2

Health care systems and health policy

Introduction

Although there are four main systems for providing health care insurance and coverage, there are many nuanced differences in these basic plans based on country-specific factors. Throughout the world there are hundreds of independent countries with differing health care system models in place that globally affect how health care is structured, delivered, and paid for. Differing societal expectations, mores, culture, history, and needs all play into how health care systems are structured. These structures drive health policy, and certainly vice versa as well.

Influencing health care systems via health policy

Figure 2.1 is a schematic representation of varying points of influence for health policy: these segments influence health policy and in turn are influenced by health policy. The processes in play are never static; there is constant movement to and fro and between these influencers.

The recent passage of health care reform legislation (Patient Protection and Affordable Care Act (PPACA)) will provide health insurance coverage options for additional Americans who currently do not have health insurance, but it is incomplete in providing coverage for all who currently lack insurance. In a Congressional Budget Office (CBO) assessment in April, 2010, there will be about 3 million individuals required to pay fines in 2016. These assessed fines will be for individuals with incomes below $59 000 and $120 000 for families of four, according to the CBO projections. The other 900 000 people who must pay the fine will have higher incomes. The collection of $4 billion from such fines will be used to partially subsidize other insurance offerings within the health care reform legislative package (PPACA). Fines will be in the range of $1000. It is noted in this CBO report that the US government will collect about $4 billion a year in fines from 2017 through 2019.
The PPACA will increase spending by $938 billion over 10 years (The Staff of the Washington Post 2010a). These increases will come from providing:

- tax credits
- subsidies to help small businesses and consumers to buy insurance
- government increases in Medicaid coverage expansion.

Spending cuts that are projected at this point will total $1 trillion (The Staff of the Washington Post 2010a). These cuts are from the following sources:

- reduction in spending within Medicare
- new taxes and penalties for non-purchase of insurance.

It is difficult at this time to assess this massive bill and its purported successes accurately (The Staff of the Washington Post 2010b). Difficulties with the PPACA stem from the fact that the largest provision for individual coverage mandate, insurance exchange, and the subsidies do not take hold until 2014 (The Staff of the Washington Post 2010b). Challenges to the success of this bill include the effects of inflation over a 10-year period, and predicting what will happen to physicians’ charges, hospital charges, and pharmaceutical costs. The experience to date in the USA with universal coverage lies in the state of Massachusetts. And the Massachusetts experience is that these costs have
increased and not been affected by the universal coverage requirements that were put into place.

**Models of health care delivery and financing systems**

In *The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care*, author TR Reid (2009) describes the methods that other industrialized democracies have used to provide health care for citizens for far less than what is spent on health care in the USA. These countries provide universal coverage for all their citizens.

Reid (2009) describes his purpose in writing this book as to “search the developed world for effective health care systems and take lessons from the ones that work best.” Not surprisingly, Reid finds positives and negatives in many of the systems he evaluates in an unbiased fashion. His conclusion that all spend less administratively than the USA, gain better outputs than the US system, and cover all citizens within countries is irrefutable (Reid 2009).

Reid couches the issue in terms of a fundamental moral decision to provide health care coverage to all citizens or not. Other democracies have embraced providing universal coverage for citizens, and in doing so, they outperform the US health care system on indices of cost, quality, and choice – three key focal points for discussion in the book. Reid (2009) notes that over 20,000 Americans die each year because they cannot afford to see a doctor, and quotes that 700,000 individuals must declare bankruptcy due to mounting bills arising from a lack of health insurance coverage.

**Four basic models of health care delivery and insurance**

Four basic models of health care delivery and insurance have evolved over time. As was noted above, these models have been adapted and combined for country-specific necessities. The four models are as follows:

1. **Beveridge model**
2. **Bismarck model**
3. **National health insurance model**
4. **Out-of-pocket model**.

**The Beveridge model**

The Beveridge model, named for William Beveridge (1879–1963), describes the British National Health Service (NHS) (http://www.bbc.co.uk/history/historic_figures/beveridge_william.shtml). William Beveridge was an economist and social reformer in the UK. In 1941, the British government commissioned a report to detail how the UK should be rebuilt after World War II (Anonymous 2010). The report, issued in 1942, detailed five “giant evils” in
need of being addressed: want, disease, ignorance, squalor, and idleness. This report served as the basis for the UK to address health care problems, the health care delivery system, and payment for health care in the UK (Anonymous 2010).

The British NHS was begun in 1948, and its initiation was based upon the work of William Beveridge and the model he proposed. As an appointed peer in the British Parliament, Beveridge was a leader of the Liberals in the British House of Lords (Anonymous 2010). Although the model was named in honor of William Beveridge, Aneurin Bevan, government Minister of Health at the time, was the chief architect of the British NHS (Klein 2006).

The British NHS is truly a cradle-to-grave insurance and health delivery system covering all British citizens (Klein 2006). In his historical treatise on the politics of the decision to form the NHS Klein (2006) noted:

Britain’s National Health Service (NHS) came into existence on 5 July 1948. It was the first health system in any western society to offer free medical care to the entire population. It was, furthermore, the first comprehensive system to be based not on the insurance principle, with entitlement following contributions, but on the national provision of services available to everyone. It thus offered free and universal entitlement to state-provided medical care (p. 1).

Delamothe (2008) notes that, in addition to the above, quality and equity should be added to this descriptor of the British NHS, since these tenets have been key segments of the NHS from its inception. Other countries have applied the Beveridge model to health care systems and include Italy, Spain, and Cuba. The Medicaid program in the USA is a Beveridge model for those with coverage, with the exception that hospitals, providers, and associated allied health providers who provide Medicaid services are not owned by the US government.

US Department of Veterans Affairs (VA) health care – similar to the Beveridge model
The VA health care system in the USA is probably the most exact duplicator of the British NHS, as is the US Indian health service (care provided to Native Americans) and the US Department of Defense (active-duty military personnel and their families through the Tricare managed care program within the Department of Defense).

VA health care issues
The number of US veterans is depicted in Figure 2.2. Also shown is the number of veterans with service-connected disabilities. The number of service-connected disabilities has increased recently as more advanced methods of treating battlefield traumas have emerged, saving many soldiers. Also, as shown in Figure 2.2, the numbers of US veterans has decreased from 1980 (elevations...
due to the number of US veterans from the Vietnam War) through the first
decade of the 2000s. However, with wars under way in both Iraq and
Afghanistan at present, the numbers of individuals expected to seek care from
VA facilities will no doubt increase in the near and long-term future. The
individuals currently receiving care through the US Department of Defense
will increase the numbers treated within the VA system. Care provided within
the VA system is considered to be good in comparison with that received
elsewhere in the US system.

Service-related concerns within the VA system
The access to care and treatment of long-term consequences of war inju-
ries or exposures has long been a sore point for US veterans. The health
effects of exposure to Agent Orange by Vietnam veterans (Schuck 1987),
Gulf War syndrome for the first Iraq War veterans (Taylor and
Stephenson 2007), improvised explosive device-related traumas and need
for subsequent rehabilitation (Gondusky and Reiter 2005), and posttrau-
matic stress disorder for many veterans from many wars have long been
controversial and contentiously debated syndromes (Seal et al. 2007).
Posttraumatic stress disorder among US veterans is not something that
just occurred with veterans from World Wars I and II or the Vietnam War.
Similarly occurring symptoms experienced by Civil War veterans were

Figure 2.2  Living US military veterans in the USA. Source: CDC/NCHS, Health, United States, 2009,
Figure 3. Data from the US Department of Veterans Affairs and the US Census Bureau. National
Center for Health Statistics; Health, United States, 2009 With Chartbook on Trends in the Health of
Americans, Hyattsville, MD: 2010.
called “soldiers’ heart,” referring to a rapid heart rate that occurred with veterans. Within other wars, veterans of those wars spoke of shell shock or battle fatigue.

**The Bismarck model**

The Bismarck model of health care structure, financing, and delivery is named in honor of Prussian Chancellor Otto von Bismarck, who unified Germany in the 19th century. As a component of unification, Bismarck oversaw the creation of the first western welfare state. This system incorporates “sickness funds” which are jointly financed by employers and employees via payroll deductions. In this instance, the Bismarck model represents what is available to employees via employer-sponsored health insurance coverage. The major difference in the German system is that the “sickness funds” companies (e.g., health insurance companies) are not profit-generating entities. These “sickness fund” companies do not make a profit.

This Bismarck model of health care can be found in Germany, France, Belgium, the Netherlands, Japan, Switzerland, and in some cases in Latin America (Reid 2009). It is also, as noted, available in the USA as employer–employee-partnered insurance for many employed Americans less than 65 years of age.

**The national health insurance model**

The Canadian system of health care approximates a national health insurance model. The Canadian system originated in Saskatchewan in the late 1940s. Saskatchewan Premier Tommy Douglas was the architect of the plan, providing public coverage for residents through the Saskatchewan Hospitalization Act. On January 1, 1947, hospital care became free for residents of Saskatchewan (Reid 2009). Through debate, short-term strikes by the medical community, rancor and discussion, the will of the Canadian people remained steadfast for a health care system nationwide. The Canadian Health Act, providing for a universal plan throughout Canada, was passed by the Canadian Parliament in 1984 (Reid 2009). Each of the 10 Canadian provinces and three territories administers its own plan (Reid 2009). This model of structure, delivery, and financing contains elements of both the Beveridge and Bismarck models. This system uses private-sector care providers coupled with universal coverage with one payer – the Canadian government. The Canadian system is a true national health insurance model, and is guided by five principles:

1. publicly administered throughout all provinces
2. comprehensive coverage for all services
3. universal, home jurisdiction covers the individual until residency status is settled during any waiting periods
portable (coverage is available for Canadians regardless of the province they are in or travel to or move to, e.g., moving from Ontario to British Columbia). However, the Ontario Health Insurance Plan (OHIP) will not pay for services deemed not medically necessary.

5 accessibility: all insured Canadians have reasonable access to health care facilities. Also, health providers (physicians, pharmacies, hospitals, and other providers) must be reasonably compensated for provision of health care services.

The Taiwanese (Republic of China), when constructing a revised health care system in the 1990s, chose a model most like the national health insurance model, with elements of the Beveridge model. The South Koreans did likewise. Those patients in the USA with Medicare coverage find their health care insurance plan is most like a national health insurance model, e.g., Canada’s. The formula for payment to physicians and the process for paying physicians on behalf of Medicare clients are in need of alteration. Three times in 2010 before the end of the fiscal year, stop-gap intercessions were made to stem the implementation of a 21–23% decrease in payments to physicians. In 1997, as part of the budget reconciliation, the US Congress passed a balanced budget law that put the current formula in place, determining how doctors will be paid.

The out-of-pocket model

Until health care reform package (PPACA) was passed, the US system was partially an out-of-pocket model for the 45–47 million uninsured in the USA. Precisely how many will become insured, and thus lose the out-of-pocket status, remains to be seen over the 10-year phase-in of the health care reform package (PPACA), and perhaps alteration based on changes in the US House of Representatives, the US Senate, and presidential elections to be conducted between now and 2014. The lack of a system, or an amalgamated series of differing plans which was and is such a patchwork of a system, has beget a legacy of currently 700,000 medical bankruptcies in the USA each year.

The additional segments which will now eliminate exclusion of pre-existing conditions for insurance eligibility, removal of insurance caps on payments over a lifetime, expansion of coverage for many currently uninsured, provision of Medicaid to more individuals due to reduction in the income eligibility ceiling, and coverage for children under their parents’ insurance plans through age 26, will be a hoped-for tremendous help for many currently desperate individuals in the USA.

Rural India, Burkina Faso, and Cambodia all have out-of-pocket models of health care system structure, delivery, and payment for health care in play. This system of out-of-pocket care may also be referred to as a market-driven process of health care delivery.
Socialized medicine

The term “socialized medicine” dates back to the 1940s, 12 US presidential eras back in the past, when there was a backlash against then President Harry Truman’s efforts to sponsor a reorganization of the US health care system to provide universal health care insurance for all Americans. Then, the American Medical Association used “socialized medicine” as a “red herring” to avert the American public’s eye away from the beneficial segments of a national health insurance for all program. In Reid’s treatise, the myth of many foreign (to the USA) systems as all being “socialized medicines” is debunked (Reid 2009). In Chapter 13 of his book, Reid explodes various myths surrounding foreign health care systems, namely:

- “It’s all socialized medicine out there.”
- “They ration care with waiting lists and limited choice.”
- “They are wasteful systems run by bloated bureaucracies.”
- “Health insurance companies have to be cruel.”
- “Those systems are too foreign to work in the USA.”

Not every one of these comparator systems is perfect and to his credit Reid (2009) points out flaws consistently and fairly. For example, he finds long queues in Canada, poorly paid physicians in Japan, undertreated patients in the UK, and challenging facilities in France. Reid interviews physicians, hospital administrators, governmental regulators, international health care experts, and finally patients receiving care.

Influence of lobbyists and special-interest groups on health policy

It is certainly not a surprise to anyone that the influence of lobbyists on many pieces of legislation is significant, pervasive, and effective in achieving specific goals of special-interest groups. One can guess as to the influence the contributions have on many aspects of what extends into laws affecting many aspects of our lives. These resultant effects (of perhaps funding shifts to other items) on health care, health care systems, health insurance programs, health professions, health professionals, and health professional educational programs are blatant and oppressive because of neglect of other worthy funding points.

Follow the money

The passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) is a case in point of how funding follows lobbyists’ collective activities. The Medicare Part D
drug program as a part of this legislation overtly favored pharmaceutical manufacturers, insurers, and pharmacy benefit management companies in an egregious fashion. Pharmaceutical companies were and are allowed to do business as usual with multiple pricing levels, and retain the ability to raise prices at will. The MMA legislation specifically prohibits the Centers for Medicare and Medicaid Services (CMS) from negotiating with pharmaceutical companies for advantageous prices that these same companies provide freely elsewhere. The Federal Supply Schedule pricing has allowed the VA to purchase drugs at reduced prices and the federal 340B Drug Pricing Program provides access to reduced-price prescription drugs to over 12,000 health care facilities certified in the USA. Pharmaceutical companies remain profitable even with these reduced pricing programs, partly due to their ability to shift price hikes elsewhere in a multilayered process of drug pricing.

To provide for optimum participation by Medicare Part D prescription drug plans (PDPs) and Medicare Advantage (MA-PDPs, as a component of managed care Medicare Part C) drug plans, a component of the MMA legislation provided PDPs and MA-PDPs with significant subsidies containing upfront funding, allowing these companies to participate with an assurance of profitability (Levinson 2007). In effect, participating plans were given a profitability fallback regardless of what happened with enrollment into their plans by eligible seniors, and were thus risk-averse from a lack of enrollment and/or profitability with their proffered plans.

As the legislation was written and enabled, for the first year of the program, due to overpayment to PDP and MA sponsors, Part D plan sponsors owed Medicaid a net total of $4.4 billion for the year 2006. This amount of overpayment has been reduced to $600 million for 2007, a significant reduction, but this amount remains sizeable. These overestimated payments provided to plans were to be returned to Medicare. However, to complicate this matter further, CMS had no mechanisms in place to collect funds from such overpayments. This was finally set up and accomplished well into 2007 for the 2006 payments; as such, sponsors held significant amounts of money for an extended period of time. Lobbyists exerted pressure to pass the MMA in the form in which it was enacted.

The health care lobbyist influence on health care matters is significant (Heid and Sook 2009). According to Northwestern University’s Medill News Service, the number of former House and Senate key staffers turned lobbyists is significant (Heid and Sood 2009). There are 14 former chiefs of staff and four former deputy chiefs of staff among the more than 200 former congressional aides now working as lobbyists and registered in 2008–2009 (Heid and Sood 2009).

These are US Senators and they work at a federal level and greatly impact health policy. Funding scenarios by these vested interests may be less intense.
in terms of dollar volumes in various state legislatures, but these groups in the health sector, providing funding at the federal level, also fund state legislators in each state. Here the competing interests for funding affecting state Medicaid programs most definitely intersect with state funding for other worthy entities.

**Changing health care systems is contentious**

The structures of a country’s health care systems are a complex amalgamation of influences, patterns, and societal expectations. Changing a system dramatically becomes more difficult as health policy influences from insurers, providers, patient advocacy groups, state and federal government entities, and society bear down on health care systems. Efforts to pass enabling legislation in the UK in 1948, in Canada in 1984, in Taiwan and Switzerland in the 1990s, and in the USA in 2010 were all contentious processes.

**Key points of stress for the future US health care system and health care policy applications**

With the passage of PPACA in March 2010, one inclination is to rest easy; problems currently in the USA health care system will now be fixed. This is far from the true state of affairs both at present and in the future. Small steps of success often herald the major cliffs yet to be surmounted. For example, the passage of health care reform legislation earlier in 2010 was heralded by suggestions of an immediate impact on public health as a result, while others suggest this bill is flawed and incomplete. Perhaps these views may both be correct. Regardless, the major influences on the health care system and patients remain to be seen and may be decades away. Oftentimes pundits will suggest that it was important to get something passed, even if not the most appropriate bill possible. In the future, problems currently in place can be readily fixed when improvements are made on the passed bill. This did not occur with the passage of PPACA and the Medicare Part D program, flawed in design and implementation from the outset.

Initial problems with the Medicare Part D drug benefit included:

- “doughnut hole” period of lack of coverage after initial co-insurance requirements met, targeted to be reduced over a 10-year period with the enactment of PPACA and specific components dealing with the “doughnut hole”
- pricing increases
- many competing plans with many choices
access to CMS website by seniors: the website has recently been updated, but readability concerns may still exist

readability of materials supplied to seniors.

This program, which began on January 1, 2006, was not significantly altered by the passage of the PPACA. Tinkering with the benefit might be the best consideration of the passage of PPACA and subsequent effects on the Part D drug benefit. A sum of $250 was provided to Medicare Part D recipients in 2010 to cover some of the “doughnut hole” gap in coverage for eligible seniors. With average prescriptions costing in the range of $70–75, roughly a 160% increase over costs in 1982, this $250 amount will not help many in a significant way. The “doughnut hole” gap is set to shrink over a 10-year phase-in of decreases in costs shared by generic and brand-name drug manufacturers. However, as optimistic as this sounds, the reality is that prices can still be increased at will by both generic and brand-name manufacturers during this period, as they have done over the years in which Medicare Part D has been in existence (since January 1, 2006). A recent analysis by the Kaiser Family Foundation (Hoadley et al. 2010) found that, between 2009 and 2010, monthly prices in the coverage gap increased by 5% or more for half of the top 10 brand-name drugs, while the consumer price index for urban consumers (CPI-U) increased by 2.7% and the CPI for medical care (CPI-M) increased by 3.5% between January 2009 and January 2010.

Competing plans are still numerous – less so with Medicare Advantage plans, which were targeted by the PPACA. The www.medicare.gov website was recently upgraded, but the site is still difficult for many seniors to wade through. Part of this difficulty rests with the degree of readability of Medicare materials: this makes understanding difficult for many, not just seniors.

When examining what lies ahead in the USA, one factor is the rapid numerical rise of the population. From the projections seen in the population growth figure estimated through the year 2050 (Figure 2.3), the number of US citizens is projected to increase dramatically over the next decades. A significant increase in those over the age of 65 is apparent. This projected increase of around 50% in the US population between the years 2010 and 2050 will be impacted by health care costs and availability of coverage, but such a large population increase will surely dramatically influence the US health care system. The true effects of the passage of PPACA upon the population remains to be seen: what can be estimated with certainty is that the system of care, insurance for care, payment levels for care, demand for health services, and the availability of health care will all be significantly challenged in the years ahead.

Individuals are covered under Medicare immediately upon reaching the age of 65 years. But approximately 15% of Medicare recipients are less than age 65 years; they may be disabled or eligible for end-stage renal disease.
services under Medicare. Even with coverage under Medicare, there are gaps in insurance for necessary health expenditures for recipients. This coverage gap will remain significant for several reasons: more seniors will be eligible for Medicare, and this number will not decrease; expenditures will no doubt increase – there has not been an overall decrease in health expenditures for as long as can be remembered; and the types of services, scope, and intensity will increase with advancements, profitability of such, and demand for more advanced treatments.

Medicare does not pay for many services that are required by recipients. For example, long-term care that is custodial in nature is not covered, whether this is home care or care in a long-term care facility. Dental services are not covered under Medicare, including dentures or routine dental care. Vision services, such as routine examinations, eyeglasses and refractions, are not covered by Medicare plans. Also, hearing aids or hearing examinations are not covered under Medicare. There are no limits (ceilings) for out-of-pocket costs on a yearly basis for Medicare enrollees – many private health insurance plans have such limits for out-of-pocket payments. Many seniors purchase Medi-Gap coverage plans to cover non-covered expenses, but these premiums can be expensive and further out-of-pocket payments are additionally required for the most part.

As can readily be discerned from Figure 2.4, the proportion of the population between the ages of 65 and 74 years is estimated to increase by 50% (from 6% to 9%) by 2050, and the population aged 75 and older will virtually double from 6% of the population in 2007 to 11% in 2050. A key point is that the proportion of those between ages 45 and 64 years, as well as between 18
and 44 years, are both decreasing during this projection. The number of eligible individuals requiring Medicare services is increasing dramatically and the proportion of those who will carry the heaviest burden of financing the Medicare program is shrinking as a percentage of the population. These are estimates, it should be noted, but sobering estimates nonetheless. The US CBO provides frequent projections for spending in coming periods. The latest projections point to a projected federal spending in 2020 with a comparison of Medicaid and Medicare percentage of total spending (Congressional Budget Office 2010). Medicare is projected to account for 17% of total federal spending, and Medicaid 8% of total federal spending.

Figure 2.5 provides a view of seniors’ longevity in the USA, and the life expectancy for additional years once reaching the age of 65 years. These

![Figure 2.4](image1)

**Figure 2.4** Selected population percentages categorized by age. Source: CDC/NCHS, Health, United States, 2009, Figure 1A. Data from the US Census Bureau. National Center for Health Statistics; Health, United States, 2009 With Chartbook on Trends in the Health of Americans, Hyattsville, MD: 2010.

![Figure 2.5](image2)

**Figure 2.5** Life expectancy. Source: CDC/NCHS, Health, United States, 2009, Figure 16. Data from the National Vital Statistics System. National Center for Health Statistics; Health, United States, 2009 With Chartbook on Trends in the Health of Americans, Hyattsville, MD: 2010.
figures are broken down further, showing differences between blacks, whites, and gender-specific trends within the two races. People are living longer regardless of race; a more pronounced increase for whites than blacks and gender separation is apparent across the two racial groupings. These trend lines again show the pervasively negative influence of race on aging. But the data indicate above other differences that Americans are living longer, and to ages never reached (on average) before. This will have significant societal ramifications in the long term, not only for health care and health care utilization but for other tangents as well.

Figure 2.6 shows that the proportion of the US population accounted for by African-Americans and Hispanic-Americans is increasing. These increases are noteworthy in that data indicate both groups receive disparate care when compared with whites in the USA. How future health care is delivered more equitably will rest on the shoulders of health professionals, health systems, insurers, and the expectations of all these and the recipients of that care.

The percentage breakdown of those living in poverty in the USA is presented in Figure 2.7 and by race and/or ethnicity in Figure 2.8. A significant number of Americans live in poverty in the USA, and minority populations suffer to a significant degree in comparison with whites. Those with fewer resources, economic and otherwise, do not fare as well as those who are better off in the US health care system. The segments of the elderly living in poverty and children living in poverty are both of considerable concern at present and certainly in the future as well. The dramatic decrease in seniors living in

![Chart](chart.png)

**Figure 2.6** Breakdown of population by race/ethnicity. Source: CDC/NCHS, Health, United States, 2009, Figure 2. Data from the Census Bureau. National Center for Health Statistics; Health, United States, 2009 With Chartbook on Trends in the Health of Americans, Hyattsville, MD: 2010. *Not Hispanic.
poverty that is seen in Figure 2.7 in 1966 is directly due to the passage of Medicare legislation in 1965 along with Medicaid. These social health insurance programs dramatically affected the levels of poverty (decreasing) and health status (increasing) at that point in the USA.

**Figure 2.7** Poverty percentages in the USA. Source: CDC/NCHS, Health, United States, 2009, Figure 4. Data from the Census Bureau. National Center for Health Statistics; Health, United States, 2009 With Chartbook on Trends in the Health of Americans, Hyattsville, MD: 2010.

**Figure 2.8** Low-income population in 2007 in the USA. Source: CDC/NCHS, Health, United States, 2009, Figure 5. Data from the Census Bureau. National Center for Health Statistics; Health, United States, 2009 With Chartbook on Trends in the Health of Americans, Hyattsville, MD: 2010.
Jones (2010) suggests that health disparities exist along lines of race/ethnicity and socioeconomic class in US society. These disparities are a moral, ethical, and class example of the shortcomings of the US health care system. As with any systemic problem within health care systems and insurance coverage for such, moral courage will be called upon to address these differences in unequal treatment for segments of the US population.

**Senior-specific health care issues and future concerns**

Figure 2.9 presents interesting data regarding vaccinations and rates for influenza and pneumococcal pneumonia vaccinations by varying age groups. The relatively low rates of vaccinations for both are startling. The rate for pneumococcal pneumonia vaccination is around 60% across all age groupings. It is lowest for those between the ages of 65 and 74 years. This is discouraging since this is a covered benefit within Medicare with no out-of-pocket expenditure required of patients. Providers of care for seniors (physicians, nurses, pharmacists) should be much more proactive in ensuring seniors receive this vaccination. Pneumonia, often a sequela after hip fracture, is a predominant cause of death for seniors. This vaccine can save untold morbidity and postpone mortality to a significant degree. Similarly, the lack of influenza vaccinations by younger as well as older seniors is troubling. Both of the rates of vaccinations (influenza and pneumococcal pneumonia) are low and indicative of serious quality issues for care provided to seniors in the USA.

![Figure 2.9](image_url)

**Figure 2.9** Vaccinations and seniors in the USA: influenza and pneumococcal vaccination. Source: CDC/NCHS, Health, United States, 2009, Figure 9. Data from the National Health Interview Survey. National Center for Health Statistics; Health, United States, 2009 With Chartbook on Trends in the Health of Americans, Hyattsville, MD: 2010.
Figure 2.10 shows the impact that chronic health conditions have upon activities of individuals. Not surprisingly, these data point to decreasing levels of activities as individuals age. By far and away the largest limiter of activity occurs with arthritis and musculoskeletal ailments, more than doubling in its intensity from the age of 65–74 years to 85 years and older. Medicare-related expenses for each of these ailments are significant at present and will increase dramatically as the numbers of individuals in Medicare-eligible coverage continue to increase. Also several ailments, e.g., vision and hearing, are not covered items under Medicare.

Figure 2.11 provides a view of how precipitously personal health expenditures have risen over a 20-year period. Rising health care costs drive each of these trend lines forward. Private health insurance payments on behalf of individuals outpace spending from these other sources. Insurance premiums for private health insurance on the part of both employers providing insurance and employees with coverage have increased by over 130% in the past 10 years in the USA. One additional reason for the rise in personal health costs is that, as Medicare and Medicaid (government-sponsored coverage) have attempted to stem health care cost increases, costs have shifted from providers (hospitals, physicians) to the private sector (private health insurance payments) (Chernichovsky and Leibowitz 2010). Medicare and Medicaid have also increased both in terms of numbers of covered individuals as well as the expenditures paid on their behalf. Examples of this cost shifting include private out-of-pocket payments for deductibles, co-payments, co-insurance, and/or payment for items not covered under health insurance plans such as over-the-counter drug products, eyeglasses, and dentures.
Medicare payments for each of the six principal procedures tracked in Figure 2.12 are increasing, as are expenditures for all methods of payment for these health services. Let’s focus on Medicare alone and payment for percutaneous transluminal coronary angioplasty (PTCA). These costs are profiled in Figure 2.13, showing PTCA/stent procedures with segmentation by age.
differentiation – 45–64 years and 65 years plus. The numbers of PTCA and drug-eluting stent procedures have significantly increased in the Medicare-eligible age group, 65 years plus. Payments for these expensive procedures are partially responsible for the increase in Medicare expenditures.

Figure 2.13  Hospital discharges for percutaneous transluminal coronal angioplasty (PTCA) procedures. Source: CDC/NCHS, Health, United States, 2009, Figure 28. Data from the National Hospital Discharge Survey. National Center for Health Statistics; Health, United States, 2009 With Chartbook on Trends in the Health of Americans, Hyattsville, MD: 2010.

Figure 2.14  Medicare decedents over age 65 with intensive care unit (ICU)/coronary care unit (CCU) stays. Source: CDC/NCHS, Health, United States, 2009, Figure 31. Data from the Dartmouth...
For Medicare recipients another unfortunate aspect of living and dying is hospitalization in an intensive care unit or cardiac care unit during the last 6 months of life (Figure 2.14). Regional differences are evident. These geographic differences may be partially explained by examining the map and considering where the major metropolitan areas are in the USA, coupled with population density data for where seniors live and where they need to seek tertiary care at the end of life. It has been estimated that upwards of 80% of what Medicare patients use in the form of health care services occurs in the last 6 months of life.

Summary

This chapter explored the relationships between various forms of health care systems and countries of origin. Many of the systems in play have evolved over time (German system since the late 19th century; British system since 1948), whereas some were recently put in place (Canada in the 1980s; Taiwan and Switzerland in the 1990s). The reform of the US system in the 2010s will await the test of time to determine its ultimate effects. What can be examined in the US context is the trends in spending for the multilayered system of care provided in the USA. Through replicating the various subsystems of care in a revised health care system, estimates of costs can be placed in debate.

The influencers of many segments impacting health policy are evident when examining each of the different forms of health care systems presented in this chapter.

Discussion questions

1. Under the PPACA, passed in 2010, fines will be levied against those who fail to purchase health insurance as stipulated in the bill. Is this fair, ethical, or feasible? Why or why not?


3. Oftentimes people point to the UK system (an example of a Beveridge system) as an estimable system to replicate. Do you feel that this system could be implemented in the USA? Do you feel it could be instituted for the first time in the UK today, over 60 years after its formation?

4. The US VA health care system is similar to the UK NHS system. Has this system of care for veterans of US military service worked positively for US veterans?
5 Ethically, what does the US government owe Vietnam War veterans exposed to Agent Orange during the war?

6 Could Medicare patients be effectively treated in US VA health care facilities? Would this be a cost-effective method of treating Medicare patients?

7 Does the passage of PPACA in the USA mean that the US health care system is now a socialized medicine system?

8 Should the influence of lobbyists on health care issues in the USA be limited in some fashion? If so, how would you implement this?

9 What would you do to improve the Medicare Part D drug plan immediately?

10 Why do you think the “doughnut hole” segment was initially placed within the Medicare Part D Drug Benefit program? Who would have advocated for this inclusion?

11 If you examine the population increase trends described in this chapter, what impact do you feel these projected increases will have on social insurance programs in the USA?

12 Why do you feel the vaccination rates for pneumococcal pneumonia for seniors is as low as it is in the USA? What are the ethical implications of this low rate?

13 With Medicare and Medicaid projected to account for 25% of total federal government spending in the USA, how do you see cost-cutting strategies meshing with increasing potential for enhanced use of pharmaceuticals?

References


Further reading


Case Study

Medicare Part D (USA)

This case study is an example of a health policy program component that might be termed a type of incrementalism (Callahan and Wasunna 2006). This refers to a health program that is designed to meet a specific need that exists in the health care system of a country. However, the program is not designed to address the problem to the extent that it perhaps could. This is certainly the case with Medicare Part D, a prescription drug outpatient benefit for Medicare enrollees in the USA. The program only partially covers the expense of outpatient drug therapy in the USA for eligible enrolled seniors.

Introduction commentary regarding health care reform

The addition of the Medicare Part D Drug Benefit in January 2006 is an interesting and revealing health policy impact worth close examination. The discussion of health care reform in the USA has been carried out in a uniquely American context. It has been a parochial discussion, and examining systems in place internationally seems not to have been an option. Curiously, successful options for care in the UK, Canada, Australia, or elsewhere are not seriously considered. A change in options was feasible if and only if current systems or insurers were retained in a “new” system. Table 2.1 provides a listing of the various Medicare programs and what items the Medicare part will cover.

When other countries revised their health care systems, systems existing elsewhere are considered in crafting a new delivery and insurance structure. For example, Taiwan looked at the best options available in numerous systems when reforming the Taiwanese system of insurance and delivery of care (Reid 2009). This process was not undertaken in the USA, which could be considered detrimental to those who need the most assistance, i.e., patients and families.
Medicare Part D and health care reform

Some of the materials presented in this case study have been adapted from Fincham (2009, 2010). Elements of health care reform receiving attention in past debates regarding potential changes in the US health care system have included elements of the following:

- universal coverage (horizontal equity in health economics terms)
- placing a cap on the amount insurance companies can spend administratively
- somehow limiting insurance company profits
- no elimination of coverage for patients with pre-existing health conditions
- standardizing care coverage at different levels (vertical equity in health economics terms)
- ensuring that all plans cover a range of benefits
- allowing for comparisons between plans by consumers in an easier fashion than currently available

### Table 2.1 Medicare insurance programs

<table>
<thead>
<tr>
<th>Medicare component (Part)</th>
<th>What does it cover?</th>
<th>What types of service are included?</th>
<th>Do you need to sign up for the plan?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part A Hospital insurance</td>
<td>Inpatient hospital services, skilled nursing facilities, home care</td>
<td>Eligible at age 65 years. Payroll taxes finance the plan so you pay no premiums</td>
<td></td>
</tr>
<tr>
<td>Part B Supplemental medical insurance</td>
<td>Physician and other health care provider office visits, outpatient services, drugs administered in an outpatient clinic</td>
<td>Pay by premiums which vary per month, and the rates are raised each year. You sign up for Part B Medicare</td>
<td></td>
</tr>
<tr>
<td>Medicare Advantage Medicare Advantage (managed care) formerly Medicare Choice, or Medicare Part C</td>
<td>Medicare Parts A, B, and D provided through a private health plan such as a managed care organization (health maintenance organization: HMO)</td>
<td>You sign up for this plan which is paid for by a combination of payroll taxes and premiums</td>
<td></td>
</tr>
<tr>
<td>Part D Prescription drug insurance</td>
<td>Outpatient prescription drugs such as those purchased in a community pharmacy or from an outpatient hospital pharmacy</td>
<td>Premiums vary depending on which plan you choose. You sign up for coverage</td>
<td></td>
</tr>
</tbody>
</table>

Source: adapted from Medicare Part D information sections, available online at www.medicare.gov.
eliminating premium markups based on differing levels of health status
minimizing premium variations based on age.

The passage of health care reform in the USA (PPACA) will no doubt change how health care is delivered and financed in the USA. Changes suggested to be possible include eliminating the taxfree status of health insurance coverage, reduced profits for providers and institutions, expansion of coverage for the current underinsured and uninsured, and penalties for corporate businesses that do not participate in the revised plans.

Congressional debate and subsequent plans for health care reform in both the House of Representatives and the Senate were not necessarily bipartisan in nature; this alone has been suggested to be extremely problematic (Iglehart 2009). With the Obama administration intent on passing legislation reforming the US health care system, how specific patients, providers, and insurers will eventually fare is anyone’s guess. Estimates placing the cost of a revised health care system amounting to $1.2 trillion or more over a 10-year period seem to lead to the conclusion that hospitals, providers, and the health professions will see unprecedented turmoil in the future.

As the health care reform debate continues after passage of health reform in the USA (PPACA), it may be instructive to consider the most recent major health care insurance proposal enacted in the past 5 years. This is the Medicare Part D Drug Benefit. Constructed during the administration of President George W. Bush and in place since January 1, 2006, the Medicare Part D program has a muddled track record of outcomes. In many ways, it provides an excellent case study of how not to implement a change in health care insurance. The Medicare Part D program is a market-based model of a government-subsidized health insurance program component.

This program was enacted with much hype and high expectations. The program helped many Medicare recipients, provided a much-needed impetus for pharmacy education and pharmacists to focus on outpatient pharmacy services necessary for patients, and was an incredibly profitable program for health insurance companies providing Medicare Part D and/or Medicare Advantage plans.

Pharmacy participation
The percentage of pharmacy participation in Medicare Part D has been high; however, not all pharmacies are participants in each of the
Medicare Part D prescription drug plans. The relatively low reimbursement rate, coupled with delays in payments for services provided, has challenged participating pharmacies (Spooner 2008).

Patient benefit

For the period of 2006–2009, the median premiums paid by beneficiaries increased by 35% (Hargrave et al. 2009). Between 2008 and 2009 alone premiums increased by 17% (Hargrave et al. 2009). Cost-sharing requirements for recipients also increased by 35% over the 3-year period (Hargrave et al. 2009).

Fiscal impact

The release of the latest Medicare Annual Report indicates the Medicare hospital insurance (HI) trust fund is projected to be exhausted by the year 2017 (CMS 2009). The annual updating report of 2008 indicated solvency of the HI trust fund through 2019, so in a 1-year period, a 2-year decrease has now been projected. Medicare Part D, along with Medicare Part B, is funded through a supplementary medical insurance (SMI) fund, which is separate from HI; the SMI is projected to be solvent over the same time period. However, the state of the economy, increased demand for services, and looming health care reform could quickly change the metrics of SMI. Considering the viability of Medicare Part D in the context of the current health care milieu is one thing; with the prospects of health care reform moving forward at an accelerated pace, current funding and future funding options may be dramatically challenged.

The passage of the MMA is a case in point of how funding follows lobbyists’ collective activities. As previously noted, the Medicare Part D Drug Program as a part of this legislation significantly favored pharmaceutical manufacturers, insurers, and pharmacy benefit management companies in an egregious fashion. Pharmaceutical companies were and are allowed to do business as usual with multiple pricing levels, and retain the ability to raise prices at will. The MMA legislation specifically prohibits the CMS from negotiating with pharmaceutical companies for the advantageous prices that these same companies provide freely elsewhere. The Federal Supply Schedule pricing has allowed the VA to purchase drugs at reduced prices and the federal 340B Drug Pricing Program provides access to reduced price prescription drugs to over 12,000 health care facilities certified in the USA. Pharmaceutical companies remain profitable even with these reduced pricing programs,
partly due to their ability to shift price hikes elsewhere in a multilayered process of drug pricing.

As noted in the main part of this chapter, in order to provide for optimum participation by Medicare Part D PDPs and MA-PDPs, a component of the MMA legislation provided PDPs and MA-PDPs with significant subsidies containing upfront funding, allowing for these companies to participate with an assurance of profitability (Levinson 2007). In effect, participating plans were given a profitability fallback regardless of what happened with enrollment into their plans by eligible seniors, and were thus risk-averse from a lack of enrollment and/or profitability with their proffered plans.

As the legislation was written and enabled, for the first year of the program, due to overpayment to PDP and MA sponsors, Part D plan sponsors owed Medicaid a net total of $4.4 billion for the year 2006. This amount of overpayment has been reduced to $600 million for 2007, a significant reduction, but this amount remains sizeable. These overestimated payments provided to plans were to be returned to Medicare. However, to complicate this matter further, CMS had no mechanisms in place to collect funds from such overpayments. This was finally set up and accomplished well into 2007 for the 2006 payments; as such, sponsors held significant amounts of money for an extended period of time. Lobbyists exerted pressure to pass the MMA in the form in which it was enacted.

With the passage and signing into law of the health care reform bill (PPACA), several key changes to the Medicare Part D drug benefit are in place to reduce Part D enrollees’ out-of-pocket payments when they reach the drug coverage gap, known as the “doughnut hole.”

Since 2006, beneficiaries enrolled in Part D plans have been required to pay 100% of their prescription drug costs for the vast majority of patients after their total drug spending exceeded an initial coverage limit. Then patients qualified for what is termed catastrophic coverage. The coverage gap was $3610 in 2010 and is projected to exceed $6000 by 2020. As noted, the vast majority of Part D plans have a coverage gap. It has been estimated that, in 2007, an estimated 3.4 million Part D enrollees (14% of all enrollees) reached the coverage gap (www.kff.org).

The recently passed health reform legislation reduces the amount that Medicare Part D enrollees are required to pay for their prescriptions when they reach the coverage gap. The gap is being phased out with differing levels of subsidies for brand-name and generic drugs in the gap, starting in 2011.
For the next few years, the follow enhancements have been codified:

- In 2010, Part D enrollees with spending in the coverage gap received a $250 rebate.
- Beginning in 2011, Part D enrollees who reach the coverage gap receive a 50% discount on the total cost of their brand-name drugs in the gap, as agreed by brand-name pharmaceutical manufacturers.
- Then in succeeding years Medicare gradually phases in additional subsidies in the coverage gap for brand-name drugs (starting in 2013) and generic drugs (starting in 2011), reducing the beneficiary co-insurance rate in the “doughnut hole” gap from 100% to 25% by 2020.
- Then by 2020, for brand-name drugs, Part D enrollees receive the 50% discount from pharmaceutical manufacturers, in addition to a 25% federal subsidy (starting in 2013). Part D subscribers would be responsible for only 25% of the total cost of their drugs out of pocket.
- Then by 2020, 75% of the cost of generic drugs in the gap would be subsidized by Medicare (starting in 2011), while beneficiaries would pay the remaining 25% out of pocket.
- Also, from 2014 to 2019, the bill reduces out-of-pocket amounts that qualify a subscriber for catastrophic coverage, further reducing out-of-pocket costs for those with relatively high prescription drug expenses. Starting in 2020, the level would revert to what it would have been without the reductions in the intervening years.

Summary

As can be deduced from the above discussion regarding the Medicare Part D program, a number of “players” interacted significantly in the passing of the legislation that enabled an outpatient drug therapy payment for Medicare recipients to be started in 2004 with a Medicare Drug Discount Card program, and in January 2006 with the Medicare Part D Drug Benefit program. These “players” included: lobbying entities representing the health insurance and pharmaceutical industries; seniors’ advocacy groups such as the American Association of Retired Persons; professional pharmacy groups such as the American Pharmacists Association; the National Community Pharmacists Association; and trade groups such as the National Association of Chain Drugstores, and the Food Marketing Institute, representing food market-based pharmacies.
Discussion questions

1. Some people suggest the Medicare Part D Drug Benefit was heavily influenced by lobbyists advocating positions favorable to the pharmaceutical industry. From a health policy perspective, how do you appraise this situation?

2. The Medicare Advantage Plans (Medicare Part C) have been successful in promoting an umbrella approach to incorporating a drug benefit plan within other coverage. What are the benefits and downsides to this approach to providing Medicare coverage?

3. Do you feel that the “doughnut hole” approach used within Medicare Part D has been successful in this approach to influence utilization by Medicare Part D enrollees?

4. The US CMS has provided a website (www.medicare.gov) to guide consumers regarding Medicare Part D plans, options, and formulary options within drug plans. From a health policy perspective, what are the benefits and disadvantages of such an approach?

5. Medicare Part D PDPs negotiate on prices directly and individually with pharmaceutical companies for preferential pricing for drugs available within plan formularies. What are the benefits of this approach?

6. Should CMS negotiate directly with pharmaceutical companies for drugs used within Medicare Part D drug plans?

7. What influence do you feel Medicare Part D drug plans have had on enrollee patient compliance with medications?

8. From a health policy perspective, what changes would you make in Medicare Part D drug plans and the benefit provided to Medicare enrollees?

9. The “doughnut hole” segment of Medicare Part D drug plans is planned to be phased out over a decade. How will this benefit patients?

10. What can pharmaceutical manufacturers implement to influence their profitability within product lines available within Medicare Part D drug plan formularies?
References


Further reading


