US trails other developed countries in access to health care

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A major focus of political debate in the United States as 2017 begins is what will happen to the Affordable Care Act, also known as Obamacare, the legislation restructuring the US health care system enacted in 2010, which took effect in 2014.

While Republicans denounce Obamacare as a total failure, and Democrats defend it as a progressive, all be it limited, success, the entire discussion revolves around an unstated assumption: that US health care is the "best in the world," requiring only minor adjustments in a system based on the profit drive of privately owned corporations that sell health insurance, drugs and medical equipment, and operate hospitals and other facilities.

A recent survey shows that this consensus in favor of the for-profit medical system in the United States is based on a lie. The Commonwealth Fund questioned adults in 11 countries: Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. It found the US ranked at the bottom in access to and affordability of health care.

Compared to the 10 other "high-income" countries, the survey found: "Adults in the U.S. are more likely to go without needed care because of costs and to struggle to afford basic necessities such as housing and healthy food. U.S. adults are also more likely to report having poor health and emotional distress."

There are numerous indicators of the failure of the U.S. for-profit healthcare system:

· One-third of US adults went without recommended care, did not see a doctor when sick, or did not fill a prescription because of costs.

· Fifteen percent said they worried about having enough money for nutritious food and 16 percent struggled to afford their rent or mortgage.

· Half of US adults struggled to get health care on the weekends and evenings without going to an emergency department.

· Fourteen percent of chronically ill U.S. adults said they did not get the support they needed from health care providers to manage their conditions.

While the ten other countries outside the US offer universal insurance coverage, their health care services have faced cutbacks in recent years. In Britain, for example, dozens of hospitals, Accident and Emergency units, maternity units, mental health units, children's heart units and GP surgeries have been downgraded or shut down, despite popular opposition. However, even after cuts, the countries surveyed have better cost protection and a larger safety net than the US, giving more people the ability to get medical care.

The Affordable Care Act has increased the number of people with private health insurance, but only by so redefining the meaning of "insurance." People are said to be "insured" when they are enrolled in policies that require enormous out-of-pocket expenses and deductibles, which means they cannot afford to use medical services and if they do, may go bankrupt. In the jargon of the industry, they are "underinsured." In fact, 31 million Americans were underinsured in 2014 .

Obama and the Democrats based their health care reform bill on the tendencies already prevailing in the private insurance market. In the US, more and more employees getting group health insurance through their employer and individuals buying insurance through a "marketplace" or an "exchange" are only being offered high-deductible health plans (HDHP).

A health plan with a deductible means that other than certain preventive services, the plan holder must pay for all medical care until the deductible is met. So people with high-deductible plans are hit hard paying for medical services before the health plan starts to pay. Even when the health plan starts to pay, a person still must pay a copayment for health care services that could be as much

as 40 percent of the cost.

A Kaiser Family Foundation report found that the average annual out-of-pocket costs per patient rose almost 230 percent between 2006 and 2015. A survey of employers found employee deductibles increased 67 percent from 2010 to 2015. In the last year for which figures are available, for example, workers' wages increased a mere 1.9 percent between April 2014 and April 2015, whereas out-of-pocket medical expenses went up 9 percent.

Kaiser reported that 43 percent of insured patients said they delayed or skipped physician-recommended tests or treatment because of high associated costs. When patients put off medical care, they are more likely to end up in a hospital Emergency Room. About 80 percent of emergency physicians said they are treating insured patients who have sacrificed or delayed medical care due to unaffordable out-of-pocket costs, co-insurance or high deductibles. This represented a 10 percent increase during the first six months of 2016.

The American College of Physicians noted: "Evidence shows that cost sharing, particularly deductibles, may cause patients to forgo or delay care, including medically necessary services. The effects are particularly pronounced among those with low incomes and the very sick. In the private insurance market, cost sharing typically is used as a blunt instrument, without regard for an individual's income or health status ... higher cost sharing is associated with adverse health outcomes among vulnerable populations, including individuals with a low income, poor health or chronic illness, or those who are elderly."

In the individual market, almost 90 percent of enrollees in Affordable Care Act (ACA) Marketplaces are in a high deductible health plan. A HDHP is one where the deductible is at least $1,300 for self-only coverage or $2,600 for family coverage. So if your 2017 ACA plan has a $1,500 deductible and you find out in January you need a CT scan that costs $1,500, you would be responsible for paying the full amount. It's easy to see why someone would put off such a test.

The increasingly poor health of people in the US is the result of a health care system based on increasing the profits of the health care stakeholders. The health insurance companies have set up models of patient treatment to maximize their profits and with lucrative benefits for doctors and hospitals.

The modus operandi in health care, which underlies patient treatment, is called value-based health care, in which the business model and the care model become increasingly intertwined. The ACA includes provisions that promote this trend in Medicare, the federally funding health insurance system for the elderly and disabled.

The federal Centers for Medicare and Medicaid Services (CMS) and private health insurance companies are moving from a purely fee-for-service payment system to payment models that reward health care providers based on the quality and cost of care provided. CMS and the Department of Health and Human Services began implementing value-based programs in 2001, billing them as "Quality Initiatives."

Through these various doctor and hospital programs, the insurance industry and CMS regulate patient care. They decide what services health care providers will be paid for (and what they will not be paid for), how much money providers have to save and how much they will be reimbursed for patient care—and their "incentive" payment if they cut costs.

One of the tenets of this model is to declare patients to be "health care consumers" who must be held responsible for the financial management of their own care. They must shop around to find the least expensive care or be able to afford the best care. One idea being floated by large employers, for example, is to set a fixed dollar amount they will pay for common but expensive procedures. For hip replacement, they could limit payment to $5,000. Since the best doctors and hospitals charge more, only the wealthy could get the best care.

The stakeholders involved with creating Obamacare—health insurance companies, the Department of Health and Human Services, hospitals, physician groups, drug companies and employers—all will be involved in what comes next. The structures and systems are already in place to make sure the stakeholders benefit and population suffers, unable to get good quality, affordable care.