



Healthcare Systems: The USA

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Introduction

The health sector in the United States is characterised by a mix of public and private funding and provision; as such, it is not governed by a single philosophy. In both the private and public sectors, medical services are generally regarded as high quality although the system is not without its problems. In 2010 the Obama administration tried to address some of these problems with the Affordable Care Act (ACA), which has gone some way towards introducing universal medical care coverage in America. This report will seek to detail the current US healthcare system and the way in which the Act is designed to change it. These reforms are now likely to go ahead to full implementation following the decision of the US Supreme Court in June 2012 to uphold their constitutionality and the re-election of President Barack Obama and a pro-ACA majority in the US Senate in the November 2012 elections, as these events have largely removed the previous possibility that the reforms would be repealed. The report will go on to explore the benefits that the US healthcare system brings to its population as well as the difficulties it faces with a view to identifying any lessons that might be pertinent to the NHS.

Public sector health programmes

In 2009 the US spent a total of \$2.5 trillion on healthcare or approximately 18% of GDP; 44.7% of that total expenditure was spent by the US government.¹ Two public healthcare programmes are dominant in the United States - Medicare and Medicaid - and both were created in 1965 under Lyndon Johnson's presidency and run by the US federal Department of Health and Human Services (HHS). Medicare is the federal government's health programme that primarily serves Americans over the age of 65, whilst Medicaid is a joint federal-state programme principally designed to finance healthcare for the poor. Both provide care for the disabled. Together, Medicare and Medicaid cover approximately 87 million Americans (2004 figures).²

Medicare

In 2004, there were 42 million Medicare beneficiaries and the total cost of the programme stood at \$297 billion, predominantly paid for through payroll taxes, general revenue, premium contributions and taxation of social security benefits.³ Unlike the great majority of working Americans with private health insurance, Medicare beneficiaries are free to seek medical care wherever they choose – a so-called “fee-for-service” model.

Most beneficiaries of standard Medicare have paid payroll taxes into the programme during their working years, which entitles them to participate in the Medicare hospitalisation programme when they reach 65 years old (called Medicare A). At age 65 beneficiaries can also choose to purchase Medicare Part B for a monthly premium of \$96.40 a month (2009 figures) which will entitle them to physician services and preventive care.⁴ 86% of elderly Medicare beneficiaries receive their care through these two programmes.

To give them protection against some of the healthcare expenses that Medicare does not cover, many Medicare A and B beneficiaries can purchase **Medigap policies** (C & D).

Medicare Part C was added to the programme in 1997 with the passage of the Balanced Budget Act. Originally known as **Medicare+Choice**, it gave Medicare beneficiaries the option to receive Medicare benefits through a number of participating private health plans, including full-service Health Maintenance Organizations (HMOs). These work in the same way as other “managed

care” plans (see below) in that they tend to reduce costs by restricting the providers that you can choose from. In 2003 with the passage of the Medicare Prescription Drug, Improvement and Modernisation Act, Medicare+Choice plans were made more attractive by the addition of prescription drug coverage (Part D) and became known as Medicare Advantage Plans.⁵

There has been fairly consistent coverage of the financial problems that Medicare faces as a result of rising healthcare costs and life expectancy. Medicare has two central accounts which manage funding: the Hospital Insurance Trust Fund that pays for Medicare Part A and the Supplementary Medical Insurance (SMI) Trust Fund that pays for Part B and Part D (prescription drug plans not covered by Medicare Advantage). The central problem is that the revenue available from the Hospital Insurance Trust Fund is projected to run dry by 2029.⁶ Meanwhile premiums paid by beneficiaries to the SMI Trust Fund only cover approximately 25% of annual spending for Part B and D beneficiaries.⁷ By law the Treasury makes transfers to the SMI Trust Fund to cover the difference and in 2010 it is estimated that the transfer of general revenue for this purpose was almost 19% of income tax revenue.⁸ It is clear therefore that strategies are needed to control federal spending on Medicare to prevent a deepening deficit and to ensure that money is available to keep Medicare Part A running.

The Affordable Care Act (2010), if fully implemented as designed, is intended to improve Medicare’s long term financial outlook by eliminating inefficiencies in the Medicare Advantage Program and ensuring that Medicare payment rates grow only very slowly. However, this means that Medicare payment rates will fall further and further behind the payment rates of private insurers and won’t be able to cover the cost of providing medical care to seniors.⁹ It is therefore an on-going challenge to manage both the cost of Medicare but also the care given in order to ensure that the scheme neither bankrupts the country, nor prevents beneficiaries from getting access to the care they need.

Medicaid

Medicaid is designed primarily to provide healthcare to those with low incomes and few assets. As of 2010 and the ACA this includes all Americans under 65 with incomes up to 133% of the federal poverty level. In 2009 the total cost of Medicaid stood at over \$366 billion, split between federal payments of \$243 billion and state payments of \$123 billion.¹⁰ As individual states are in charge of the management of this revenue, they have a great deal of leeway in designing their Medicaid programmes. Accordingly, there is great variation across the country over who is eligible for Medicaid, what services are covered, and how much doctors and hospitals will be paid for treating Medicaid patients.

Medicaid recipients theoretically have access to a very rich package of health services and are entitled to receive healthcare services through the same public and private hospitals that serve the general public. However, as is increasingly the case with Medicare, in reality their access to private physicians is often limited by Medicaid’s commonly very low payment rates, thus making healthcare providers unwilling to take on Medicaid patients. A closely related state-managed federal programme established in 1997 to cover uninsured children, the **State Children’s Health Insurance Program (SCHIP)**, has similarly low reimbursement rates. States are likely to provide Medicaid through the private insurance market using managed care plans (see section on ‘Managed Care’).

Veterans Health Administration (VHA) and Other Federal Health Programmes

Though Medicare and Medicaid are the main two healthcare programmes overseen by the US federal government, there are others. TRICARE is a civilian programme administered by the US Department of Defense that operates in a similar fashion to Medicare and is available to US military personnel and their immediate families. The Veterans Health Administration (VHA), a civilian system sometimes compared to the UK NHS in that it is centrally-run and all hospitals and staff in the system are publicly-owned, is overseen for military retirees and their families by the US Department of Veterans Affairs. Both perform well in consumer satisfaction surveys on healthcare in the US, especially the VHA, which boasts 85% and 82% satisfaction for its inpatient and outpatient services respectively¹¹ (TRICARE scored 73%, while satisfaction with the private insurance market was 72%).¹² However, the VHA had to undergo substantial restructuring in the 1990s after suffering from a previously very poor reputation, and as a result of this turnaround it is now noted internationally as a shining example of successful reform in a failing health system^{13 14}. This may be particularly relevant from a British point of view, given some of the relative similarities between the US VHA and the core of our own national health system.

The reforms that VHA underwent in the 1990s included:

- The replacement of a previously complex structure (4 regions, 33 networks and 159 independent centres) with 21 joined-up Integrated Service Networks (VISNS)
- VISNs were tasked with “budgeting and planning health-care delivery for veterans over a particular area”¹⁵ and were financed by centrally-decided budget capitations, based on numbers of patients and historically-projected demand
- A strengthened focus on primary care and increased funding for it, moving away from the previous dominance of hospital care in the system
- Eligibility criteria was expanded to most US veterans and their families, rather than merely those on low incomes (though this was later re-tightened in the face of excessive demand)
- Stronger pharmaceutical coverage was implemented, with the VHA bargaining with pharmaceutical companies for lower costs
- A national centre for patient safety was set up and investments were made in research
- Performance criteria were implemented to hold regional managers accountable and to incentivise better performance, both financially and non-financially. This included performance-related bonuses, the publication of information on the performance of each VISN and the granting of additional autonomy to VISNs that performed well
- After two decades of development, a system of electronic health records carrying all patient data was introduced in 1999, and has been widely praised. It costs about USD \$90 per patient each year and has allowed patient charts to be immediately available to medical staff in 100% of instances (up from 60%), which has been found to prevent the repeat testing common in the rest of the US health system, where 1 in 5 tests need to be repeated due to inadequate record-keeping. However, much of the improvement in the VHA was observed before 1999, suggesting that the organisational and performance-incentive reforms were more decisive¹⁶
- Under the new ACA reforms the VHA is seeing further successful reforms in terms of electronic records interoperability, comparative effectiveness research, wellness programmes and accountability¹⁷

Another NHS-style public system, the Indian Health Service (IHS), is operated by the HHS on Native American tribal reservations, though it is often criticised for chronic underfunding and poor service and is therefore still in need of reform.¹⁸ Another federal programme, the Federal

Employees Health Benefits Program (FEHBP) overseen by the independent Office of Personnel Management, operates as a purchasing cooperative for government civil servants and is highly regarded (see 'Healthcare Purchasing Co-operatives' below).

Community Health Programmes

Community-based 'Health Centers', are private, not-for-profit facilities that provide high quality, cost-effective and comprehensive primary and preventive care to the uninsured and medically under-served. In 2009 nearly 19 million people were treated through these centres.¹⁹ It is estimated that by reducing costly emergency hospital and specialty care and by reducing inter and intra community health disparities, these centres and the treatment they offer save the US economy approximately \$24 billion a year.²⁰

As part of healthcare reform, the Obama administration has focused on enhancing the scope of Community Health Centers, recognising the work they do for US health outcomes and the economy. For example, under the American Recovery and Reinvestment Act (2009), intended to spur economic activity and long term growth, \$2 billion was set aside to be invested in Community Health Centers to expand their number and the services available.²¹ More recently an extra \$28.8 million in grants was pledged for the same purpose.²² These funds are allocated through the US Department's Health Resources and Services Administration (HRSA) and are supplemented by state and local grants, patient fees and private donations (patient cost-sharing is means-tested according to income).

Private sector health programmes

In 2010 195.9 million people in America (64% of the population) were covered by private health insurance.²³ In 2000 these figures were 200 million and 72% respectively, meaning that proportionately fewer people have private insurance now compared with ten years ago.²⁴ This may suggest that access to private insurance may not be keeping pace with population growth in the US, as the population of the US has grown by 27 million between 2000 and 2010 and among the population group responsible for majority of that growth, Hispanics, only 42% are privately insured.²⁵ However, in 2011 the percentage privately insured (63.9%) was not statistically different from 2010, which was the first time in a decade that there had been no decrease in the rate of private coverage.²⁶

Until the 1990s, most private health insurance coverage was provided through a fee-for-service model that allowed patients to visit the doctor or hospital of their choice. As health insurance costs began to rise in the 1980s and 90s however, many employers hired health plans to "manage" their employees' healthcare by controlling access to care and lowering costs.

Managed Care

Managed care refers to an institutional arrangement that puts administrators and designated "gatekeepers" in charge of guiding patients through a healthcare network with a goal of managing costs. Capitated managed care is paid on a per person rather than per service basis meaning that managed care organisations do not set payment rates for individual services. Patients often have to check with their health plan for approval before visiting a specialist or receiving a medical procedure.

Today, a significant proportion of insured Americans are in some type of managed healthcare plan, although the number of people participating in managed care has begun to decline since the rapid increase and peak of the 90s.²⁷

There are three main managed care plans in the commercial sector:²⁸

- Health Maintenance Organizations (HMOs): 66.21 million people were enrolled in HMOs in 2010.²⁹ These plans generally only provide care through hospitals and clinics that the plans own, with physicians, nurses, and other personnel employed by the HMO. A primary care doctor coordinates the majority of a patient's care.
- Preferred Provider Organizations (PPOs): in 2010 53.2 million enrolled into a PPO scheme.³⁰ PPOs are networks of doctors and hospitals that have agreed to treat participants in these plans for reduced fees based upon pre-negotiated contracts. PPOs will pay a portion of treatment sought outside of the network.
- Point of Service (POS) plans: these let you choose between an HMO or a PPO each time you need care and the above enrolment figures include those who have chosen either an HMO/PPO through POS.

While employers instituted managed care to control rising health costs, many Americans became frustrated at the end of the 1990s with the growing system that essentially placed barriers between them and the medical care they wanted and/or needed.³¹

Medicaid is increasingly provided by states through a managed service because it is an attractive option with regard to costs and predictability. By contracting with managed care plans and paying a lump sum for each enrollee that covers all the health services needed, states know at the start of the year exactly how much Medicaid will cost them. If costs exceed that amount then the health plans assume the financial risk, not the state. However with the increase in the number of people covered by Medicaid under the Affordable Care Act (see below) it is uncertain as to whether states will continue to be able to afford the same level of care. States cannot roll back Medicaid eligibility but they can reduce provider payments or eliminate optional benefits such as dental care. Such a scenario may increasingly be seen and there are fears that Medicaid managed plans will either pull out of the market, unable to cover costs, or they will fail to recruit enough specialist doctors willing to accept reduced payments.³²

Employer-Provided Health Insurance

Health insurance provided by employers took off after World War II when employers used the offer of health benefits in order to compete for employees because, unlike wage levels, such benefits weren't subject to federal control.³³ Generally employers pay most of the health insurance premium and require employees to pay a share, usually deducted from their salary. Some employers may not require employees to pay any of the premiums, while others may require employees to pay half or more. The tax law makes employment-based insurance an attractive prospect for workers as well because contributions to insurance are not considered part of workers' taxable income. In 2006 the value of the tax subsidy for employer-based insurance was estimated at around \$150 billion a year (Krugman)³⁴. Thus, although rising healthcare costs are making it more difficult for employers to offer health insurance, employment-based health insurance is still the dominant vehicle through which the majority of Americans receive healthcare; in 2010, 55.3% of Americans, or 169.3 million people, received their coverage through the workplace (although this is down from 62.8% in 1999 and 59.7% in

2006, reflecting erosion in the employer-based system due to rising costs).³⁵ Some market-based reform proposals have recommended ending subsidies to employers in favour of individual subsidies, as this could save the government money, relieve American employers of some of the cost of paying for their employees' insurance and make insurance more portable (because most Americans rely on employers for their insurance, unemployment or career moves can entail huge personal financial risk, which results in a 'job-lock' drag on the US economy and arguably hampers social mobility). A more individualised insurance market would also increase competition and make individuals more cost-conscious, as they would be directly involved in choosing their insurers, rather than receiving their coverage through a third party (their employer). Several reform bills proposed in 2009 during the congressional debates over the reform of the US system sought to address this issue, most notably the Wyden-Bennett Healthy Americans Act, but reform of this nature is not currently part of the health reforms under the ACA.³⁶

There are several variations of private health insurance policies which depend upon what employers can afford and what employees have negotiated. Currently 60% of employers who offer health insurance benefits offer their employees a choice of health plans.³⁷ However, the rest will either have to take the plan offered by their work place or go without coverage altogether if they are not one of the 9.9% of Americans who are willing or able to purchase insurance directly.³⁸ Crucially, not all employers offer insurance, and it is worth noting that around 80% of uninsured Americans (pre-ACA) come from working families.³⁹

Innovation: Health Savings Account

There is a consistent search for new and more creative solutions to engage consumers in the decision-making process about their health coverage and to provide incentives for them to use services wisely. One result of this was the introduction of Health Savings Accounts.

Congress passed legislation in 1997 creating the Medical Savings Accounts (MSA) insurance option, but made it available only to individuals and workers in small firms. In 2003 the idea was extended to create Health Savings Accounts, available to everyone.⁴⁰ HSAs, like MSAs before them, are tax-favoured savings accounts which are combined with a qualifying HSA insurance plan that has a high deductible (voluntary excess). By putting money into an HSA you receive a tax deduction and can also spend the money in the HSA tax-free as long as it's spent on qualified medical expenses. Once your deductible is met the health insurance covers your medical expenses as defined in the policy.

An appealing aspect of HSAs is that they encourage individuals to stay healthy and be cost-conscious. Any money from your HSA account that is not used to pay medical expenses is yours to keep (although you will pay taxes on amount withdrawn if it is spent on non-medical expenses). The theory is therefore that consumers will be more cautious when spending their own money compared to spending money that they see only indirectly through their employer or health insurance provider.

Healthcare Purchasing Co-operatives: The Federal Employees Health Benefits Program

Envisioned by Alain Enthoven, healthcare purchasing co-operatives (also known as purchasing pools and alliances) are public or private organisations which secure health insurance coverage for the workers of all member employers. The goal of these organisations is to consolidate

purchasing responsibilities to obtain greater bargaining clout with health insurers, plans and providers, to reduce the administrative costs of buying, selling and managing insurance policies.

The Federal Employees Health Benefits Program (FEHBP) which began operation in 1960 is a purchasing co-operative and provides insurance to federal civilian employees, retiree policy holders and their families. The US federal government typically pays two-thirds of the actual premium of each person's chosen plan and employees pay the difference via payroll deductions. All insurers must community rate – this means that a retired person pays the same as an 18-year old trainee. Insurers must also accept all applicants regardless of pre-existing conditions.

Owing to the size of the federal work force, federal workers have their choice of a wide range of health insurance plans that enable employees to choose the benefits package that best suits their particular healthcare needs and budgets.

To meet the minimum standard for accreditation, plans must fulfil criteria including access for patients, coordination of care, and medical decision making which adheres to acceptable standards of practice. Plans are rated for consumers by the 5-star system under categories like access and service. This provides consumers with the information to make an informed choice. Because choice and competition are hallmarks of the programme, the FEHBP reports one of the highest levels of satisfaction of any healthcare programme in the country.⁴¹ Similarities between FEHBP and the exchanges being developed under the ACA reforms have also been noted.⁴²

The Uninsured and the Unofficial Safety Net

In 2010, an estimated 49.9 million Americans did not have health insurance, up from 38 million in 2000.⁴³ This figure is slightly skewed as it will include people between jobs who rely on workplace insurance, as well as high income earners or non-citizens.⁴⁴ A significant proportion however is made up of those who simply cannot afford to obtain health insurance in the individual market. They decide instead to spend that money on food, housing, transportation, and other necessities. The proportion of Black and Hispanic Americans who go uninsured is particularly high, standing at 20.8% and 30.7% of their respective total population numbers in America (2010). The number of uninsured non-Hispanic Whites in 2010 meanwhile stood at just 23.1 million or 11.7% of the total non-Hispanic White population.⁴⁵

Being uninsured does not mean that all medical care is out of reach. Any hospital in the United States that accepts Medicare or Medicaid patients is legally bound to provide medical treatment and stabilize any patient who presents a medical problem, whether or not that patient can pay the bill. Hospitals that treat a substantial number of poor patients, including those on Medicaid, Medicare, or without health insurance, receive a Disproportionate Share payment from the federal government to help compensate them.⁴⁶ The uninsured also receive medical care through additional, joint private-public sector health programmes, including free clinics and Community Health Centres, described earlier. However there are many that slip through the net altogether and many will frequently wait until late stages of illness before seeking care because, in general, they will only have reliable access to emergency, not preventative care. Thus the uninsured or under-insured are more likely to face bankruptcy through illness or accident. It also makes hospital costs particularly high due to the aforementioned tendency for patients to be sicker and require more radical and expensive treatment when they finally seek help, than those who can come forward earlier.

Regulations and Mandates

Health insurance is fairly heavily regulated not only at state levels but by various federal agencies such as the Food and Drug Administration. Health insurance regulations in many states tell insurers what benefits they must offer, to whom (obligation to contract), and what prices they may charge (community rating). These regulations are intended to keep costs down or maximise coverage: for example, community rating laws require insurers to limit premium differences across individuals. Although this is generally of benefit to the community there are studies which have shown that some regulation is harming the individual insurance market by pushing up premiums and has actually increased the number of uninsured because the basic general premium becomes unaffordable.⁴⁷ Now that health insurance is compulsory, there will have to be careful studies into the right amount of regulation that prevents enormous differences between premiums but also ensures that people will not have to rely unduly on government benefits in order to afford the premiums.

Reform of US Healthcare: the Obama Administration

When Obama took power in 2008, healthcare reform was a major part of his platform and in many ways it was easy to see why. Healthcare costs were skyrocketing in the US: in 10 years the cost of healthcare for a family of four had doubled and looked set to continue rising.⁴⁸ Half of all personal bankruptcies in the US are at least partially the result of medical expenses and it is expected that by 2025 the US government would have been spending approximately 7% of GDP on Medicare and Medicaid (the figure was 4% of GDP in 2007).⁴⁹ As noted above, the US spends more on healthcare as a percentage of GDP than any other OECD country and yet doesn't seem to enjoy generally better health outcomes as a result. For example life expectancy stood at 78.7 in 2010, compared with 80.6 in the UK, whilst infant mortality stood at 6.7 per 1000 live births in 2009, compared with 4.8 in the UK.⁵⁰ There is also a large amount of waste in the system and the problem of dividing the population between those with good health insurance and those without: one study found that among Americans diagnosed with colorectal cancer, those without insurance were 70% more likely than those with insurance to die over the next three years.⁵¹ Therefore, rather than pouring additional millions of dollars into a system that suffered from these problems and seemed to waste a lot of the money given to it, attempts were made to formulate an improved system that would eventually cost less and achieve more.⁵²

Obama's original reform plans envisaged an insurance exchange whereby people could choose between the 'public option' (a government-run insurance scheme) or private insurance. This insurance exchange would enable greater portability of insurance. In practice, 'exchanges' will effectively mean government-overseen online marketplaces. Obama also intended to expand federal government funding for Medicaid and provide subsidies for those who made too much to qualify for Medicaid but still struggled to afford insurance premiums. Many of these elements were included in the bills passed by the House of Representatives and the Senate in late 2009.⁵³ However, the final Patient Protection and Affordable Healthcare Act followed the Senate in opting for state health insurance exchanges without the controversial public insurance option. Perhaps more importantly, in order to protect the employer-based system portability was restricted somewhat by the inclusion of a 'firewall' provision in the design of the exchanges, which effectively narrowed eligibility for the exchanges to the small segment of the population not already covered by employer insurance or a public programme, except if their employer was requiring them to pay more than 9.5% of their household income on insurance premiums.⁵⁴

Key points included in the final Act:⁵⁵

- **Cost:** the Act is expected to cost \$1.1 trillion over the next 10 years but more immediately reduce the deficit by \$143 billion. The costs will be offset by cutting waste and introducing higher payroll taxes, higher fees to prescription drug companies and lower payments to hospitals.
- **Coverage:** the Act brought coverage to 32 million currently uninsured Americans by expanding Medicaid and offering subsidies to low-income earners purchasing insurance through the new exchanges. This will increase total coverage to 94% of the population by 2019 (an increase from around 85% pre-implementation), bringing the US substantially closer to universality.
- **Medicare:** before the Act people had to pay if their prescriptions cost more than \$2700 and they only qualified for coverage again if the cost passed \$6154. The Act closed this gap (known as the 'Medicare doughnut hole') and also gives people rebates and discounts on brand name drugs. The Act also eliminates inefficiencies in Medicare Advantage and slows payment rates (see above), saving the US federal government \$716 billion.
- **Medicaid:** an extra 16 million people will become eligible for Medicaid as it is expanded to include families under 65 with a gross income of up to 133% of federal poverty level.
- **Insurance reforms:** insurers can no longer deny coverage to those with pre-existing conditions and their use of annual limits will be restricted. Young adults will be able to stay on their parents' health plans until they are 26. Currently many insurance companies drop dependants when they turn 19 or finish college. Insurance companies are also legally barred from spending more than 15-20% on administration, marketing and profits, and must spend the remainder on claims and quality improvements.
- **Insurance exchanges:** the uninsured, self-employed and those expected to pay more than 9.5% of their household income on premiums by their employer are now able to purchase insurance through state based exchanges. It is not compulsory to buy within the exchange but companies in the exchange are regulated (and therefore perhaps safer) and generally cheaper due to shared risk.
- **Subsidies:** as well as subsidies offered to low-income individuals and families wanting to purchase their own health insurance, subsidies will be available for small businesses to ensure that they can afford to offer health insurance to their employees. Meanwhile, employers who have 50 or more workers could face fines if they do not provide a health insurance plan.
- **Individual mandate:** from 2014 those not covered by Medicaid or Medicare must be insured or face a fine of at least \$695 a year or 2.5% of their income.
- **Tax:** taxes on high end health plans were relaxed by the Act but the Medicare payroll tax on upper income earners was increased. From 2013 families with an income of over 250 000 will have to pay an additional 3.8% on their investment income and contribute more to Medicare from income tax.
- **Other:** the act also aims to streamline the American healthcare system and reduce costs by encouraging the use of preventative care and electronic records. Access to services on the Indian Health Service (IHS) will be strengthened somewhat
- **Implementation Timetable:** on December 14th 2012 the deadline for state governments to choose to establish and run their own exchanges (rather than have the federal government intervene) passed, and online exchanges will then open in October 2013. In January 2014, the ban on insurance companies discriminating based on pre-existing conditions, the Medicaid eligibility expansion and the individual purchase mandate will

begin to apply. The fine associated with the mandate will increase year-by-year. The law will be fully implemented in January 2020.

Despite making substantial and needed reforms to the American healthcare system, the ACA has some drawbacks. First, despite the expansion of coverage it represents, 94% coverage still falls short of full universality when compared to European healthcare systems and to some competing healthcare reform proposals that were under consideration by Congress in 2009. Second, it remains to be seen to what extent the ACA will tackle cost inflation in the American healthcare system. The expansion in access may tackle the 'free-rider problem' in American healthcare (the systemic costs associated with the uninsured seeking free catastrophic care in Emergency Rooms) and somewhat strengthen risk-pooling in the insurance market due to the presence of an estimated 15 million extra consumers, it is still questionable whether risk pooling in the new exchanges will be large enough for substantial cost reductions, due to the imposition of the firewall and the decision to cover another 15 million through Medicaid. For most Americans third-parties (primarily employers and public programmes) will also continue to handle their coverage, minimising individual choice and cost-consciousness. Alain Enthoven expressed concerns about the act's cost-control features on this basis.⁵⁶ Yale University economist Theodore Marmor has also criticised the ACA as being unlikely to achieve cost control, though he attributes this to the decision of policymakers to focus on relatively unproven cost-control mechanisms that are broadly popular (health information technology, prevention, pay for performance and comparative effectiveness research) rather than imposing stronger controls in terms of price restraint, spending targets and strict insurance regulation. The latter set of measures would have provoked strong opposition from powerful stakeholders in the insurance, hospital and pharmaceutical industries, however.⁵⁷ Finally, post-ACA the US healthcare system will still remain somewhat of a 'patchwork' without a defining philosophy, with the ACA exchanges and reforms to other parts of the system essentially supplementing rather than replacing the other myriad mechanisms of coverage.

State Variations

The federal structure of the United States is also a factor that must be considered in terms of developments in their health system and the on-going implementation of the ACA, as the 50 state governments retain substantial control over healthcare policy. At current, marked differences can be noted in how the states have responded to the federal mandate requiring them to set up exchanges; approximately 24 states have proactively sought permission to either set up their own exchanges or to partner with the federal government, which in turn will likely produce variances in practice, while the remainder have declined and will instead have to accept federally-planned and run exchanges.^{58 59} Similarly, varied reactions from the state governments to the Medicaid expansion they are required to implement under the ACA are another factor, due the substantial discretion that the states retain in this sphere of health policy (see section on 'Medicaid' above).⁶⁰

A universal system based on an insurance mandate, regulations and subsidies has already been in place in the state of Massachusetts since 2006, and in fact served as part of inspiration for the national ACA. Massachusetts has had to apply under the ACA for permission to continue with its state-based exchange, and is adapting certain elements to ensure it is consistent with the ACA mandate. The ACA also contains a 'waiver for state innovation' allowing states to opt-out of the requirement to establish insurance exchanges altogether from 2017 and spend the federal grant money provided under the ACA as they see fit, provided that they can demonstrate to the

federal Department of Health and Human Services (HHS) that they can establish an alternative system that can achieve at least the same level of access to quality, affordable care as the ACA aims to achieve at similar or reduced cost. This may create a powerful incentive for states to innovate and economise.

So far, the state that has made its intention to reject private insurance exchanges and seek such a waiver clearest is Vermont, where in May 2011 a law was passed creating a public-run, universal single-payer system known as Green Mountain Care.⁶¹ This will include an electronic system of medical records in order to ensure efficiency, an innovation that has already worked well in parts of Europe and is explicitly promoted by the national ACA law. The designer of the plan is William Hsaio, who previously helped design the single-payer National Health Insurance (NHI) system in Taiwan, which in turn was modelled on the Canadian Medicare system (see the 'Healthcare Systems: Canada' briefing). However, there may be some difficulties with Vermont's approach. First, it may face some of the issues that Canada, the UK and other nations with single-payer systems have had to deal with (waiting times, the need for rationing, somewhat lower health outcomes, slower technological uptake, limits on patient choice) and the 2011 law leaves until after January 2013 some crucial details, including how the law will be financed. Second, Vermont is the second-smallest state in the US by population (626,431 residents), so concerns have been raised about economies of scale and whether adequate pooling of risk can be achieved, although some nation-states in Europe with similar populations (such as Iceland) have been able to achieve relative success with single-payer systems, it should be noted. Third, the ACA does not allow innovation waivers to be granted until 2017, three years after states are required to implement private insurance exchanges, creating uncertainty as to whether states such as Vermont can get alternative state-run systems authorised as 'exchanges' or whether they will have to through a costly exercise of setting up a private insurance exchange first.

Future reform? Defined Contribution Plans

Most employment-based health insurance is a defined *benefit* plan where the employer defines the level, model and cost of health insurance coverage offered to employees. However in a Defined Contribution Plan (DCP), employers may provide a specified amount of money toward the employee's health insurance coverage which the employee can then spend in the health insurance market in a way that best suits him.⁶² By putting consumers in charge of their health insurance, DCPs allow them to be more aware of the cost of health insurance coverage and medical services. This, combined with a more competitive marketplace created by consumers shopping for plans, could be the key to reducing medical price inflation. Hence the 'Rivlin-Ryan plan' has been put forward by Paul Ryan and Alice Rivlin in an attempt to cut Medicare costs. The plan suggests moving Medicare away from a defined benefit plan towards a defined contribution set-up. This would be done by giving Medicare beneficiaries a voucher to purchase private health insurance, therefore shifting more of the risk of escalating healthcare costs onto the beneficiaries rather than the taxpayer (the annual growth of the Medicare voucher would be capped to the growth of GDP plus one percentage point).⁶³ It will remain to be seen whether this proposal, which failed in 1995 when it was known as a "premium support model", will gain more support this time round.

Health Outcomes

It is notoriously difficult to judge the effectiveness of a healthcare system, especially against others. Indeed the WHO did not try, after their 2000 comparison of healthcare systems, to

repeat the exercise, arguing that it was too complex to satisfactorily draw a comparison between widely differing systems. When attempting to gauge performance however, the indicators that are generally used are quality and access. Under quality one might look at medical research, life expectancy, infant mortality and mortality amenable to healthcare. In the first of these four healthcare outcomes it could be argued that the US healthcare system performs very well.⁶⁴

- Cardiac deaths have fallen by two-thirds over the past 50 years.
- Childhood leukaemia has a high cure rate
- 8 of the top 10 medical advances of the past 20 years were developed in or had roots in US, a figure that also explains why Nobel Prizes in medicine and physiology have been awarded to more Americans than to researchers in all other countries combined
- 8 of the 10 top-selling medical drugs in the world are made by US companies.
- The US has some of highest breast, colon and prostate cancer survival rates in the world.

Thus it would appear that the large amount of money spent on health in the USA has benefited the population in terms of research and innovation in equipment and procedures. However, generally speaking the majority of research funding comes from individually wealthy benefactors rather than the federal government and therefore to export this generous attitude towards research to the UK would be less than straightforward. There is also a problem of access because although those with good health insurance can afford to be given the best possible drugs and procedures, many others are denied the opportunity, particularly if they are covered under Medicaid alone.

Although the USA performs well in terms of cancer outcomes and research prizes, it does less well on performance indications such as life expectancy and infant mortality. Although this can partly be attributed to a failing of its healthcare system, there are other factors which are less directly linked. For example, the US suffers from high levels of obesity, which can only partly be blamed on a failure in the healthcare system to provide adequate preventive medicine that encourages healthier lifestyles. The school drop-out rate is also high, which makes it more likely that people will be unable to afford insurance in future.⁶⁵ Car accidents and homicides are also more common in America than elsewhere in the developed world, and income inequality, often noted to correlate with lower public health, is very high.⁶⁶ However, although some commentators have argued that these societal factors should be considered the main reason for the difference between the US and other developed nations on general life expectancy and infant mortality, rather than healthcare system structure or access, it is worth noting the US has also performed poorly in several studies that sought to specifically estimate mortality amenable to healthcare.⁶⁷ A study by the US-based Commonwealth Fund of deaths thought to be preventable by healthcare in industrialised nations found that the US ranked last out of 16 countries examined and had around 84,000 preventable deaths (the UK ranked 15th, with France performing best)⁶⁸, and two other analyses of preventable deaths for the OECD have shown the US underperforming the UK, Canada, Western Europe and the OECD average.⁶⁹

This can only partly be solved by improving medical access to the unemployed and low-income earners: after all the money pot for helping low earners to purchase health insurance is not bottomless. The high levels of litigation also add to spiralling healthcare costs as doctors would rather undertake expensive but ultimately unnecessary procedures and tests rather than be sued for not doing them (a practice known in the US as 'defensive medicine', and one which is becoming more noticeable within our system as well⁷⁰). This has sometimes led to calls for

medical malpractice laws to be reformed to make litigation more difficult⁷¹. These factors therefore make it difficult to judge the US healthcare system against others as to some extent solving these problems goes beyond improving healthcare. However there are some lessons that can be drawn from the American experience.

Lessons for the NHS

Inequity: The US health system is still inequitable in its access despite moving closer towards a “social insurance” model whereby all individuals are required to purchase insurance and financial help is given to those who need it. However, lower payments to providers in Medicare and Medicaid mean that many will still be ‘under-insured.’ In Britain it seems unlikely that the political climate would allow such disparities in health system access.

Price-consciousness: Employment-based insurance does not encourage price-consciousness: apart from their co-payments and deductibles, individuals have little incentive to economise and there is little patient choice. This is slowly being addressed however by increasing numbers of plans based on defined contributions rather than defined benefits. If Britain was to adopt a social insurance model of healthcare, patient choice through DCPs would be preferable to strictly defined benefits as they would keep costs low and competition high. The only difficulty would be in ensuring that there was adequate consumer information available for people to make informed choices.

Innovation and Research: There is a greater attempt at innovation in terms of cost cutting and extending coverage due to the involvement of the market rather than just the government. There is also pride in the high quality of pharmaceutical research that is undertaken in the USA, which encourages people to invest in it. Furthermore the advantage of having large numbers of people with private medical insurance is that in general more people will have access to top quality drugs than in the UK where there is less money in the system from high level premium payers. However, cost effectiveness within the system is clearly an issue as healthcare outcomes and coverage are not demonstrably better than in other countries that spend far less than the USA.

Quality of Care: As in the UK, government-funded programmes Medicare and Medicaid suffer from decreasing revenue and increasing numbers of beneficiaries. By offering lower reimbursements, there is often also a demonstrably lower quality of care. However, because the private insurance market drives quality more generally amongst providers and ensures faster treatment for those who can pay a higher premium, the average length of waiting lists and average patient satisfaction with quality is quite high.

Statfile (most recent figures from the OECD unless otherwise stated, most recent UK figure and OECD average given for comparison)⁷²

Funding

Total Health expenditure: 17.6% GDP (UK: 9.6% OECD average: 9.5%)
\$8232.9 per person (US \$, adjusted for PPP) (UK: \$3433.2, OECD Average: \$3265)

Public expenditure: 48.2% of total health expenditure (UK: 83.2% OECD Average: 72.2%)

Out of pocket expenditure: 11.8% of total health expenditure (UK: 8.9% OECD Average: 19.5)

Resources

Practising physicians (per 1000 population): 2.4 (UK: 2.8 OECD Average: 3.1)

Practising nurses (per 1000 population): 11 (UK: 9.1 OECD Average: 8.7)

MRI scanners (per million population): 31.6 (UK: 5.9, OECD Average: 12.5)

CT scanners (per million population): 40.7 (UK: 8.9, OECD Average: 22.6)

Waiting Times⁷³

Percentage waiting four weeks or more for a specialist appointment (study of 11 OECD nations): 20%, 3rd lowest out of 11 (UK: 28%, Average: 37%)

Percentage waiting four months or more for elective surgery (study of 11 OECD nations): 7%, 3rd lowest of 11 (UK: 21%, Average: 13.3%)

Outcomes

Average life expectancy (at birth): 78.7 years (UK: 80.6, OECD Average: 79.8)

-Male: 76.2 years (UK: 78.6, OECD Average: 77.0)

-Female: 81.1 years (UK: 82.6, OECD Average: 82.5)

Infant mortality (per 1000 live births): 6.1 (UK: 4.2, OECD Average: 4.3)

Maternal mortality (per 100 000 live births): 11 (2005)

Mortality Amenable to Healthcare (OECD, Nolte & McKee Method*): 103 per 100,000 deaths (UK: 86, OECD Average: 95)

Mortality Amenable to Healthcare (OECD, Tobias & Yeh Method⁷⁴):** 124 per 100,000 deaths (UK: 102, OECD Average: 104)

Mortality Amenable to Healthcare (Commonwealth Fund⁷⁵): 96 per 100,000 deaths & 16th (worst) out of 16 countries (UK: 83 per 100,000 and 15th out of 16 countries)

* Nolte & McKee method: mortality amenable to healthcare defined as “premature deaths that should not occur in the presence of timely and effective health care”

** Tobias & Yeh method: mortality amenable to healthcare defined as “conditions for which effective clinical interventions exist [that should prevent premature deaths]”

¹ OECD Health Data (most recent statistics)

² Kaiser Family Foundation: Key Medicare and Medicaid statistics

<http://www.kff.org/medicaid/upload/Key%20Medicare%20and%20Medicaid%20Statistics.pdf>

³ Ibid KFF stats

⁴ Centers for Medicare and Medicaid Services www.medicare.gov the official U.S. website for Medicare

⁵ KFF Medicare Advantage Fact Sheet <http://www.kff.org/medicare/upload/2052-12.pdf>

Note: Part D can also be bought as a standalone plan that is added to standard Medicare rather than being provided through Medicare Advantage

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