preexisting medical problem, more often than not, they will be unable to purchase new insurance, creating another sector of uninsured Americans.

Labor constraints within the medical community also drive up the costs and strain the already immense work load of physicians. For example, the United States has more specialists than general practitioners; the median annual income for anesthesiologists was \$321,686 in 2004, whereas family-practice doctors earned \$156,010.⁴¹ The disparity of specialists to general practitioners has caused fewer doctors to enter the medical profession.

Not only is a shortage of general physicians developing, replacement of other medical professionals, such as nurses, is declining. Within two years of entering the health care industry, sixty percent of young nurses are leaving the field.⁴² Between the disparity in salaries among specialists and non-specialists, the patient-doctor ratio strain and rapid decline in a new generation of health care providers entering the field, the costs are driven up tremendously.

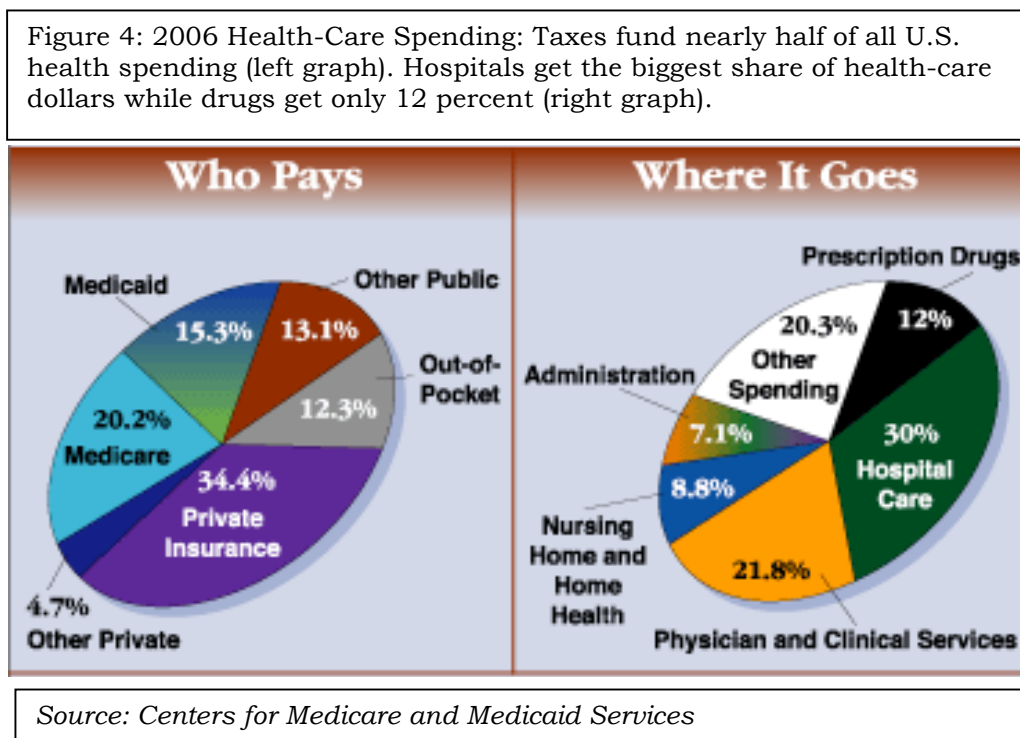
⁴⁰ Chenven.

⁴¹ Marcia Clemmitt, "Rising Health Costs," 83.

⁴² Chenven.

The medical liability system and payment systems are two additional factors driving the cost of health care. Lawsuits have decreased by over fifty percent in the medical community, subsequently decreasing the burden of having to raise visitation fees;⁴³ but are still an ongoing problem. Finally, the system as it stands is fee for service instead of fee for outcome. So instead of paying for the outcome of the care, patients currently pay an itemized bill, regardless of whether treatment is productive.

The graph below illustrates who pays for medical benefits and how the funds are distributed.



⁴³ Ibid.

While private insurance accounts for the majority of spending, a disparity of how much is paid out-of-pocket still exists. Why do so many Americans lack insurance when it is the largest contributor into the health care system? The amount of funds that are distributed to administration alone seem disproportionate to the care itself. More is spent on hospital care than preventative services, which could be reversed if health care was more affordable to begin with.

An overview of the United States health care costs, brief policy history and international relevance will be discussed in the next section.

Chapter 2: Overview of U.S. Health Costs

Figure 5: Auto Industry Health Care

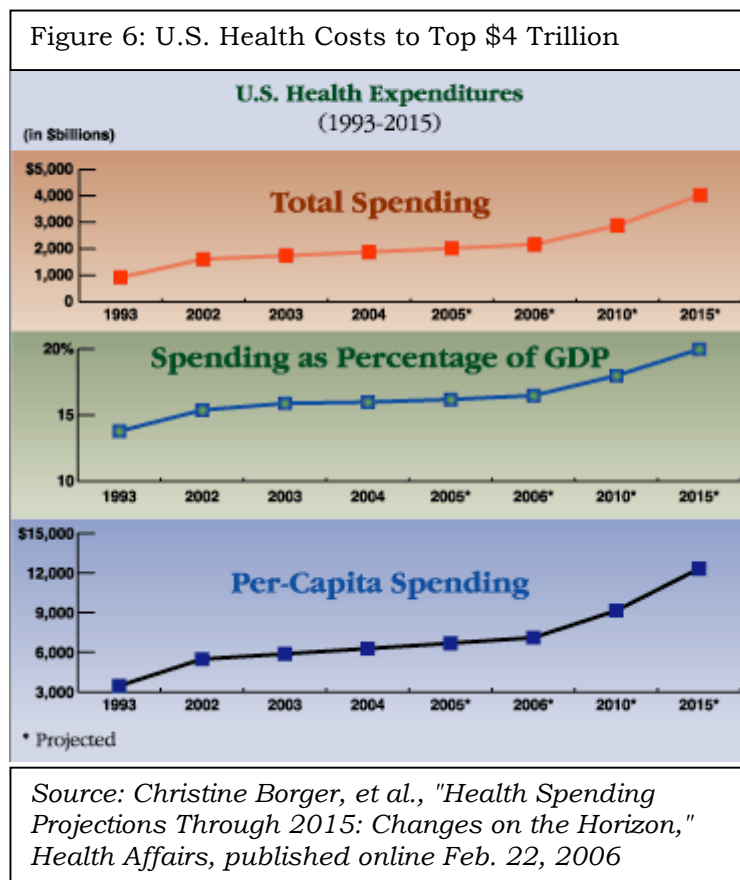


Source: *The Black Commentator*, by: Mark Hurwitt

The above cartoon illustrates that the United States health care system is failing because there is no national health care system, like there is in other industrialized countries.

The United States spent over \$2.3 trillion on health care in 2007 -- more than was spent on food.⁴⁴ Yet forty seven million Americans lack health insurance. The U.S. is ranked 37th in the world for overall quality care,⁴⁵ 43rd in infant mortality rates, behind Cuba, the Czech Republic and the United Kingdom, and 54th in access.⁴⁶

At one-seventh of the national GDP, the United States spends a larger share on health care than any other industrialized country.⁴⁷ Given the rate



of health care cost increases combined with the amount of the GDP that is spent on healthcare, the federal government currently has an unsustainable

⁴⁴ Shannon Brownlee AARP Why Does H.C. Cost So Much?

⁴⁵ Marcia Clemmitt, "Rising Health Costs," 85.

⁴⁶ Brownlee.

⁴⁷ AHRQ Fact Sheet Health Care Costs.

long-term fiscal budget path (see above chart).⁴⁸ With health care such a large share of government expenditures, the proportion that the burden of health care consumes only will increase if policy is not changed. A history of how health care has progressed in the United States is necessary to understand why the current policies exist today.

A Brief History of How Health Care has Progressed in the United States

Regulation of health care in the United States dates back to the Nineteenth Century when the first drug safety law was passed in the 1840s to control the sale of imports.⁴⁹ Then, the quality of health care services provided and the education of physicians were recognized at the beginning of the twentieth century. Once technology and resources began to revolutionize the quality of care, access to health care and services became a more important issue; thus, health insurance which was created for the first time in 1929 at Baylor Hospital in Houston, Texas, was developed to grant unlimited access to teachers for a small fee.⁵⁰

Shortly after World War II and the Great Depression, the Hill-Burton Construction Act of 1946 (the first federal initiative to regulate health care services) was passed to provide federal assistance to developing hospitals.⁵¹ It was in the mid-1960s that Congress took the initiative to become more

⁴⁸ GAO Long Term Fiscal Outlook

⁴⁹ Field, 5.

⁵⁰ Ibid., 6.

⁵¹ Theodor J. Litman and Leonard S. Robins, *Health Politics and Policy*, 3rd ed. (Albany: Delmar Publishers, 1997), 23.

directly involved with health care and provided health care programs by region and aid for the elderly and disabled, which eventually led to implementation of Medicare and Medicaid.

During the 1970s and 1980s, Presidents Nixon and Carter proposed their own plans for universal health coverage and price-controls because of the growing concern of ever-increasing health care costs.⁵² However, because Americans feared too much social involvement of the federal government, any proposals of universal coverage through the 1990s until recently were repudiated. Whereas many European countries believed in a "social democracy" or "the belief that the free market cannot supply human necessities, such as minimum income to purchase food, clothing, housing and access to health services," Americans supported a work-based insurance system which "echoed themes that distinguish the more general history of the United States."⁵³

Health spending receded in the early 1990s briefly when employers utilized managed care systems and President Clinton promised health care reform. After much campaigning and significant health care reform initiatives the Clinton Administration ultimately failed in passing any health care proposals. In 1993 the Health Security Plan failed and spending began to increase rapidly again.⁵⁴

⁵² Marcia Clemmitt, "Universal Coverage," in *Issues for Debate in American Public Policy: Selections from CQ Researcher*, 8th Edition, ed. Stephen Pazdan (Washington D.C.: CQ Press, 2008), 58.

⁵³ *Ibid.*, 59.

⁵⁴ Marcia Clemmitt, "Rising Health Costs," 82.

More recently, expenditures were expected to rise 6.9 percent in 2007, twice the rate of inflation and faster than spending on health care has risen in the last two hundred years! In the next ten years, health costs are expected to reach \$4.2 trillion by 2016, an amount equal to twenty percent of the United States GDP.⁵⁵

Shortcomings in the United States Health Care System

Nearly forty seven million Americans lack health insurance, which translates to more than fifteen percent of the population. Those who lack health benefits tend to be those that are unemployed or only earn minimum wage, students, employees of small businesses, or those that received early retirement. Over a third of people between the ages of nineteen and twenty four were estimated as not having insurance coverage in 2004. Only about forty percent of businesses that have part-time or minimum wage workers provide health care benefits. Average family insurance packages are priced around \$11,480 annually, which is more than the salary of someone earning minimum wage.⁵⁶

One of the biggest myths in the United States is that people who do not have health insurance still receive the medical attention that they need. This assumption is simply not true. Huge disparities exist between socioeconomic status and health status for citizens in the United States.

⁵⁵ National Coalition on H.C. Rising Insurance Costs

⁵⁶ Marcia Clemmitt, "Universal Coverage," 49-50.

The lower the income, the higher incidence of reduced quality of health care, if any is even received. Those in poverty generally receive less preventive care, resulting in a higher incidence of chronic disease, need for emergency care and higher mortality.

The health care system, as it stands in the United States, is more profit-driven than public health motivated. In fact, no distinction even really exists between for-profit and non-profit hospitals anymore due to the monopoly of managed care. The sheer fact of the matter is that hospitals are a business and exist to earn money to support their staff like any other enterprise.

As a result of profit-driven medical care, life expectancy in the U.S. ranks 24th among other industrialized nations, yet the country spends nearly double that of any other country.⁵⁷ It would seem that with the amount of money federal and state governments provide in assistance programs, the entire nation would have access to benefits. Unfortunately this outcome is just not the case.

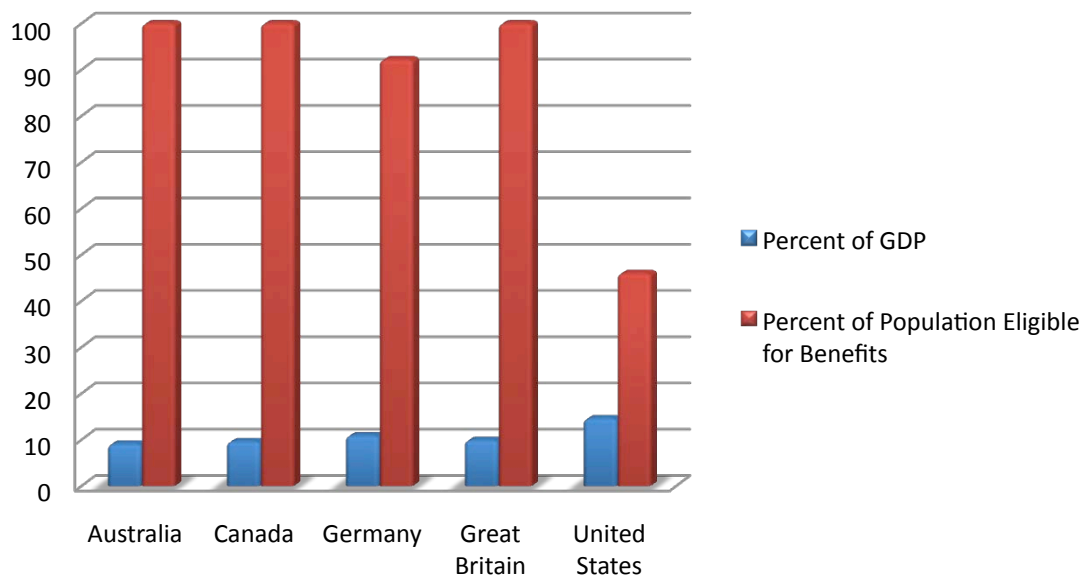
International Relevance

Not only does the United States spend more on health care than any other industrialized nation by fifty three percent, but individuals receive half of the benefits of other OECD countries. This limitation is due to the fact

⁵⁷ Ibid., 55.

that other countries such as Germany, Australia, Canada or Great Britain, have relied on tactics like supply constraints to control spending. For instance, controlling the spread and use of medical technology, limiting hospital beds and restricting the number of physicians have seemed to save on cost. Ironically, while the United States lacks waiting lists that other countries utilize as an additional means to control costs, Americans continue to lack access to health care resources more frequently than those in other industrialized countries.⁵⁸

Figure 7: Comparison of Spending to Benefits Awarded among Select OECD Countries



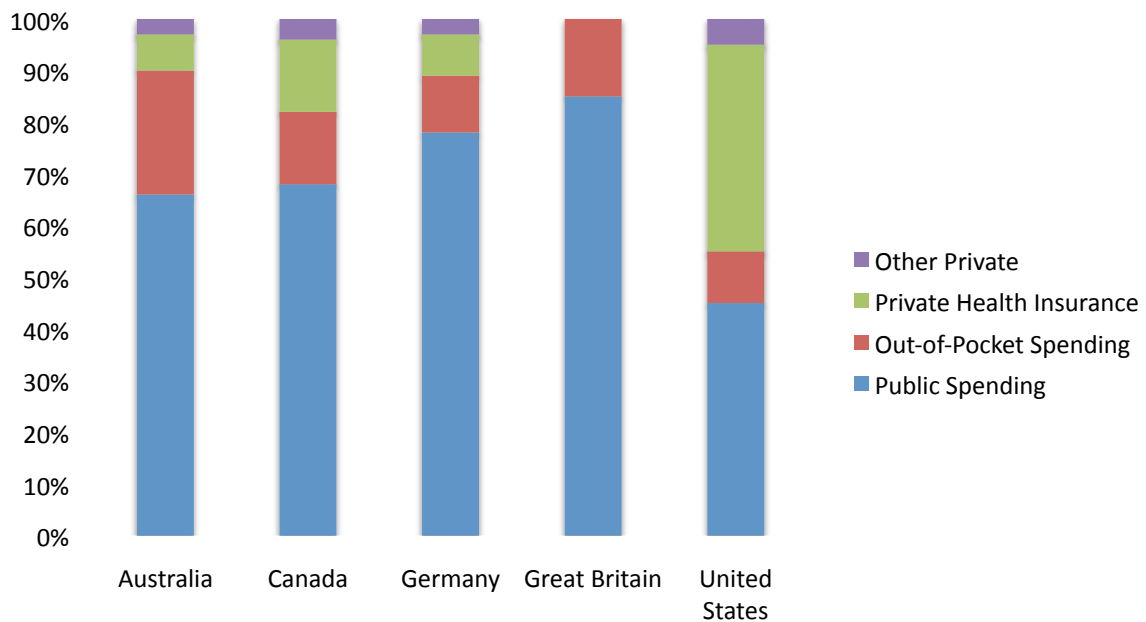
Source: Anderson, et. al. *Health Spending in the United States and the Rest of the Industrialized World*⁵⁹

⁵⁸ Gerard F. Anderson, Ph.D., Peter S. Hussey, Ph.D., Bianca K. Frogner et al., *Health Spending in the United States and the Rest of the Industrialized World*, The Common Wealth Fund, 12 July 2005 <http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=283969> (30 September 2008).

The United States spent \$5,267 per capita in 2002, which was \$3,074 more than the average OECD (Organization for Economic Cooperation and Development) country.⁵⁹ Where Australia, Canada, Germany and Great Britain spent approximately nine to ten percent of their GDP, the United States spent close to fifteen percent.⁶⁰ The chart above illustrates this disparity.

The majority of OECD countries finance their health care through taxation; as of 2004, an average of seventy three percent was funded publicly, as opposed to the average six percent paid for by private insurance

Figure 8: Source of Financing for Select OECD Countries



Source: Anderson, et. al. *Health Spending in the United States and the Rest of the Industrialized World*⁵⁹

⁵⁹ Gerard F. Anderson, Peter S. Hussey, Bianca K. Frogner and Hugh R. Waters, *Health Spending in the United States and the Rest of the Industrialized World*, Health Affairs, The Policy Journal of the Health Sphere (2005), <<http://content.healthaffairs.org/cgi/content/full/>> (29 September 2008).

⁶⁰ Ibid.

companies.⁶¹ The trend in other countries has been that insurance is used more to cover prescriptions and hospital care, saving a significant percent of the burden on the public sector. In 2004, federal assistance covered only about twenty four percent of pharmaceutical cost in the United States, as opposed to the thirty eight percent in Canada. In contrast, nearly two thirds of spending on pharmaceuticals was covered.

The next and final chapter will address the need for reform in the United States health care system, as well as, potential policy solutions.

⁶¹ Harrington, 376-377.

Chapter 3: The Need for Reform

Figure 9: "Who Has Something to Lose with Reform?"



Source: TheWordPress.com, March 7, 2003

This cartoon illustrates the complexity of not only the healthcare system, but the bureaucratic interconnectedness with regards to funding, marketing, consumers, the economy and employers.

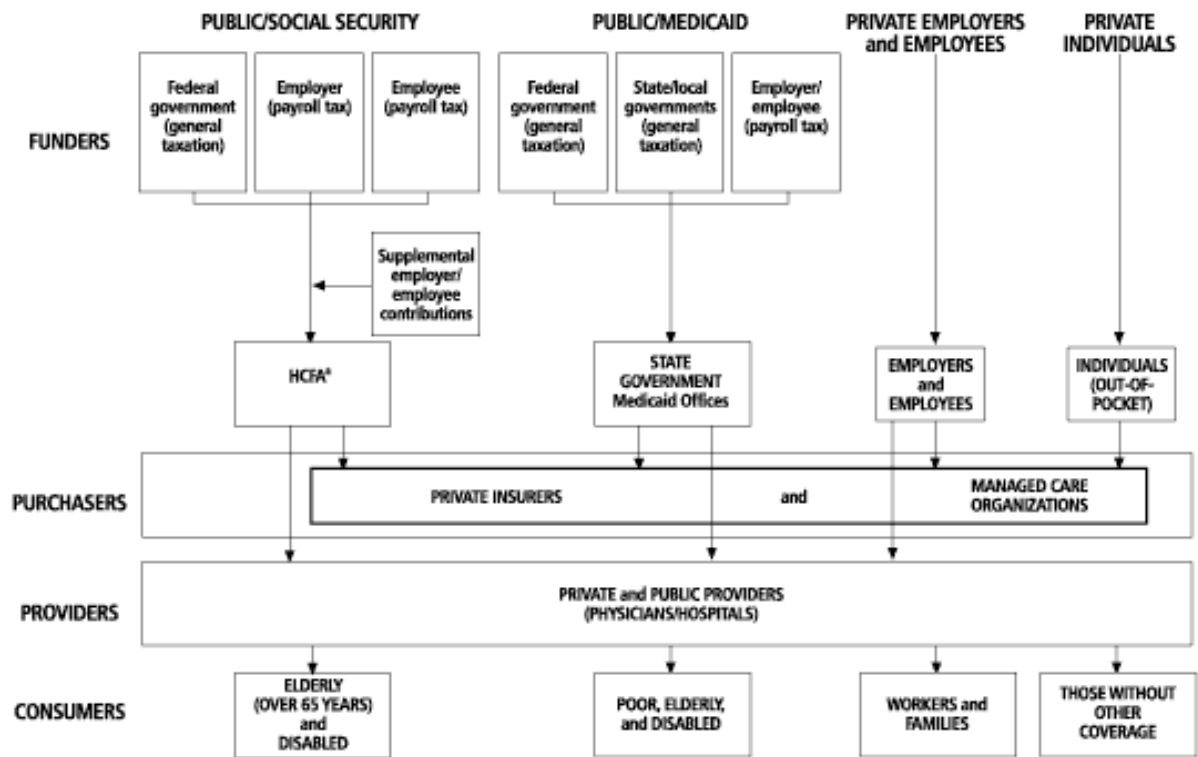
The shortcomings of the United States health care system are undeniable. The rising costs combined with the uninsured Americans who lack any alternative access to care are enough to cause worry. Globally, however, the United States ranking among other industrialized nations is astounding, with some of the poorest quality of care, lower life expectancy and increased mortality rate. It is certain that there is a definite need for organizational reform and financial reign-in of the medical market. The question then becomes: how does the country address health care on a national level?

Dozens of policy solutions have been introduced over the last few decades, but none have survived the partisan barriers and health care industry lobbyists. Fundamentally, American citizens have suggested that health care is a right, while continuing to remain a privilege of the wealthy, with limited or no access for those in poverty. Other industrialized countries, such as the United Kingdom, Germany or Canada, have already answered the philosophical debate of whether it is a right or privilege by providing universal access to their citizens. If the United States decides to incur the responsibility of a national health care system, what will that system look like and how will it transcend the failures that other countries have had to overcome?

Necessity for Change

The health care system in the United States is so fragmented and commercialized that it is nearly impossible for consumers of a medical service to navigate the reimbursement programs or acquire services themselves.

Figure 9: Flowchart Illustrating Organization of the U.S. Health Care System



Source: Sekhri N., *Cross Border Health Insurance*, California Health Care Foundation and Healthcare Redesign International, 1999.

Americans consistently consider health care as ranking first over other domestic issues that Congress should resolve. In a Gallup poll conducted

24-27 September 2007, it was found that the majority of Americans support all existing health care proposals that have been tested, including a national plan modeled off of the Canadian system or government regulation.⁶²

Seventy seven percent of those surveyed favored reducing government regulation to allow more health insurance provider competition; and fifty four percent supported the creation of a program funded by the government. Regardless of the plan that Americans support, health care costs rank as one of the most important financial problems facing their families. In order for affordable health care to be more readily available, reform is necessary.⁶³

Table 1: Most Important Family Financial Problem by Age, September-November 2006				
	18-29	30-49	50-64	65+
	%	%	%	%
Too much debt/Not enough money to pay debts	16	12	6	5
Lack of money/Low wages	15	13	11	11
Energy costs/Oil and gas prices	9	10	8	5
College expenses	9	12	5	2
Cost of owning/renting a home	8	9	6	3
Healthcare costs	5	12	19	25
High cost of living/inflation	5	4	6	7
Retirement savings	1	6	11	4
None	14	12	18	30

Source: Carroll, J. *Healthcare Costs Top Americans' Financial Concerns*⁶³

Rising costs affect Americans' pocketbooks and financial security.

⁶² Lydia Saad. *Any Healthcare Reform Plan Will Do for Americans-Broadest support for plans that expand access to private health insurance*. (25 October 2007) <<http://gallup.com/poll/102349/Any-Healthcare-Reform-Plan-Will-Americans.aspx>> (1 September 2008).

⁶³ Joseph Carroll. *Healthcare Costs Top Americans' Financial Concerns-Gas prices no longer a top financial problem for Americans*. (17 November 2006) <<http://www.gallup.com/poll/25486/Healthcare-Costs-Top-Americans-Financial-Concerns.aspx>> (1 September 2008).

Some families are forced to weigh their costs and save less to afford their medical bills. The table above illustrates health care costs, among others like gas prices or debt, are an important priority, especially for those aged fifty or above. As fewer employers offer insurance plans, the percentage of workers uninsured only continues to rise because they are left with minimal alternatives. Insurers are increasing copayments and deductibles, resulting in the individual insurance market unaffordable and even unavailable to people with chronic health conditions or the elderly.⁶⁴

Table 2: Individual Market is Not an Affordable Option for Many People

Adults ages 19-64 with individual coverage or who thought about or tried to buy it in past three years who:	Total	Health problem	No health problem	<200% poverty	200%+ poverty
Found it very difficult or impossible to find coverage they needed	34%	48%	24%	43%	29%
Found it very difficult or impossible to find affordable coverage	58	71	48	72	50
Were turned down or charged a higher price because of a pre-existing condition	21	33	12	26	18
Never bought a plan	89	92	86	93	86

Source: *The Commonwealth Fund Biennial Health Insurance Survey (2005)*

Reforming the System

The problems within the United States health care system are multifaceted and each needs to be addressed, especially price controls. No cost constraints have been introduced or implemented to address one of the

⁶⁴ Sara R. Collins, Ph.D., Jennifer L. Kriss, Karen Davis, Ph.D., Michelle M. Dogy, Ph.D., and Alyssa L. Holmgren, M.P.A. *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families*. (14 September 2006). Health Policy, Health Reform, and Performance Improvement, vol. 33. <<http://www.commonwealthfund.org>> (30 September 2008).

biggest problems of health care today. There is no simple answer that can be given; however, there are a number of incremental steps, as well as, larger-scale policies that could help to turn the country in a new direction. Some policy proposals have been introduced and even tested, such as the state-mandated insurance plan in Massachusetts.

Historically, a number of presidents have proposed methods to reduce medical spending. President Nixon suggested price controls, and Carter extended the concept to hospital revenue controls; Presidents Reagan and George W. Bush capped spending on Medicare and Medicaid;⁶⁵ however, containing the costs at a federal level requires attention at more local entities, as well.

The United States needs to resolve the issue of small businesses not offering health benefits by either implementing policies or providing financial assistance. This situation could be something as basic as an incentive program with a tax reimbursement. There are too many hard working Americans who have full time jobs and receive no benefits because either their wages are not high enough or their employer does not provide insurance. How can this condition be resolved so that those without benefits still obtain the health care that they need?

⁶⁵ Henry J. Aaron and William B. Schwartz with Melissa Cox. *Can We Say No? The Challenge of Rationing Health Care*. (Washington D.C.: Brookings Institution Press, 2005) 5.

Aside from small business and employee benefits, the medical workforce itself is in shambles. Nurses and doctors are retiring prematurely, and there is little incentive for young workers to enter the healthcare industry. At the current rate of employment, the healthcare workforce is unsustainable in comparison to the demand of the ever-growing American population. The demand for United States residents is projected to grow eighteen percent from 2000 to 2020, yet the RN supply is expected to drop by eleven percent; resulting in a projected twenty nine percent shortage by 2020.⁶⁶

Physicians constantly battle with a power struggle between managed care and their individual autonomy. In addition, there is a conflict of interest between primary care physicians and other categories of health providers, such as pharmaceutical and insurance companies. Strain within the work environment is caused by a lack of manpower and high administrative demands. With poor working conditions and a decrease in job fulfillment, physicians are becoming increasingly disinclined to either enter into or remain in the healthcare industry.

Existing Policy Proposals

Little change will occur in the United States if the foregoing problems are not addressed. Over the past few decades a number of policy proposals have surfaced. Smaller scale policies such as Medicaid or Medicare have

⁶⁶ Harrington, 199.

already been implemented to target a specific area of the population that requires the most aid in financing medical care. Other ideas to provide coverage to all Americans have been more difficult to develop. Some possible solutions have included state-mandated insurance, employer-based coverage, or universal healthcare. The common characteristic each of these solutions shares is the problem of funding.

State-mandated insurance refers to the idea that Americans depend on expanded healthcare benefits to their respective state based on their particular needs. This prospect stems from the idea that each state faces different challenges with regard to access to care, disbursement of benefits, or insurance costs, to name a few. In the past few years, states have been forced to become more proactive in expanding healthcare coverage because the federal government has not implemented any reform policies to expand coverage and benefits to Americans. For example, Massachusetts and Vermont passed universal coverage laws in 2006, requiring all citizens to carry health insurance.⁶⁷

As more and more states implement policies, it will be necessary for the federal government to reform the healthcare system and. Unfortunately, not all states can afford to implement a policy such as the Massachusetts model. Though it has bipartisan support, the program was not that significant of a transition for the state to make. Only ten percent of its

⁶⁷ Marcia Clemmitt, "Universal Coverage," 56.

population was uninsured, and Massachusetts was already spending over \$500 million annually to provide compensation to hospitals treating the uninsured.⁶⁸ Ultimately, a similar policy would have to come from the federal level because not all states have the resources for adequate implementation.

An employer mandate refers to implementing a policy that would require employers to offer health insurance packages to their employees. This method of coverage would be a good policy in theory if so many small businesses did not already have to drop their policies due to the skyrocketing and disproportionate costs, especially not for those working at or just above minimum wage. State subsidies are not enough to supplement the ever-burdening costs. An employer mandate would be as unsuccessful as attempting to impose purchasing health insurance on every single American because it is just not feasible for those in the lower-income brackets.

Universal health care, an idea that every citizen has access to health care, has already been enacted in all other industrialized countries. However, national healthcare systems are extremely complex and set up differently in every country. Some countries with a national healthcare system are no larger than some small states in the United States, so it is arguably easier to impose such a policy at a national level. The problem

⁶⁸ Ibid., 57.

with universal coverage in the United States is the lack of federal funding and budgetary burden. How could the country afford insuring all citizens on a national level?

Conclusion

Ultimately, it appears the federal government will need to take a more active role in reforming the healthcare system that exists today. The issue of funding is an important one that will have to be taken into consideration, especially with the ever-increasing budget deficit and national debt. It has already been established by consensus of the American people and by other industrialized countries, that healthcare is a fundamental right, not a privilege. The system as it stands is not effective and undoubtedly requires reform. Arguably, the best compromise that the federal government could make for the American people would be to allow state-mandated programs, but regulate price capping through a federal agency.

Congress could form a regulatory agency to maintain healthcare standards on a national level, but allow the states elasticity with how their individual programs are implemented and funded, much like the current Medicaid program apparatus. The United States is far too diverse and expansive to implement a national healthcare program based on the European models. A combination of national regulation and state-mandated programs is both practical and more manageable. The country does not need an administrative or costly conundrum to bog down the

system and ultimately prevent access to care even more than it already does.

States know better than the federal government what their citizens need, and how much funding is necessary to provide benefits to all of their population. States also understand who and why there are uninsured people in their states, what the shortcomings of their local providers are, and the best solution to resolve those issues. Ultimately, a one-size-fits-all program will unlikely fix health care across the entire country. What works in Massachusetts might not work in Texas or California. That is why a compromise between a federal mandate on the standard of healthcare and benefits received combined with individual state-mandated programs might be an effective solution. Uncapped health care costs and their impact on the United States budget have serious impacts on the national health care system and undoubtedly need to be addressed. The remaining question is how.

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