

Political Economy of the US Healthcare System

definitions

Political Economy:

Intersection of legal, economic and political aspects

Healthcare system: network of individuals, companies, institutions, government structure to provide care to individuals to prevent and treat disease and promote public health

Measuring a good health care system

- Health outcomes

- Cost

US has worse health outcomes compared to 15 developed/wealthy countries

- Adverse birth outcomes

- Injuries and homicides

- Adolescent pregnancy and STIs

- HIV/AIDS

- Drug related mortality

- Obesity and diabetes

- Heart disease

- Chronic lung disease

- Disability

Fragmented care system

Weak public health and primary care system

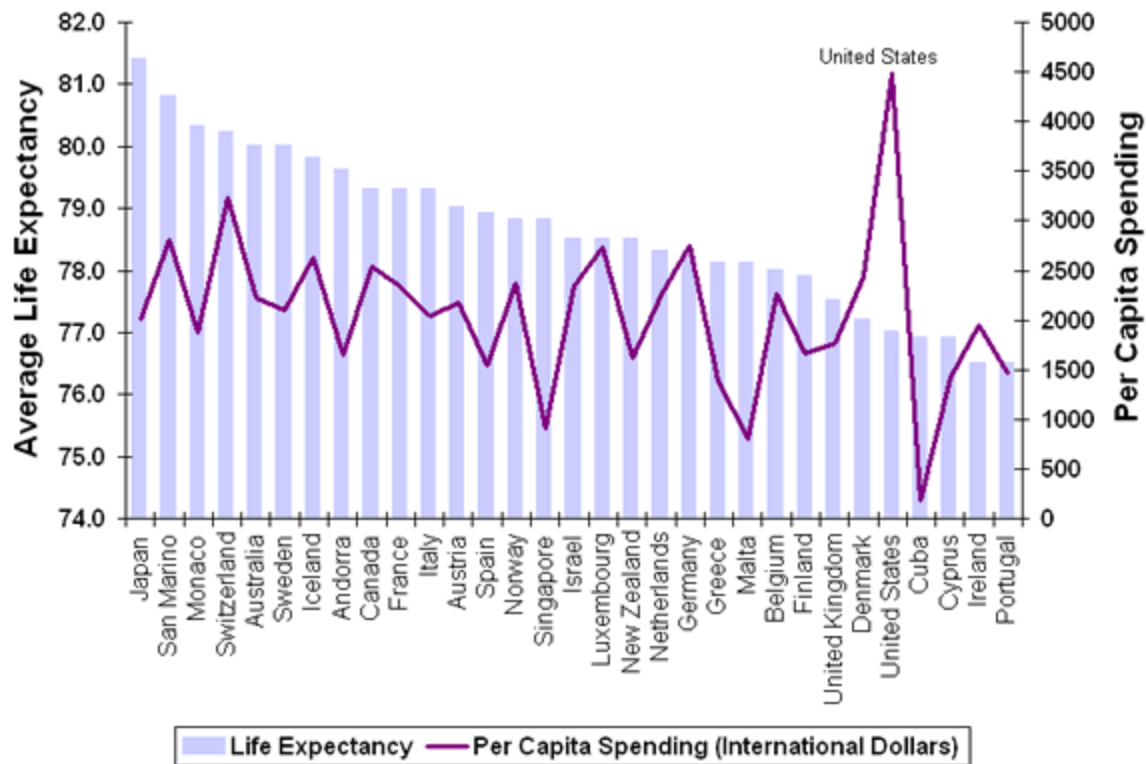
More lapsed and interrupted healthcare coverage

Larger income gap

Poorer safety net system

Physical and social environments (pollution, roads built for cars not pedestrians, food deserts,)

The Cost of a Long Life



Our values as embodied in healthcare system

Individualism-

If health is important to us, we will make independent lifestyle choices

Meritocracy-

we have access and receive the level of healthcare that we have earned through our hard work

Technocracy-

technology will solve our problems with better biomedicine (surgery, medicines)

What a healthcare system does-

For both body and mind

Primary Care: disease PREVENTION & health promotion

Secondary Care: disease DETECTION

Tertiary Care: disease TREATMENT

Models of care

Established US healthcare system: utilizing system of regulated care (government-recognized licensure and oversight)

Based primarily on biomedical worldview of disease prevention, treatment

Alternative/complementary/other traditional systems of care eg acupuncture, chiropractic,

naturopathy (often not regulated, limited licensure)

Based primarily outside of a biomedical worldview

Integrative models

Care services

Preventive and primary Care: Primary Care Providers (PCPs), state/city health departments

Acute Care – Hospitals, “Urgent/Emergency Care”

Auxiliary Services – Lab, imaging, pharmacy

Rehabilitation and long-term care – Home Health Nursing, Nursing Homes, Assisted living

How do we pay for healthcare?

Employer based insurance

Private/individual insurance/self pay

Government funded

Medicaid

Medicare

Military/government employees

Indian Health Services

“Charity” care

What is insurance?

Pooled resources

Assumes that only a few people will need really expensive care

<http://kff.org/understanding-health-insurance/>

What is an HMO?

Intended to keep costs down

Insurance plan

Functions within defined providers of care and hospitals

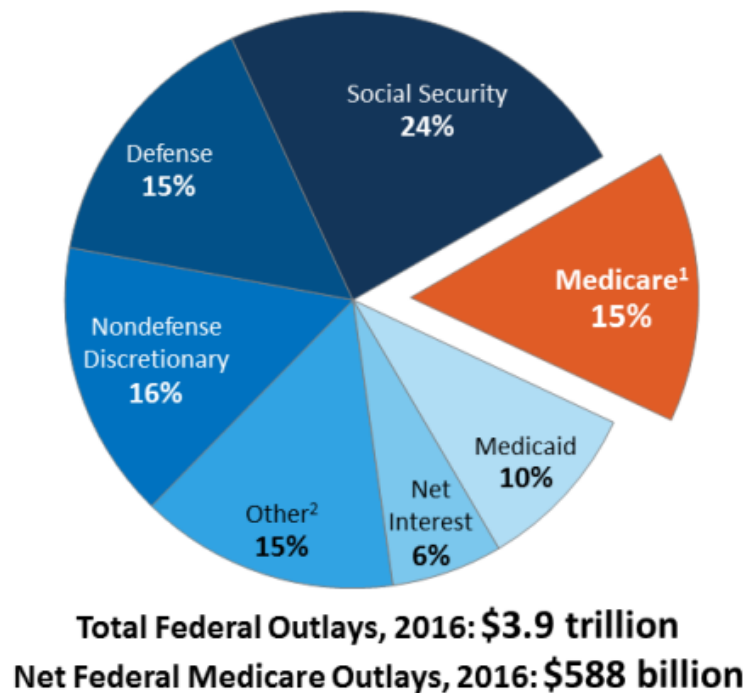
What’s a co-pay?

Medicare – “Elderly”

- 57 Million recipients – \$675 billion (2016)
- Federally-funded
- > 65 years old if “qualified”
 - >65 years old
 - Disabled ~8 million
 - Disabled or in need of hemodialysis and eligible for social security
- Future: rising health care costs + aging population = situation for concern?

Figure 1

Medicare as a Share of the Federal Budget, 2016



NOTE: All amounts are for federal fiscal year 2016. ¹Consists of mandatory Medicare spending minus income from premiums and other offsetting receipts. ²Includes spending on other mandatory outlays minus income from offsetting receipts.
SOURCE: Congressional Budget Office, An Update to the Budget and Economic Outlook, 2017 to 2027 (June 2017).



Social safety 'net' when living in poverty
Fragmented mix of local, state and federal programs
Tax credits (earned income and child care)
SNAP (supplemental nutrition assistance program)
Housing assistance
SSI (Supplemental security income - "disability")
TANF (temporary assistance for needy families)

other components: Pell Grants, WIC, Head Start, school lunches, job training, food banks, shelters, etc)

Medicaid – "Poor"

- 72 million recipients - \$581 Billion in 2017
- Federal-State Partnership
- Eligibility – varies by State. Generally poor + children, parents of dependent children, pregnant women, disabled
 - "Dual eligible" with Medicare – chronically ill, long-term care
- Covers most clinical services + prescriptions

- <https://www.healthcarecounts.org/blog/2017/8/why-it-could-be-worse-or-better-to-be-sick-in-some-states-than-others>

Gap in Coverage for Adults in States that Do Not Expand Medicaid Under the ACA

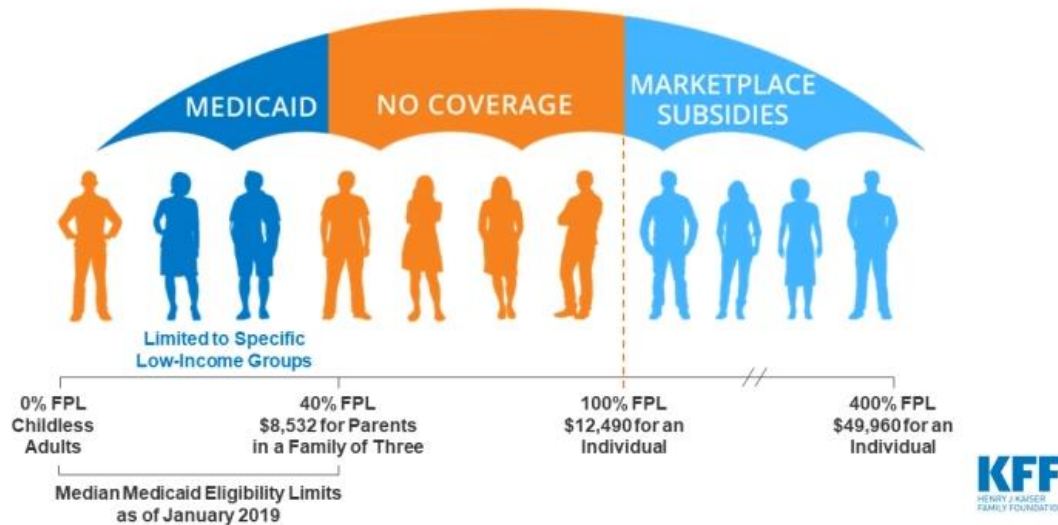
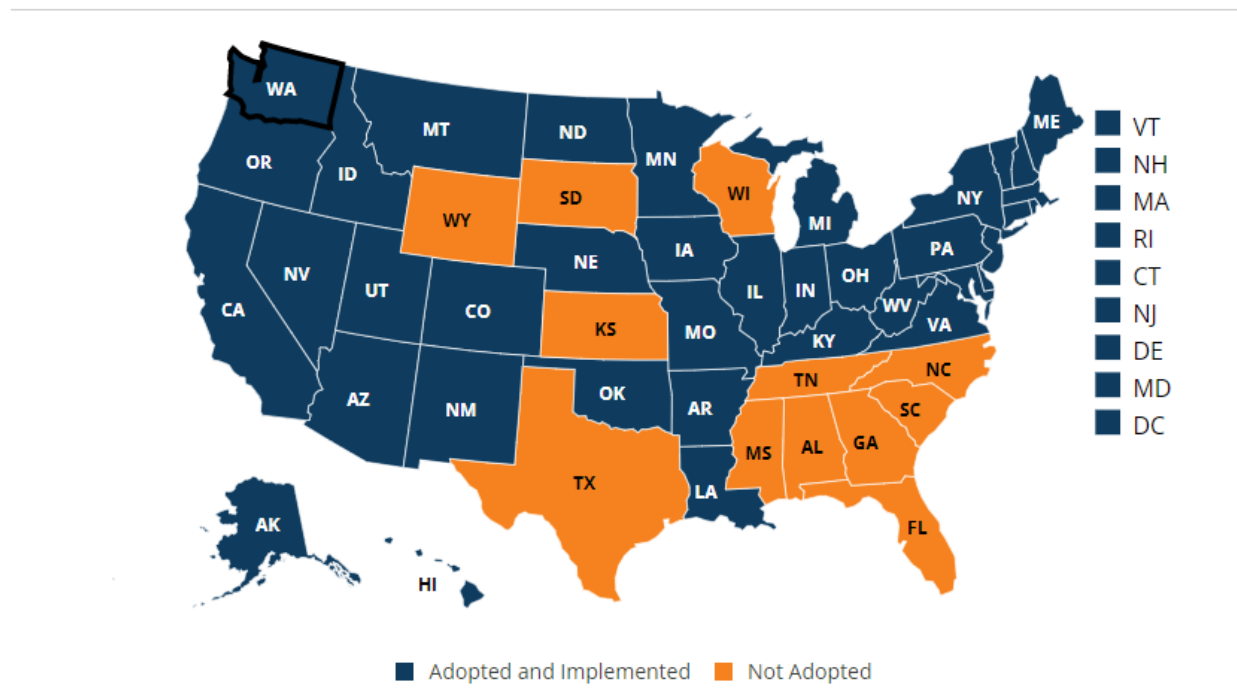


Figure 1: Gap in Coverage for Adults in States that Do Not Expand Medicaid Under the ACA

Status of State Action on the Medicaid Expansion Decision



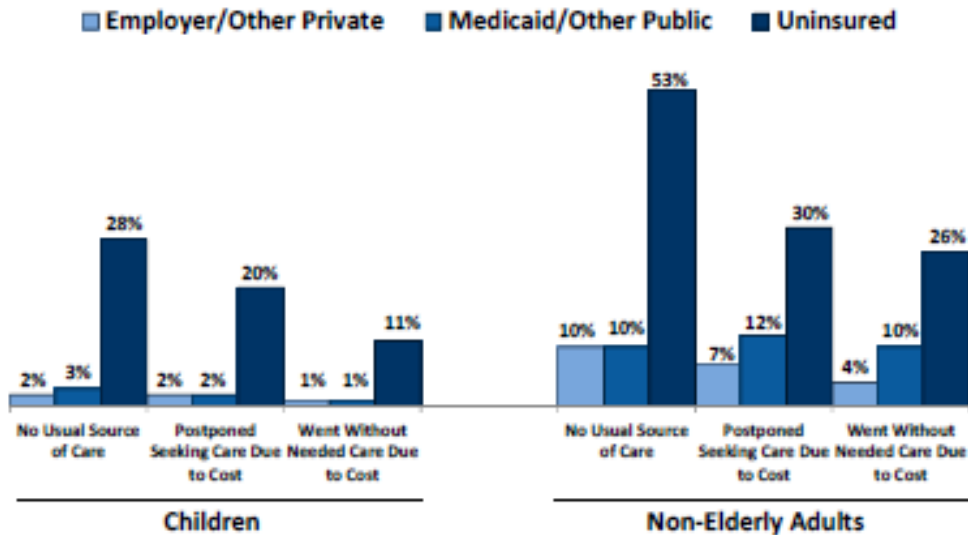
Uninsured

- Over 47 million in 2010- and CHANGING 27 million in 2016!!!

- Coverage = services. No coverage = no services.
- “But can’t they just buy insurance?” ??
 - Employer size as predictor – Large firm – 98% offer coverage, small firm – 59%
 - 8/10 come from working families
 - Price sensitive to premiums AND utilization
 - When price goes up, people decreasingly use that resource. People get sicker and sicker before their medical problems are addressed.

Figure 8

Access to Care by Health Insurance Status, 2011



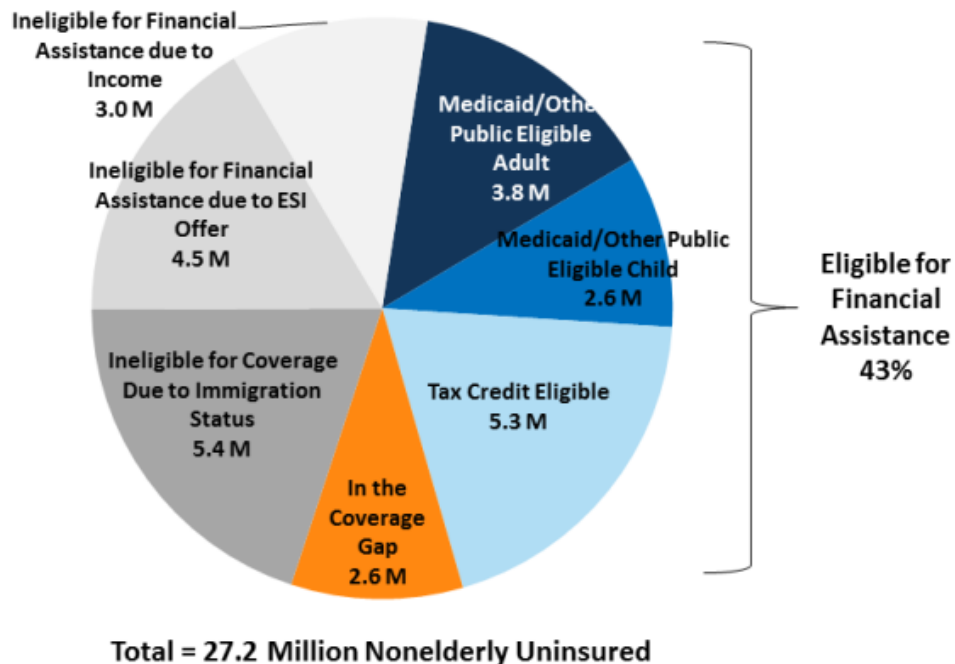
NOTE: In past 12 months.

Respondents who said usual source of care was the emergency room were included among those with no usual source of care. All differences between the uninsured and the two insurance groups are statistically significant ($p < 0.05$).

SOURCE: KCMU analysis of 2011 NHIS data.

Figure 1

Eligibility for ACA Coverage Among Nonelderly Uninsured as of 2016



NOTES: Numbers may not sum to totals due to rounding. Tax Credit Eligible share includes adults in MN and NY who are eligible for coverage through the Basic Health Plan. Medicaid/Other Public also includes CHIP and some state-funded programs for immigrants otherwise ineligible for Medicaid.

SOURCE: Kaiser Family Foundation analysis based on 2016 Medicaid eligibility levels and 2016 Current Population Survey.



Quality of Health Care

Quality of care

U.S. residents receive about 50% of care that is recommended

Is this good? Acceptable?

Attributes of quality care?

Consumer directed?

Changing access to health care

March 2010 Patient Protection and Affordable Care Act

March 2012 Supreme Court hearings on constitutionality of "Obamacare"

Most components in effect Jan 1, 2014

Medicaid Expansion Jan 1, 2017

Obamacare and women's health

Birth control coverage

Abortion coverage

Equal rates of insurance costs

- Must cover maternity care- traditional
- Pregnancy not “pre-existing condition”
- Can’t charge more for women than men
- Health maintenance and preventive services
 - Pap tests, mammograms, vaccines
- Lactation consultants
- Breast pumps
- Medicaid- mandatory tobacco cessation support and newborn coverage
- Pumping milk at work- >50 people business, must have a room that is not a bathroom
- Mental health care- on par with medical treatment
 - Can’t be restrictive pre-existing condition
- Abortion under ACA
 - Explicitly not included, many states have separate restrictions
- Birth Control
- Insurance must cover all forms of contraception
 - Cover all aspects without co-pays
 - Who is exempt?
 - non profit houses of worship (employees – no guarantee)
 - *all for-profit must cover contraceptives
 - non-profit – Notre Dame, catholic hospitals can have waiver

Burwell v Hobby Lobby Case 2014
SCOTUS
Religious Freedom Restoration Act (1993)
“Shall not burden a person’s exercise of religion”
Is a privately-held company a person?
SCOTUS – 5/4 ruling yes
Opens debate for other preferences

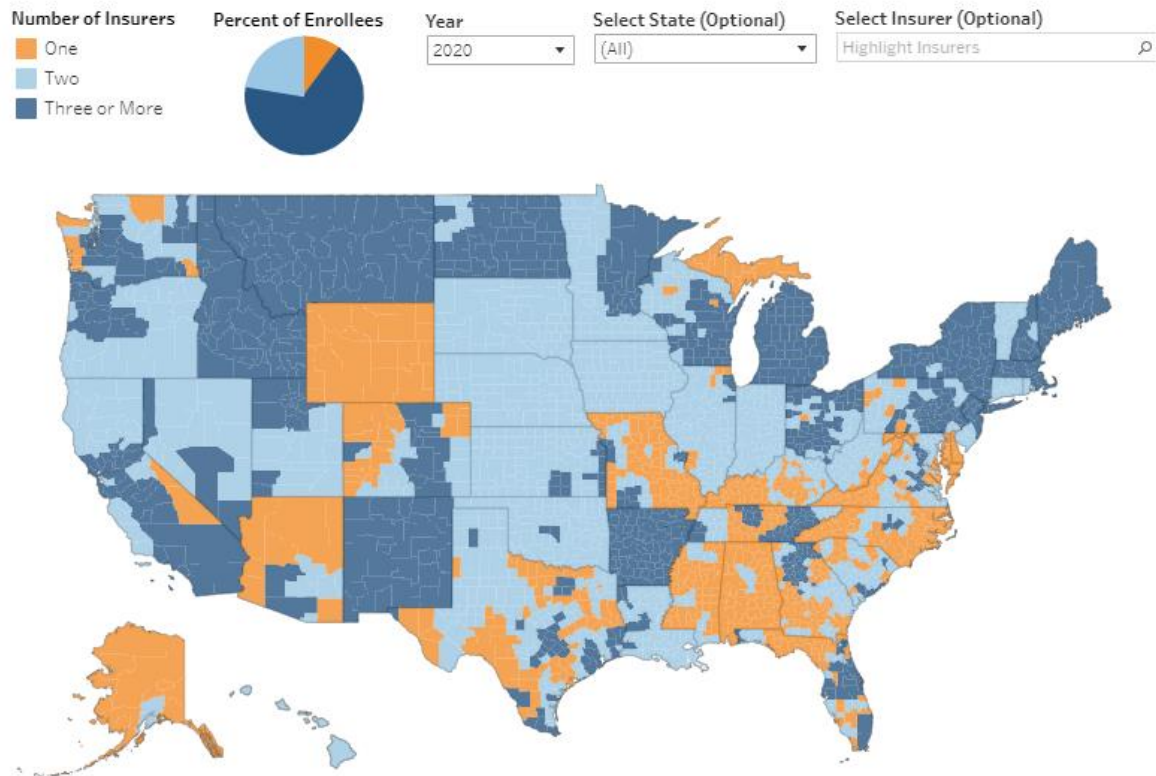
What is happening now with Obamacare?
Increasing premiums

- Health care costs rising
 - Insurance companies lost money in marketplace because newly insured more expensive than previously thought
 - 49% of healthcare costs is for sickest 5% of population

Shortening and not advertising enrollment in marketplace this year (open enrollment Nov 1-Dec 15, 2019)

Fewer insurance choices in the “Marketplace”

Insurer Participation on ACA Marketplaces, 2014-2020



Move towards single payer model?

Quality of Health Care

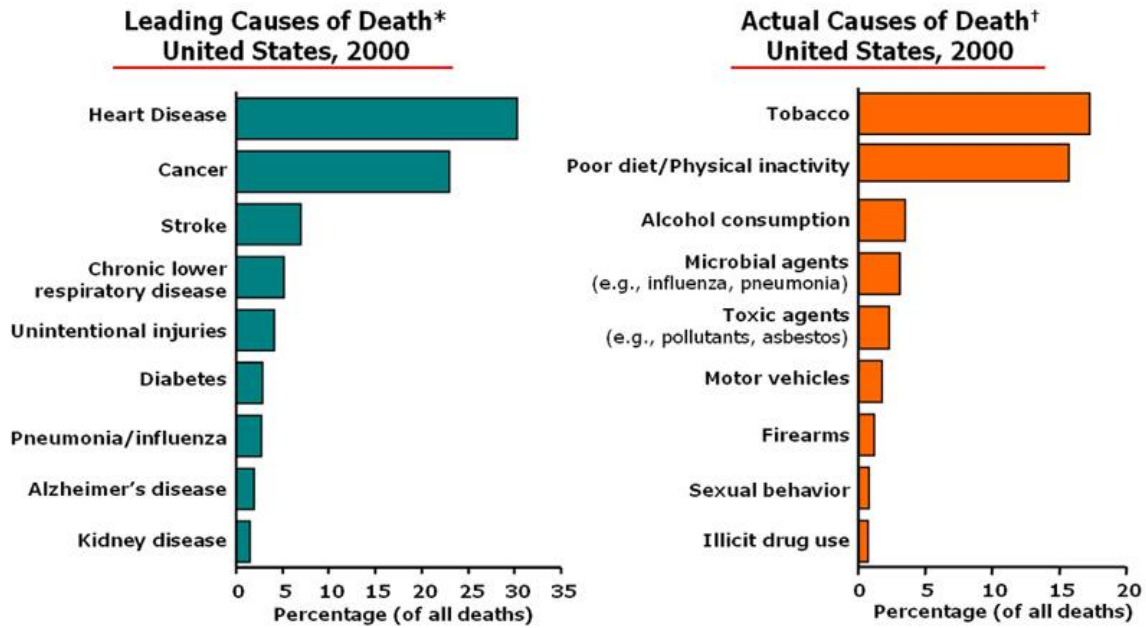
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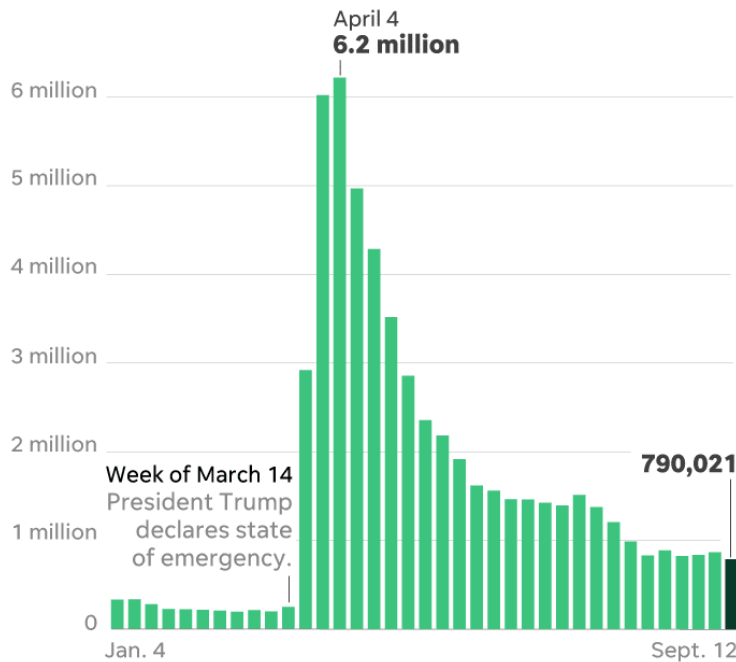
* Miniño AM, Arias E, Kochanek KD, Murphy SL, Smith BL. Deaths: final data for 2000. National Vital Statistics Reports 2002; 50(15):1-120.
† Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual causes of death in the United States, 2000. JAMA. 2004;291(10):1238-1246.

What the COVID-19 pandemic shows us...

- Health insurance tied to employment- massive rise in unemployment

790K workers filed for unemployment last week

Jobless claims for the week ending:



SOURCE Department of Labor, not seasonally adjusted
George Petras/USA TODAY

Focus on technology

- Delay in testing capabilities
- CDC lab contamination delayed production of COVID-19 testing
- Lack of leadership/supervision
- Lack of sufficient reliable tests- ongoing
- ventilators and ramping up technological support
- Access to equipment
- Information on treatment
- Rapid research publications, inadequately designed/reviewed

Systems of supplies/equipment

PPE

Ventilators

Communication

- Communication and reporting- not centralized
- Questioning CDC guidelines/political influence

Public Health difficulties

- hand washing
- social distancing
- wearing masks
- contact tracing
- eventual vaccine distribution

Health Care financial crisis

- Health care facilities (hospitals, clinics) rely on elective care to remain solvent

What should we work towards

Individualism-> community and nation wide health

Meritocracy->basic health care for all

Technocracy->prevention

resources

Kaiser Family Foundation: kff.org

State reform update: www.statereform.org