

United States of America: Health Care System Overview and SWOT Analysis

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Abstract

This is the first article of the International Health Care Systems series. The first part of this article will provide an overview of the U.S. health care system, including its historical evolution, health insurance coverage, service delivery organization, and aspects such as equity, efficiency, and cost-control. The second part of the article will analyse the strengths, weaknesses, opportunities, and threats for the U.S. health care system.

Keywords: United States of America, U.S. health care system, health care reform, health insurance, health maintenance organization, Affordable Care Act

An Overview of the U.S. Health Care System

The United States (U.S.) stands out among developed countries in lacking universal health care. The healthcare landscape is fragmented, with a multi-payer system that is reliant largely on privately financed insurance. About 17.7 percent of the GDP is spent on health.

Historically, the first insurance schemes entered the U.S. from Europe in the early twentieth century.^[1] These were largely voluntary and benevolent initiatives directed at providing life insurance, assistance during sickness, and health and funeral expenses, often involving cumbersome weekly premium collections. Early insurance was hospital-based, fueled largely by reduced affordability of care and reduced hospital occupancy during the Great Depression. The latter inspired provider-controlled insurance programs such as Blue Cross (by the American Hospital Association) and the Blue Shield (by State Medical Societies). Employment-based health insurance, the dominant form of private insurance today, emerged during the World-war 2.^[1] In response to a booming economy, consumer goods shortages, and resultant inflation during the war, ensuing wage controls led em-

ployers to offer more of fringe benefits to attract employees. Health insurance was such a fringe benefit, and was subject to tax exemptions for both the employer and employee, which continues till date.^[1,2]

About 9.1 percent of the population was uninsured in 2015, a fall from 16 percent in 2010, owing to the Patient Protection and Affordable care Act (PPACA) 2010.^[3] Private insurance is largely employment-based, driven largely through managed care organizations (MCO) while traditional, fee-for-service programs (allowing unrestricted choice of providers) service a very small share of employment-based insurance. Medicare is a federal government scheme for disabled and elderly (65 years and above) individuals. Medicare Part A is financed through social security contributions, is mandatory, and covers mainly inpatient care. Part B is financed through monthly premiums from beneficiaries (25%) and federal taxes (75%), is voluntary, and covers mainly outpatient physician, hospital, and diagnostic services.^[1,4] Medicare Part D provides partial coverage for prescription drugs and is financed through premiums. Medicare is replete with deductibles and coinsurance provisions and entails considerable out-of-pocket spending, leading to beneficiaries seeking supplemental insurance coverage ('MediGap Plans').^[1] Medicare reimburses hospitals based on Diagnosis Related Group (DRG) system, while physicians are paid on a fixed fee-for-service basis.^[4]

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Medicaid is a federal scheme run by states for certain low-income groups including children, pregnant women, and disabled individuals - with the federal government financing about 50 to 76 percent to total expenses. ^[1,4] Eligibility and benefits package for Medicaid varies from state to state, but covers long-term institutional care, unlike Medicare. ^[4]

Government hospitals at state and local levels also provide health care. ^[5] The Department of Veteran Affairs provides hospital care for veterans with service injuries and other conditions conditional on income and availability. The Department of Defense provides coverage to military personnel and their families. The Federal Employees Health Benefits Program covers federal government employees and their dependents. ^[5]

The U.S. has perennially lacked a gatekeeper system and has a loosely organized and regulated health-care delivery arrangement. Physician practices are either solo or group practices, and are predominantly for-profit. Hospitals are largely non-profit (around 70 percent share in total beds), while nursing homes are predominantly for-profit. ^[4] The Health Maintenance Organization (HMO) Act, 1973 and various selective contracting acts in the 1980s gave impetus to MCOs, which attempted to limit patient choice to a given range of physicians and hospitals. Among MCOs, HMOs allow care to be delivered through a circumscribed network of providers, either through own facilities (staff-model, 1st generation HMO) or a contracted network of providers (Independent Practice Associations, 2nd generation HMO). ^[6] Preferred Provider Organisations (PPO) maintain a preferred network of providers, and patients who access non-network providers pay a greater portion of the cost out of pocket. HMOs have a gatekeeping system while PPOs don't. Point-of-Service (POS) plans fall between HMO and PPO plans, and offer the flexibility of PPOs while employing a gatekeeper. Post the mid-1990s, enrolment in PPO plans have exceeded that of HMOs, covering about 58% of covered workers in 2010. Lately, High-deductible Health Plans (HDHP) with lower premiums/high deductibles have become popular. ^[6]

The boost to MCOs and alternative payment models has been the main cost-control measure. MCOs entailed a number of features including utilization review, quality assurance, and selective contracting, which were thought to reduce costs, improve quality and increase efficiency. While their impact on the overall picture of cost-control has been limited, there is some evidence that managed care encouraged more preventive interventions, reduced hospitalization, re-

duced costly interventions with little impact on quality of care. ^[6] A good proportion of Medicaid beneficiaries and a smaller proportion of Medicare beneficiaries are also enrolled in MCO plans, with cost-control and improved efficiency in sight. ^[4,6]

Some of the major healthcare accreditation agencies include The Joint Commission, Accreditation Association for Ambulatory Health Care, National Committee on Quality Assurance (NCQA) etc. NCQA is predominant among managed care plans. ^[6] As of 2017, 85.9% of physician offices used some form of Electronic Health Records (EHR). ^[7] Under the Health Information Technology for Economic and Clinical Health (HITECH) act, incentives and penalties for adoption and non-adoption respectively of EHR/EMR exist.

The PPACA 2010 is the major latest reform aimed at expanded insurance coverage and access to care, while improving the focus on preventive and primary healthcare. Beneficiaries under 133 percent of the federal poverty level were included in Medicaid, and those between 133 and 400 percent received subsidized insurance. ^[3] Other important provisions included 10 essential health benefits, discouraging risk-selection in insurance, covering pre-existing conditions, provision for dependent coverage for children, and encouraging use of EHRs. ^[3,8] The PPACA has been revised multiple times since inception, including a 2012 reform which made medicaid expansion a state choice, and doing away with a tax penalty under the PPACA individual mandate since 2019. ^[8] While the PPACA expanded coverage substantially, many also lost coverage principally owing to price increases in the unsubsidized insurance segment.

Medical savings accounts and mandated benefit laws are some other recent developments. The COVID-19 pandemic is expected to impart a huge boost to telemedicine and digital health.

SWOT Analysis

Strengths

Despite its many drawbacks, the U.S. arguably has one of the most advanced health care systems in the world. It leads in terms of availability of hi-tech and sophisticated healthcare technology, and stands at the forefront of biomedical and pharmaceutical research. Lacking price regulation of pharmaceuticals and favorable patenting provisions back innovation in the pharmaceutical sector, and this supports quicker availability of new, advanced drugs (albeit for those who can afford). The U.S. also has better 5-year cancer sur-

vival than its neighbour Canada, attributable in part to earlier cancer detection. [9] Better survival among premature babies and a relatively high life expectancy after 80 years are attributable to advanced technology. [4]

The U.S. system allows greater patient autonomy and rapid accessibility for elective interventions. Waiting times for hospital care are much lesser in comparison with countries like Canada and UK. The PPACA, 2010 has sought to better regulate the fragmented health insurance sector, has expanded insurance coverage significantly, fostered greater utilization of EHRs, and enhanced the emphasis on preventive and primary care. Additionally, it has aimed to discourage long-standing practices such as risk selection and pre-existing condition exclusions which affect equity and access.

Weaknesses

The U.S. is the biggest spender on health as a percentage of GDP and has one of the highest per capita health spending, making it one of the costliest health systems in the world. This however, doesn't translate into commensurate levels of healthcare access, coverage, and outcomes. It fares rather poorly in terms of life expectancy at birth, infant mortality, and birth weight than many OECD nations. Americans also tend to have high levels to obesity, diabetes, hypertension, and mortality due to accidents. The U.S. also has fewer physicians per capita, fewer physician visits per capita, and lower average length of hospital stay than many advanced Western countries, indicating that high prices, and not high quantities of care, is majorly responsible for high overall spending. [10]

A fragmented, multi-payer system results in inefficiency and high and wasteful administrative expenses. Around 31 percent of total health spending is incurred as administrative expenditure, largely attributable to cumbersome paper- and billing-work and increased administrative share in the workforce. [10] U.S. physicians have been held as the world's most second-guessed physicians, and medical practice is prone to litigation and defensive medicine.

Despite high healthcare spending, a considerable section of the population remains uninsured or underinsured. Since the 1970s, the percentage of uninsured had been increasing (until the PPACA 2010), as has been healthcare price inflation. A large section of those who are uninsured are employed, and high premiums have often discouraged smaller firms from offering insurance benefits to employees. [2,11] Relating insurance with employment makes healthcare access precarious for employees, as witnessed during the COVID-19

pandemic where a large number of Americans lost insurance due to job losses. It also fosters deformities like 'Job Lock'. Even those with insurance remain susceptible to catastrophic out of pocket spending through deductibles and co-payments.

The U.S. is one of the most expensive health care systems, and absence of universal coverage entails high levels of inequity. There are great disparities in terms of healthcare access, insurance coverage, and morbidity and mortality across ethnicities (for e.g. African-Americans and Latinos have lower insurance levels, Native Americans have poorer health indicators than whites) and income levels. [11]

While the PPACA has attempted to improve access and coverage, it has also resulted in a number of people losing insurance due to high premiums, and in rampant adverse selection leaving out healthy people from the insurance market. [3] It has also had limited success in checking rise of out-of-pocket costs, ensuring access to health care services (e.g. having a personal physician and not having to forego physician visits) commensurate with insurance coverage, and has even resulted in narrow physician networks and a decline in proportion of workers enjoying employment-based insurance. [3]

A lack of emphasis on primary care has been a traditional drawback. While localities with more primary care physicians report better health, areas with higher number of specialists and hospital beds per capita report problems such as supplier induced demand, lower use of preventive services, and reduced continuity of care.

Opportunities

The passage of the PPACA with its aforementioned desirable features has presented a great opportunity to better regulate and enhance equity in the healthcare landscape, particularly health insurance. The PPACA has survived multiple repeal and undermining attempts over the years, and looks strong given the current Democratic control over the House of representatives and the act's persistence over many years. [8]

Public consensus on the federal government's responsibility to ensure healthcare coverage has witnessed an increase from 42 percent in 2013 to 60 percent in 2017 June. [12] Health care ranks high on the political agenda, and surveys have shown public support for 'Medicare for All'. [8] All of the above could yield a substratum for extending coverage further, supported by high levels of health spending. Further, the COVID-19 pandemic has exposed the long-standing flaws of the U.S. health care system and offers an op-

portunity to rethink and revamp the same.

Threats

Persistence of a fragmented, multi-payer landscape based on private insurance remains the biggest threat. While the PPACA has sought to regulate this landscape, gaps have remained, multiple provisions of the law have been or stand to be diluted, and organized medicine still resists major attempts at regulating the health and pharmaceutical sector. Further, despite having survived, the PPACA lacks bi-partisan support,^[3] making it prone to dilution.

The PPACA has made insurance unaffordable for many, and given widespread adverse selection, losses to many insurers have occurred, raising sustainability concerns about the act's provisions. It has been argued that much of the cost reductions since the passage of PPACA have been due to the Great Depression, and costs can escalate in future.^[3] This becomes especially worrying in the context of rising wasteful administrative costs. Much of the growth in healthcare workforce has been due to administrative staff, who comprise a large percentage of the total workforce. Workforce productivity gains have been minimal despite growth in healthcare labour.^[3] Along with added regulatory requirements under PPACA, these warn of significant cost implications.

Cost implications become particularly acute in the context of the COVID-19 pandemic in the near- and medium term, and due to an aging population in the longer term.

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