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Symkovych Anton

AN INQUIRY INTO THE U.S. HEALTH CARE SYSTEM

The article provides a brief overview of the U.S. health care system. The historical overview of genesis of the modern U.S. health care system is presented, and current trends are discussed. Policies in the arena are explored and the implications for social work practice are articulated.

Introduction

Is health care a right or a privilege? Present U.S. health system appears complicated and the attitude towards it is controversial. In 2000 the health care spending in the USA reached $1.3 trillion or $4,500 per person. At the same time 37—42 million of the U.S. residents have inadequate or no health insurance (Pathi, 2001; A.D.A.M., 2002).

The present level of the U.S. health care promotes surviving of premature infants, prolonging lives, and people benefiting from super-modern medication and sophisticated technologies. On the

other hand, there are complaints about the high cost of the health care in the USA, inadequate spending (for instance, primary health prevention and promotion are frequently neglected while activities to prolong last months of life utilize enormous finances), institutional racism and so on (A.D.A.M., 2002; Randall, 2001).

This paper, through the utilization of the systems approach, aims to give a brief insight about the U.S. health care system's functioning, its strengths and problems.

Historical overview

Colonists came to North America mainly from the British Empire at the early XVII century; hence they imported the dominant protestant values and the English Poor law mentality, which fostered the introduction of institutional and home based assistance (Dolgoff et al., 1997; DiNitto, 2000). This shift to responsibility to local governments (parishes), which maintained almshouses, orphanages, hospitals, workhouses, and collected taxes, became the foundation of the British and U.S. welfare policy. But still up to nineteenth-twentieth centuries most ill people were treated at home before the technological development created a situation when specialized treatment could be delivered only in specialized institutions.

Along with technological changes in the medical industry the shifting paradigms in morality occurred as well. The public and professional attitude toward the mentally ill changed. To postpone the shameful practice of medieval "treatment" of people in "madhouses" outstanding social reformers called for various social reforms in the health sector. For instance, Dorothea Dix lobbied an Indigent Insane Bill to bring change in mental health, but President Franklin Pierce vetoed it in 1854 due to the belief that "the federal government could not give legal sanction to charitable governmental acts" (Dolgoff et al., 1997; Garvin & Tropman, 1992).

The twentieth century witnessed the broader involvement of federal and state governments in health care system. According to Garvin and Tropman (1992), in 1921 the Maternal and Infancy Act was adopted, the Hospital Survey and Construction (Hill-Burton) Act followed in 1946 bringing change by introducing health planning. The Act was amended in 1964 and 1970, plus the legalized sphere was broaden by introducing of Public Health Service Act Amendments in 1966 (Garvin & Tropman, 1992). Until the Great Society program of *President L. Johnson*'s *Administration, there were* no federal insurance or assistance programs. The absence was largely because of the resistance of such powerful institution as American Medical Association. Because of its lobbying campaigns, health insurance bills failed many times from the beginning of President Franklin Roosevelt's Administration until the President Kennedy's Administration.

Only in 1965 under Title XIX of Social Security Administration the Medicaid, a public assistance program predominately for poor Americans, and Medicare (under the Title XVIII of Social Security Administration), the federal insurance program, were established. They are the main programs that shape present U.S. disintegrated welfare policy in the health care (DiNitto, 2000). In 1981 the governors were granted the right to eliminate regional health planning by the Omnibus Budget Reconciliation Act. To address the gaps in the health care system, non-governmental activities have been occurring, included creation of hospital planning councils and councils to plan community health (Garvin & Tropman, 1992).

Williams and Torrens (1980) assume that the third stage of health care development in the USA occurred in post Second World War period, when the interest shifted towards the issues of financing. This time was remarked by the development of insurance plans, such as Blue Cross and Blue Shields, internal plans of for-profit companies, and the introduction of the Medicare and Medicaid. At present there are around 74 state and local Blue Cross and Blue Shield plans, which cover approximately 73 million people (Managed health care, 1995). The last decade, broadly shaped by the President W. Clinton's Administration, encompasses the edge of XX-XXI centuries, questions present health care policies and practice and calls for universal medical care and accessibility of health system to entire population of the nation.

Medicare

The U.S. government was accused of avoiding responsibility for health care system for years. To bring change around, and to address the fact that only half of elderly people had any insurance coverage at the age that is vulnerable for health problems, the Medicare program was adopted in 1965. The program is designed to meet the needs of people of age 65 and older, and in some cases of younger people who have some types of disabilities (renal failure). As it is an insurance program (part of *the Social Security system), it requires both em-*

ployees and employers to pay fees (the type of Bismarck's model, widely used around the world) during the work years to be eligible for benefits of the Medicare.

The *program consists of two parts, so-called Part A and Part B. Part A, or* hospital insurance, is compulsory (1.45 % tax of all wages). It pays the costs of hospital, hospice, nursing care, and some home health care. But it covers only a certain percentage of actual costs in special time terms. For instance, a covered person must pay a deductible ($768 in 1999), and Medicare covers the rest of the costs for the first sixty days of hospital care. After that term, the personal expenditures increase to $192, and later to $384 per day in the hospital. After 150 days, the insured hospital patient cannot claim for Medicare benefits. But still, the social nature of Medicare is revealed in the opportunity for people who do not qualify for Social Security to utilize the benefits of the governmental insurance program by paying monthly premiums, which depend on the employment history (in 1999 - from $170 to $309) (DiNitto, 2000).

Part B, or supplemental medical insurance, is a volunteer, and it covers the outpatient medical services. For people who are eligible for part A, the costs to participate in Part B are low ($45.50 monthly in 1999). People eligible for Part B's benefits are required to pay 20 % of received services' expenses (they must cover initial $100 of services), the other 80 % of the services' fees are covered by (the) Medicare) (DiNitto, 2000). The initial charges for the beneficiaries are introduced to discourage the abuse of the Medicare funds and to refund some expanses of the program. According to DiNitto (2000), Medicare spending is estimated to be $252 billion ($ 160 for Part A and $92 for Part B), or 13 % of the federal budget in year 2003. But still, there is essential need for additional money to cover the perspective expenses related to the demographical situation, as baby-boomers' generation is entering the 65-year age.

Medicaid

Medicaid was implemented as a public assistance program for certain groups of poor people. This program was a large improvement of the former Kerr-Mills Act. It is an entitlement program, which means that services must be provided for everyone who qualifies. Generally, Medicaid covers all SSI recipients and all pregnant women and children under six with the incomes less than 133 % of the official poverty level (DiNitto, 2000).

The beneficiaries can rely on the next services: in/outpatient hospital care, x-ray examinations, screening and examinations (under age of 21), physicians' services, family-planning, family and pediatrie nurse practitioner services. Medicaid is run both by federal and state governments, it means that states can expand the range of services (by adding transportation, eyeglasses, emergency hospital care, etc. for some categories) or vice versa, narrow the circle of eligible recipients (for instance, exclude legally admitted immigrants with 5 years of residence after August 1996 or adults who do not meet Temporary Assistance for Needy Families (TANF) work requirements, etc.). The federal government contributes about 57 % of Medicaid costs, which in 1998 was $104 billion. The reimbursement by the federal government varies from state to state and is calculated by using per capita method (DiNitto, 2000).

The social content of Medicaid is manifested in the access to the services: recipients are not required to make initial contributions as health care providers are directly reimbursed by the government thus it more likely that consumers will utilize these services. According to DiNitto (2000), Medicaid is in a permanent changing process and there are some calls to make all uninsured low-income people eligible. But even today, the number of participants of the program is considerable: 12 % of the U.S. population. Nevertheless, half of the poor people in the USA are uninsured (A.D.A.M., 2002), which is a call for social workers to promote campaign for social justice and the need to bring change in U.S. welfare policy.

Health Care Reform

In 2000 health care expenditures were $4,500 per person in the United States (Pathi, 2001). Despite the considerable spending, the situation in the present U.S. health system requires changes, as the latter cannot meet the needs of the nation in health care. The main motto of the reform is to change the expensive and complicated system to make the entire population eligible for quality health care. The debate includes two main ideas: single payer, or national insurance plan (as in many countries), and a competitive market of managed care. Due to the AMA pressure as well as a traditional fear to appear too "socialistic", the latter model is more in favor (A.D.A.M., 2002).

Managed care is created to address the rapid increase of health care spending (under traditional fee-for-service model health care providers fre-

quently are not controlled in costs of their services). The managed care is predominantly shaped by two concepts: Health Maintenance Organizations (HMO's) and Preferred Provider organizations (PPO's).

The HMO contract requires choosing of a primary physician, and later it is physician's decision whether to refer the patient to a certain specialist or not. The consumer pays a fixed monthly fee, which covers all visits to doctors, except $5-15 per each visit (Managed health care, 1997). HMO system has four models: group, IPA (individual practice association), network model, and staff model (A.D.A.M., 2002). The advantage of the HMO plans is, according to DiNitto (2000), absence of complexity (no reimbursements) and health preventive character of the program.

If the consumer chooses a PPO plan, s/he is allowed to freely select providers, but "insurance builds in financial incentives" for participating parts to choose providers within a particular group or system (A.D.A.M., 2002).

The weak point of the coverage by the managed system is the reluctance of hospitals to provide prolonged services or narrow awareness of consumers about the HMO practices. To postpone the shameful practice, the U.S. Congress passed a law in 1996, which changed some policies; for instance, women who had given birth were allowed to stay in the hospital for two to four days depending on the nature of the delivery. Other managed care system's problem includes costs. It was an unforeseen problem, which no one is able to fix at the moment. It is particularly a problem with Medicaid. In the states which have allowed their Medicaid programs to be taken over by managed care, more money is being spent while fewer services are being provided. Mental health in particular is in a state of crisis due to managed care for Medicaid. To provide some rescue measures, states focus on enrolling the less needy in health care, like children or nondisabled adults into Medicaid managed care plans (DiNitto, 2000).

One of the features of present shifting paradigms in the U.S. health care is increasing interrelations among different systems. For instance, so-called Medicare Part C was added and under the Balanced Budget Act of 1997. An enrollee now can select from wider health care options, including two additional managed care options. What is more, states nowadays are allowed to require many Medicaid participants to participate in managed care plans without a waiver to restrict their choices (DiNitto, 2000).

One of the main tasks of the President William Clinton's Administration was pursuit of new health care philosophy, which absorbed the advantages of national health care systems of Canada and other countries. It was supposed to cover the entire population while preserving the competition of providers to maintain the high quality of health care. It also proposed to strengthen the coordination of all subprograms (such as Medicare, veterans' health system, etc.), to raise money from tobacco taxes, employers' contributions (80 %), employees' fees and money from Medicare/Medicaid (through cost-savings). But the innovative plan was defeated by both Republicans and Democrats as they "reverted to incremental means to increase the insured population" (DiNitto, 2000). Reinhardt and Iglehart (1994) observed that the failure was largely due to the "ambivalence-open espousal of a lofty goal, but open hostility to the only means of achieving that goal", which was caused by traditional ethical dilemma to adopt the idea of universal coverage, higher governmental intervention into the health care system.

Failure of the governmental attempts of the broad reform in health care system does not discouraged states to endeavor steps in the field. For instance, according to DiNitto (2000), some states received waivers from the federal government to serve the uncovered population by allowing people to "buy into" through premium payments to Medicaid. After Californians defeated a health insurance program of the State of California, the Health Insurance Plan of California was still pursued, as it did not utilize taxes. The volunteer program allows employees to choose from different plans. The program is financed by the contributions of the employees' premiums and employers' minimum contributions, which appear to be a less expensive plan for each employee.

Conclusions

USA passed a long way from total withdrawal of federal government from any actions in the health care system to calls for governmental-run national health insurance system. This way was shaped by a great influence of PACs that lobbied policies in favor of certain groups (insurance agencies, pharmaceutical companies, political groups and so on). The choice of further development of the U.S. health care is disputed as both systems - national insurance plan and competitive market of managed care - have both advantages and disadvantaged. For instance, according to Meier (2002),

governmental health care and single-payer systems are "dysfunctional", they lack modern equipment and facilities. Such governmental programs such as Veterans Administration's, Defense Health's and Indian Health's programs, Medicare and Medicaid face similar problems. On the other hand, traditional insurance practice created steep prices in health care that withdrew a considerable percentage of the U.S. population and fostered the deeper institutional discrimination and segregation, as poor or other disadvantaged people are made to rely only on poorer health care services. It is hard not to agree with the conclusions of Kinney (2002) that in the current American political and cultural environment the requisite rhetorical consensus does not exist to establish universal health-care coverage today. This fact poses a significant barrier to the protection of many Americans who need some subsidy to access adequate health-care services.

And the perspectives of changes are dim, and pessimist prognoses dominate today. For instance, DiNitto (2000) assumed that "we cannot really hope to provide all the health care that everyone wants". But the evidence utters that the change is essential, hence, social workers should be more assertive in their mission of bringing change for the better by active lobby campaigns to change the expensive and complicated system to make the entire population eligible for qualitative health care. Without actions, the change could not be brought in, and we know that Rome was not built in a day, but it was built eventually. Hence, social workers' leitmotiv should be an action to change the situation in the present U.S. health system by creating and promoting accessibility to sufficient qualitative health, making primary health prevention a right, and not a commodity.

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Антон Симкович

АНАЛІЗ СИСТЕМИ ОХОРОНИ ЗДОРОВ'Я США

У статті подано короткий огляд американської системи охорони здоров 'я. Екскурс у витоки існуючих програм доповнено обговоренням нинішніх тенденцій розвитку цієї системи. Реформи та політичні рішення в цій сфері розглядаються крізь призму можливих наслідків для здійснення соціальної роботи.