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Anthropological Perspectives from Medical Professionals on the Affordable Care Act

Mikhaila Smith
University of Pennsylvania

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The purpose of this research was to explore the ways in which the Affordable Care Act will affect Americans and the medical professionals who provide them with healthcare. This was completed by exploring universal healthcare systems in other industrialized nations that served as models for the Affordable Care Act, examining the politics within the United States that created the Affordable Care Act, and illuminating perspectives from medical professionals on the impact of the Affordable Care Act on the patient-doctor experience. Upon examining this data, it becomes clear that the Affordable Care Act is merely the foot in the door in healthcare reform, and by no means creates a universal system nor completely solves the major challenges in American healthcare access and delivery. By showing the progression of the Affordable Care Act to present day, this research highlights a major turning point in healthcare in the United States, and also acts as a critique for the bettering of healthcare reform legislation.

Disciplines

Anthropology

ANTHROPOLOGICAL PERSPECTIVES FROM MEDICAL PROFESSIONALS
ON THE AFFORDABLE CARE ACT

By

Mikhaila Smith

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Department of Anthropology
University of Pennsylvania

Thesis Advisor: Dr. Marilynne Diggs-Thompson

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The purpose of this research was to explore the ways in which the Affordable Care Act will affect Americans and the medical professionals who provide them with healthcare. This was completed by exploring universal healthcare systems in other industrialized nations that served as models for the Affordable Care Act, examining the politics within the United States that created the Affordable Care Act, and illuminating perspectives from medical professionals on the impact of the Affordable Care Act on the patient-doctor experience. Upon examining this data, it becomes clear that the Affordable Care Act is merely the foot in the door in healthcare reform, and by no means creates a universal system nor completely solves the major challenges in American healthcare access and delivery. By showing the progression of the Affordable Care Act to present day, this research highlights a major turning point in healthcare in the United States, and also acts as a critique for the bettering of healthcare reform legislation.

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Introduction

As my aunt, a first generation American with three adult children, walked down the front steps of the house she had purchased a decade before, her ankle clumsily slipped to the side. Just like that she developed a complex fracture that would require extensive surgery and rehabilitation. In her early sixties and believing she was in perfect health, she like many others in the midst of the economic downturn of 2009 had faced the decision of how to minimize her expenses. One of her cost cutting measures was to cancel her employer provided health insurance, and the timing could not have been worse—two weeks before her fall. Now, my aunt was unsure of how she was going to pay for the medical care she required to return to her normal level of functioning. To complicate matters, she was unable to go to her job as a practical nurse because she could not walk. Incapacitated, uninsured, and momentarily without earnings my aunt lamented over how she could receive and afford the cost of her necessary medical care. In order to receive treatment with no insurance, she had to arrange a payment plan with her medical service providers to cover the exorbitant cost of her treatment and rehabilitation. Even after she received the necessary treatment, she found it difficult to handle the payment plan she had set up. After struggling to keep up with payments for some time, the medical service providers threatened to garnish my aunt's wages. Paying for my aunt's

medical bills quickly became an extensive financial demand on my aunt and her already struggling family, including her twenty-four year old daughter, who was living with her at the time. Working part-time and wading through premedical coursework, her daughter significantly contributed to my aunt's medical bills. Ultimately, my aunt and her family were able to pay off the cost of her medical bills, but only after significant emotional and financial strain on the family.

Unfortunately for many families in the United States, this story is all too common because of the increasingly exorbitant cost of medical care in the United States. On average, Americans as of 2008 were spending \$4,479 per individual and \$12,106 per family on healthcare per year (Tanner 2008, 3). With such high costs, perhaps it can be understood why an estimated 47 million Americans remain without health insurance at any given time (DeNavas-Walt et al. 2006). The families mainly affected by high health care bills are those who fall into the gap of too rich to get Medicaid but not rich enough to afford basic comprehensive insurance, not old enough to be eligible for Medicare, or those that are locked out of the market due to pre-existing conditions. The financially debilitating cost of medical care has been the subject of criticism by many.

On February 20, 2013, Steven Brill's *A Bitter Pill: Why Medical Bills are Killing us* was published in the *Times* providing numerous personal stories of Americans who were financially ruined by the hyper-inflated cost of care. In one case Janice S, a recently unemployed and uninsured Connecticut woman,

accumulated a bill of \$21,000 for what turned out to be a quest for the medical facility to differentiate a heart attack from simple indigestion (Brill, 2013). The three troponin tests that she received—a test that measures protein levels in the blood—were billed at \$199.50 each because she had no insurance. If Janice S. had this scare one-year later, at the age of 65, she could have enrolled in Medicare, which would have covered the majority of her medical bills. Additionally, through her Medicare enrollment she would have only been charged the government negotiated rates for the medical services she received, and each of these tests would have cost fifteen times less at \$13.94 for each troponin test (Brill 2013).

Beyond the high cost of care borne by individual patients, healthcare expenses in 2008 totaled 16% of the United States Gross Domestic Product, which is about 6.1% more than other industrialized nations (Tanner 2008, 2). In Michael Tanner's 2008 policy analysis of national healthcare systems around the world, he suggests that healthcare spending in the United State is not indicative of over-inflation of cost, but as wealthy nation, indicative of its choice to spend an exorbitant amount of money on healthcare. As a comparison, the United States healthcare system is ranked 37th in the world behind Slovenia, and in the United States, healthcare is disproportionately available to wealthier communities (World Health Organization 2000).

President Theodore Roosevelt introduced the idea of healthcare as a right in the United States in the early twentieth century. For decades, numerous presidents were unable to achieve this goal for all Americans (The Washington Post Staff, 2010). In January 1993 President Bill Clinton made it his goal to achieve universal healthcare in the United States, particularly since the US was the only modern democracy lacking universal healthcare at the time (Pfiffner 2001). To achieve the goal of universal healthcare, President Clinton announced that his wife, Hillary Clinton, would lead the initiative to create healthcare reform legislation with a target time of completing the plan in 100 days (Pfiffner 2001). Despite the valiant efforts to give all Americans the right to healthcare, by the spring of 1994, all hopes of universal healthcare were gone for a variety of social and partisan political reasons.

In the initial reform efforts in the spring of 1993, the idea of instituting a managed competition universal healthcare system in the United States was met with enthusiasm by Democratic Congressmen and the general public, because it maintained private insurers and employee-mandates that already existed within American healthcare (Pfiffner 2001). As the new healthcare bill began to take shape, President Clinton decided that the most important part of the bill would be universal coverage inherent with cost control. These cost control measures would be implemented through caps on insurance premiums, mandates for employers to provide insurance to their employees, and mandatory participation

in cooperatives—insurance companies owned by the pool of insured patients (Pfiffner 2001).

Needless to say the inclusion of all of these requirements created a very large and complex bill that would impact about 14% of the US economy due to the complete overhaul it would impose on such a large portion of the economy. The proposed economic impact was unacceptable in the eyes of politicians at the time. Concurrent allegations about President Clinton’s involvement in the Whitewater real estate scandal in Arkansas further caused the approval for the healthcare bill to wane (Pfiffner 2001). Republicans criticized the size, cost, and governmental involvement the healthcare bill would require, and their lack of involvement in creating the bill was also a major part of these criticisms (Pfiffner 2001). Ultimately, the nation and its lobbyist representatives were not ready for the Clinton healthcare reform bill. Clinton’s approval ratings were down, and there were valid criticisms of the bill that spoke to Americans, who were resistant to large government involvement. Republicans and major lobbying groups were against the proposed plan, and nearly everyone felt that the healthcare bill was just too complex. By the summer of 1994 universal healthcare for all Americans had been squashed (Pfiffner 2001).

Sixteen years later in March 2010, the problems faced by my aunt, Janice S, and numerous other Americans were finally to be addressed by the Patient Protection and Affordable Care Act. For the first time in American history,

patients could not be denied insurance based upon pre-existing conditions, the underinsured and uninsured would be accounted for, and health insurance should no longer be unattainable with financially devastating consequences.

Although the provisions of the Affordable Care Act are much needed, several questions remain: Will the healthcare system set up by the legislation be for the greater good of Americans? Will the Affordable Care Act really solve the fundamental problems in accessing healthcare in the United States? Will it solve the ever-rising cost for individuals and on the American economy? This thesis will seek to answer these major questions by exploring the universal healthcare systems that served as models for the Affordable Care Act, the formulation of the Affordable Care Act in Congress, and the perspectives of medical professionals whom I have asked to weigh in on what impact they believe the Affordable Care Act will have on Americans. As an aspiring medical professional myself, I have sought the perspectives of medical professionals on how the Affordable Care Act will reshape their profession, patient experience and the United States. These are their stories and perspectives on the United States' newest attempt to provide its diverse citizenry with "universal healthcare."

Chapter 1: Constructing Healthcare Reform In The US Through Assessing Universal Healthcare Systems Around The World

“Everyone should have access to the health services they need without being forced into poverty when paying for them.” (WHO 2013)

The Clinton administration paved the way for universal healthcare in the United States, championing the concept of managed competition health insurance, but ultimately failed due to the complexity of the healthcare legislation and bad timing. The Affordable Care Act came at a time when Americans seemed ready, particularly in the context of the personal financial devastation that many Americans faced as a result of being uninsured or underinsured. In addition, the United States continues to spend a significantly higher percentage of its Gross Domestic Product and higher percentage per capita on healthcare comparative to any other industrialized nation.

The US now spends 17.9% of its Gross Domestic Product on healthcare, and healthcare costs are growing faster than the United States’ Gross Domestic Product. Other industrialized nations, such as France, Switzerland, Great Britain, and Sweden, with national healthcare programs, spend significantly less per capita than the US and insure essentially all residents, but unlike many other western nations, the United States has chosen to include private insurers in the Affordable Care Act. As a consequence, the country has in effect maintained the profit and market based structure on which healthcare in the United States

existed prior to healthcare reform. Some suggest that using the original healthcare system as the foundation for healthcare reform, helped to cut down on political resistance—differentiating this effort from previous attempts to create and implement healthcare reform, particularly as was seen in the Clinton health care reform attempt. Also, it is fundamentally easier to change an already existing system than to completely start over from scratch.

There are three main healthcare models that other industrialized nations have formulated to cover their citizens: Single-Payer System, Employment-Based System, and Managed Competition (Tanner 2008, 7). In this section, I will explore these three systems that the United States has used as base models to ultimately formulate its new healthcare system. Whether or not the United States has developed the best model most suitable to its diverse socioeconomic populations and its partisan politicians remains to be seen.

Managed Competition

Managed Competition healthcare systems such as the national systems in Switzerland and the Netherlands, Clinton’s 1993 proposed Healthcare Plan, and the 2006 Massachusetts healthcare reform are based upon the premise of the use of private insurers. The private insurers in this system exist within a fabricated marketplace, which is strictly regulated by the government (Tanner 2008, 7). In most managed competition national healthcare systems, it is mandatory that individuals buy insurance, but it can also be required that employers provide

insurance to their employees (Tanner 2008, 7). The managed competition national healthcare system allows for competition between insurers based upon cost sharing, price, and benefits (Tanner 2008, 7). To illustrate how a managed competition healthcare system is practiced, I will use the example of Switzerland.

An opinion editor and senior fellow at the Manhattan Institute for Public Policy, Avik Roy considers the Swiss National Healthcare System, Santésuisse, the best in the world (2011). It is also considered the model most similar to the one created in the United States by the Affordable Care Act (McManus 2009). Prior to Santésuisse, Switzerland had a healthcare system similar to that of the United States with voluntary health insurance and rapidly increasing healthcare costs. To combat the increasing costs, the health minister and later president Ruth Dreifuss presented LAMal, the Swiss equivalent to the Affordable Care Act (Fuller 2012). LAMal was passed through Swiss parliament in 1994 and implemented by 1996. As in the United States, passing the bill was difficult and the vote was very close to fifty-fifty (*Sick around the world* 2008). In fact, LAMal only passed through Swiss parliament through a national vote to reject or accept the legislation (Fuller 2012).

Switzerland has a national healthcare system based on the private insurer system, which requires all citizens to buy health insurance. This mandatory health insurance has a minimum benefits package outlined by the government.

There is no government insurance system, such as Medicaid/Medicare in the United States, and very few employer-sponsored programs exist in Switzerland (Roy 2011). Ninety-three insurers exist within Switzerland, and in contrast to the United States prior to the Affordable Care Act, none can deny an applicant based on health status. The Swiss government does provide subsidies based upon income level, which allows this system to work without a governmental health plan as a safety net. As expected, low-income populations receive the highest subsidies and upper-income populations receive no subsidies, and the healthy pay higher premiums to fund the less healthy (Tanner 2008, 26). Under Santésuisse the Swiss government sets price controls for hospital and physician reimbursement, and sets the price for every medical procedure. Physicians can still order tests and prescribe medicine as they see fit. However, if the physician's billing exceeds the regional median by too much, they will receive a blue letter, which is a bill that requires them to return some of those fees to the insurance company (McManus 2009). Swiss insurers cannot compete based upon number of services covered by the insurance benefits package or pricing based upon the calculated risk of becoming ill, but compete solely on price, which is composed of a grid of deductibles and co-payments levels (Tanner 2008, 26). Swiss citizens are solely responsible for paying for insurance, and due to this leverage, the Swiss often opt for high deductible insurance. As a result they pay an out-of-pocket cost equal to about 31.5% of their healthcare expenses,

which is twice as much as the highest deductible in the United States (Tanner 2008, 26). Outside of the minimum benefits package required by Santésuisse, the Swiss can buy supplemental insurance, which can cover the cost of providers who have chosen to operate outside the negotiated fee schedules mandated by the government. The reason for choosing these higher cost providers stems largely from user's desire to have a higher level of care, more advance services, or private rooms in hospitals under negotiated fee schedules. It is estimated that 40% of the Swiss have supplemental insurance (Tanner 2008, 27).

As of 2007, \$4,417 USD was spent per person as part of the Swiss Gross National Product compared to the \$7,290 USD per person in the United States (McManus 2009). In addition, about 11.4% of the Swiss Gross Domestic Product is spent on healthcare making it the second most expensive healthcare system only to the United States, which spends 17.9% of its Gross Domestic Product on healthcare (OECD 2013). Unlike other nations that have a universal healthcare system, Switzerland's emphasis on a market-oriented healthcare system eliminates the wait for medical procedures because of an amplified level of patient choice that is contained within its unique healthcare system. Despite the increased autonomy of the individual in the health insurance coverage process, Swiss citizens still have higher out of pocket cost than American citizens and comprehensive national coverage has not halted the trend of rising healthcare cost.

The care seeking behavior of the Swiss in the context of high quality insurance enables a system in which the Swiss residents visit the doctor more than their American counterparts (Roy 2011). The Swiss physician, however, faces a unique dilemma. If a patient comes in and requests a particular test or procedure, even if it is expensive, the physician usually does not deny the request because the patient can just go to another physician—an option facilitated by the market nature of the healthcare system in Switzerland. In addition, if the physician elects to perform patient requested expensive procedures, he or she is at risk of receiving a blue slip for exceeding median costs (McManus 2009). Another peculiarity of Santésuisse is that citizens have to pay deductibles in January, even though they have just started their doctor’s visits for the calendar year. However, the payoff is that later in the year when a patient has hit his/her out-of-pocket premium, healthcare essentially becomes free. After this point, the Swiss can visit doctors as much as they wish to without cost, and they do (McManus 2009).

While there are a number of drawbacks of Santésuisse, Swiss physicians are the best-paid physicians in Europe. General practitioners make about \$150,000 USD and specialists have an earning potential of \$300,000 USD or more a year—comparable to physician incomes in the United States (Roy 2011). Essentially, Switzerland has achieved universal coverage with 99.5% of the population covered, and the nation has a life expectancy of 82 years of age

compared to the 79 years of age in the United States (Roy 2011). It is unheard of for someone to be financially devastated by medical bills in Switzerland (as in the case of my aunt), and by all accounts, the quality of healthcare is superior to that of the United States (*Sick around the world* 2008). Overall Santésuisse is the closest example to a managed competition national healthcare system in the West, and seems to be mostly successful.

The United States has created a very similar system to managed competition model through the Affordable Care Act. The Affordable Care Act created an online insurance marketplace. This was intended to provide a single location where the best insurance plan could be purchased at the best value as determined by an individual. Like Santésuisse, the United States' government has made health insurance mandatory for citizens as of March 31, 2014, requiring that every citizen either purchase or possess (for example through an employer) at least a minimum standard healthcare insurance package—now available on its new website. Also, insurance companies can technically not deny claims. The intent of the previous provisions is to eliminate the financial devastation incurred by individuals or families because of under-coverage and the resulting exorbitant costs often incurred once insurance coverage limits were reached. The Affordable Care Act was also designed to include those previously not eligible for health insurance due to pre-existing conditions. The United States has also started providing subsidies based upon income level to

make insurance more affordable for lower income populations—particularly individuals from 100% to 400% poverty. Like the Swiss, there exists an out-of-pocket maximum limit (\$6,350 USD for an individual and \$12,700 USD for a family), after which the insurance plan will cover all *essential* health benefits (out-of-pocket maximum/limit 2014).

However, unlike Santésuisse, the United States does not set reimbursement rates for physicians on a national level, although the government does set reimbursement rates for Medicare/Medicaid. By eliminating set reimbursement rates, US physicians are not subjected to incurring a penalty for exceeding the median cost of health insurance for the region. Even the idea of instituting a set reimbursement rate plan would be difficult to implement in the United States for two reasons. Firstly, in the US, there is a higher risk of malpractice lawsuits compared to Switzerland due to the imposed quality of care metrics in Switzerland (Reinhardt 2007). If American physicians were somehow dissuaded from conducting more expensive tests or procedures in order to reach the regional median, and thus not have to pay back money to the insurance companies, they could be at an increased risk for misdiagnosis. This could be extremely financially detrimental to the physician from a malpractice perspective. Secondly, there would be a significant uproar by the physicians. One of the major complaints voiced by all physicians that I interviewed was that the negotiated price for Medicare/Medicaid forced the

physicians to work at a loss for those patients. If these rates were applied to all patients this would de-incentivize doctors and dissuade individuals from working in the medical profession. An important point to note is that under the Affordable Care Act, the lack of pay scale for special services allows hospitals, physicians, and insurance companies to maintain the same costs as prior to its implementation. The features of the managed competition healthcare model as implemented in the United States therefore do not serve to cut the cost of healthcare services or reduce physician income.

Employment-Based Systems

The employment-based system such as is used in Germany, France and even the United States, mandates that employers must provide workers with health insurance provided through a private fund. The funds are determined across industry sectors, and the government determines the premiums and benefits. The premiums usually come from the payroll tax in the system. The providers are separate from the funds and negotiate prices with these funds for reimbursement (Tanner 2008, 7). To illustrate how an employment-based healthcare system is practiced, I will use the examples of Germany and France.

Germany, ranked 25th on the World Health Organizations list of the world's best national healthcare systems, is an example of an employment-based system, and often used as a model of national healthcare (Mattke et al. 2006). Under the German national healthcare system, citizens who make less than

\$65,000 USD a year are required to enroll in one of the 250 sickness funds (Blümel 2012). Although it was not previously mandatory for all citizens to enroll if they were above this income level, 90% of the population was still enrolled in the sickness funds leading to almost universal coverage (Tanner 2008, 29). However, the effectiveness of universal coverage has been reduced more recently with the number of uninsured tripling over ten years by 2008. As of 2009, it became mandatory for all citizens and permanent residents to have health insurance in Germany. Undocumented immigrants are now covered by social security in case of illness (Blümel 2012). The social security program is similar to the program that exists in the United States in that it is paid for by taxation of German citizens. The German social security program covers the elderly and disabled, and in the case of healthcare, it can be used to cover the cost of undocumented immigrants' healthcare expenses (US Social Security Administration 2010).

Germans receive their health insurance through competing, not-for-profit, and non-governmental insurance funds called sickness funds in the statutory health insurance scheme (SHI). The SHI are funded by mandatory contributions determined by income (Blümel 2012). Since 2009 there has been a standard contribution rate (in percent) set by the government, but as of 2012 earnings above about \$59,000 a year are exempt from contribution. The standard contribution rate for employees is about 8%, and the sickness funds or

employers pay for about 7% creating a combined monthly maximum contribution of about \$760 USD (Blümel 2012). Once the contributions are collected they are nationally pooled and redistributed to each sickness fund based upon a formula that accounts for age, gender, and morbidity from certain illnesses (Blümel 2012). In addition to government insurance, supplemental insurance (PHI) is also available, and about 9% of the population pays for the supplement insurance, in order to cover services not included in the standard benefits package (Tanner 2008, 29).

PHI covers mainly two groups of citizens: civil servants and the self-employed who are exempt from SHI. PHI is still regulated by the government to ensure that there are no risk-related increases in premiums for age (Blümel 2012). German patients have some copays, but modest ones, which typically relate to prescriptions, outpatient care office visits, inpatient stays and rehabilitation care, and a few other treatments. Prescriptions and office visits mentioned are priced at an average cost of \$13 USD each (Blümel 2012). However, this pricing does not apply to children under the age of 18 because children in this age group are exempt from co-payments and as dependents their insurance is free of charge. Adults have a 2% of household income cap on copays, which is reduced to 1% for the chronically ill. To be considered chronically ill, a patient must show they participated in screening procedures or recommended counseling before becoming ill (Blümel 2012). Overall out-of-

pocket spending accounted for about 13% of overall healthcare spending in Germany in 2010 (Blümel 2012).

In Germany, the majority of outpatient general practitioners and specialists work in private practices, but are required to be members of regional associations. These regional associations serve the purpose of determining contracts with the Sickness Funds, act as financial middlemen, and organize care. Forty-four percent of physicians in outpatient care are general practitioners and the remaining 56% are specialists (Blümel 2012). Patients can choose a specific practitioner, specialist, and hospital—in the case of the hospital, only if they are referred. Outpatient physicians are paid according to a fee schedule negotiated between sickness funds and physicians. These payments are limited to a predefined maximum number of patients and reimbursement points per patient (Blümel 2012). Despite being able to choose a physician, individuals in Germany, particularly the elderly and terminally ill, can be subjected to rationing as a result of a medical professional deficit. Also, due to lack of adequate facilities and budget constraints, there are often wait times for poorer patients. Lastly, Germany has lesser access to medical technology than the United States because of cost constraints. It is estimated that the United States has four times as many MRI machines per million people compared to Germany (Tanner 2008, 30). Overall, as of 2004, 76% of Germans thought healthcare reform was urgent (Tanner 2008, 31).

Another employment-based system is France, which is considered the best healthcare program in the world according to the World Health Organization. Health insurance in France is provided by mandatory occupation-based healthcare funds called noncompeting statutory health insurance (SHI), which are private entities, but are highly regulated by the French government (Durand-Zaleski 2012). The French government defines the premiums, benefits, and provider reimbursement rates for all citizens. There are three major funds that cover 90% of the French population based upon occupation: salaried employees, rural workers, and self-employed persons. Under the French system there is universal coverage, meaning that employed residents, retired persons, students, illegal residents, persons from countries in the European Union (EU) are fully covered by the SHI, even non-EU persons are covered fully for emergency care (Durand-Zaleski 2012). Under SHI, 99% of French residents are covered (Tanner 2008, 8).

Beyond the SHI exists a complementary private insurance system (PHI) that covers additional charges and excluded services, and covers 95% of the French population (Tanner 2008, 8). SHI covers hospital care, specialists, outpatient care, dentistry, prescription drugs, medical appliances etc. The high rate of private insurance stems from the refusal of the best physicians and medical providers to adhere to the fee schedules imposed by the insurance funds (Tanner 2008,8). This system of buying private insurance would seem to create a

quality of care and access gap based upon income, but because of the French's dedication to egalitarianism in healthcare, a program in 2000 was created that provides vouchers for low-income residents to also take advantage of the private insurance system (Durand-Zaleski 2012).

Seventy-seven percent of the money used to fund French health insurance comes from public funds and is financed largely by employer and employee payroll taxes (Durand-Zaleski 2012). Although there is a mandate to provide universal healthcare in France, the nation still has the third most expensive healthcare system in the West accounting for 11% of France's Gross Domestic Product. In 2010, out-of-pocket spending accounted for 7.3% of total health expenditures, and PHI accounted for 13.7% of total health expenditure (Durand-Zaleski 2012). To help keep these costs down, similar to Switzerland, France defined a standard fee schedule for all procedures throughout the nation regardless of insurance plan or location in France. One major impact of this regulation is that French doctors do not make as much as American physicians. The average primary care physician's salary in France is about \$96,000 USD, which is about half of what an American primary care physician makes annually (Kamrany et al 2014).

Most recently the French government has imposed "coordinated care pathways," which encourages a patient to seek a preferred general practitioner (Tanner 2008, 10). The purpose of this is to use the general practitioner as a

gatekeeper and thus limit access to specialists and some advanced treatment in order to mitigate cost; however, this is not strictly enforced. Also, more stringent budget regulations have been placed on hospitals. The strict policies on cost regulation in the hospital setting has led to a lack of capital investments in hospitals, which in turn has decreased patients' access to newer technology and more advanced treatments (Tanner 2008, 10). The result of the lack of access to technology in hospitals has also delayed treatment for some patients. Furthermore, there are disparities in the allocation of health resources geographically, which makes accessing healthcare easier for some patients than others. Generally, there is no wait list for healthcare in France, but the lack of advanced treatment and technology can lead to lines for special treatments (Tanner 2008, 10). In addition to cost cutting in hospitals, a problem on a smaller scale is that the French government has attempted to reduce the use of prescription drugs, which has prevented some patients from getting the medication they need (Tanner 2008, 10). Due to the many regulations imposed by the government, the French healthcare system has been accused of only slowly reacting to changing conditions. This can be problematic during epidemics, such as in 2004 when there were not enough hospital beds during a flu and bronchitis outbreak (Tanner 2008, 10). Despite these drawbacks, the impacts have been significantly diminished and offset by the private insurance

programs available. Overall, a 2004 poll showed that French are the most satisfied of all Europeans with their healthcare system (Disney et al 2004).

The employment-based schemes employed in Germany and France are similar to the main mechanism by which Americans received health insurance prior to the Affordable Care Act and continues to be the main form of how employees receive their insurance—but that could change. The main difference between Germany, France, and the United States is that sickness funds do not exist in the United States. Employees do not contribute to a not-for-profit fund that is ultimately redistributed directly; instead employees and employers pay money to the private insurers and receive benefits based upon the plan chosen. The drawback of the American system comparatively is that the American system does not promote equity or access for everyone in healthcare. However, the United States Medicare/Medicaid program is comparable to Germany's sickness funds, since the US government taxes income in order to fund government insurance for low-income populations and the elderly. The key similarity between these two nations is that health insurance eligibility is predicated on the fact that someone is working, and by fulfilling one's expectation as working citizen, one is thus worthy of health benefits.

In examining the French model, we are able to see elements of the Swiss managed competition and the German employer based system. While the French's employer based system is more closely aligned with the German

universal health system, it is quite notable that heavy government regulation is distinctly characteristic of French and Swiss systems. By incorporating elements of employment-based models and managed competition, France has essentially been able to cover its entire populace while cutting cost. Lauded as the best healthcare system in the world, the French's hybrid model offers many lessons for the United States, which is taking a very similar approach by building a healthcare model that borrows successful elements of the standard models and applying the methods where appropriate.

Single-Payer System

The single-payer system, such as those found in Great Britain, Canada, and Brazil, is a healthcare model in which the government pays for the healthcare of all of its citizens (Tanner 2008, 7). The government's role is to collect taxes from the citizens, which ultimately covers the cost of the system; to pay healthcare providers; and to administer the supply of healthcare (Tanner 2008, 7). The government generally determines a budget of healthcare expenses for the year, and reimbursement rates and prices are subsequently based upon that budget. In some cases the healthcare professionals become employees of the state and in other systems healthcare professionals can remain independent (Tanner 2008, 7). To illustrate how a single-payer healthcare system is practiced, I will use the example of Great Britain.

Britain's healthcare system, the National Health Service (NHS), is a highly centralized version of the single-payer system. The NHS was founded in 1948 and is funded by the taxes of its citizens. As of 2010, Great Britain spends 9.6% of its Gross Domestic Product on healthcare. 76% of the funding for the healthcare system comes from general taxation and 18% from a national payroll tax (Harrison 2012). Outside of the NHS, British citizens can have voluntary health insurance, which is usually a work benefit provided for citizens who are "normally resident" and who are provided with *largely free* healthcare through the NHS (Harrison 2012). In the British healthcare system, illegal immigrants and visitors can receive medical treatment only in the case of certain infectious diseases and in emergency situations. Under the NHS, patients can receive preventative care, dentistry, mental health services, rehabilitation, and the majority of any other services one could need if ill. Medications prescribed at NHS facilities are free, but medications prescribed in an outpatient setting have a copayment of \$12.23 USD (Harrison 2012).

General practitioners are the first point of contact for individuals in the British healthcare system, and individuals are required to register with a local general practitioner. Most of the general practitioners work under national contracts and are paid through contractual payments for specific services through taxes paid by British citizens and additional compensation can be received through positive performance evaluations. A significant number of

general practitioners work in private practice with other general practitioners (Harrison 2012). In contrast, almost all specialists are salaried employees of government hospitals. Individuals can choose to visit any hospital and in the last few years are now able to choose the specialist they would like to see within the hospital (Harrison 2012).

In the British single payer system, the National Institute for Health and Clinical Excellence (NICE) sets guidelines for effective treatments and assesses new health technologies and medications to ensure their efficacy and cost effectiveness. NICE is responsible for ensuring quality care and in preventing redundancies and ineffective treatments from entering Great Britain's healthcare market. By doing this the British government can cut down on excess costs by ensuring significant improvement in new technology, drugs, or methods (Harrison 2012). Outside of the NICE, the NHS sets overall caps on expenditure approximately every three years. Despite the very concerted efforts to control cost, Great Britain had a £700 million deficit as of 2006 (Tanner 2008, 24).

Although almost all of the population can access healthcare for *free*—sponsored by the taxation system—there are some major complaints about the British single-payer system. Patients may be subjected to extensive wait lists to get into NHS hospitals, and these waits have had very detrimental effects on patient health outcomes. For instance, it is estimated that some cancer patients have waited as long as eight months for treatment, and that 20% of colon cancer

patients are considered treatable when diagnosed, but were incurable by the time treatment was offered (Browne 2001). In addition, some hospitals have imposed wait times to prevent resources from being used too quickly. In 2004, the NHS, in a cost-cutting measure, negotiated low salaries for general practitioners in exchange for a cutback in hours (Martin 2007). This meant even less access to physicians. In addition to wait times and lists, there is rationing of certain procedures. Individuals, who are too ill for procedures that are particularly expensive, can be denied treatment. As of 2004, 63% of Britons believed reform in healthcare was urgent, and about 60% believed that spending one's own money on healthcare would improve the quality (Disney et al 2004).

The United States also employs a single-payer system through the Medicare mechanism. Medicare is a federally run program funded partially through payroll taxes and by premiums deducted from social security checks (socialsecurity.gov). Under the program, people over the age of 65 and with certain disabilities can receive Medicare, and the program helps pay for hospital visits, medications, and long term care. The key difference between Great Britain's single payer system and Medicare is that supplemental insurance is highly suggested with Medicare because it does not cover most medical procedures for *free—no out-of-pocket expenditures for the patient*. Medicaid might also be considered a single-payer system, but eligibility is determined by the state (rather than federal government) based upon income. The Affordable Care

Act by federal directive has extended Medicare and Medicaid to 2029, and by increasing the level of preventative procedures at a reduced cost, these mechanisms become more in line with a comprehensive single-payer system (The Affordable Care Act & Medicare).

Arriving at the Affordable Care Act

As illustrated throughout this chapter, the Affordable Care Act has been formulated by borrowing segments from the three most popular universal healthcare models that exist currently in the industrialized world. The system created in the United States as a result of the Affordable Care Act is most similar to the managed competition model in Switzerland, but uses methods characteristic of the other two healthcare models to address specific populations—e.g. Medicare/Medicaid as a single-payer system for the elderly or low-income populations. Although the three models discussed attempt to provide all citizens with the right to healthcare, there are still major problems within each healthcare model similar to the challenges that the United States faces, and in some instances, perhaps even more extensive. Switzerland still has the second most expensive healthcare system in the world only behind the United States, and Swiss citizens face exorbitant out-of-pocket costs. Germany and Great Britain suffer from rationing and wait lists that negatively impact healthcare outcomes, particularly in middle-class and low-income populations. Germany, France, and Great Britain all have decreased reimbursement for

medical professionals and have significant income taxes imposed on the general population. Lastly and most notably, all nations are still facing debilitating healthcare deficits with healthcare costs being a significant portion of their gross domestic product (*see table 1*). Despite all of these negatives, these nations have made a right to healthcare a priority, to some extent trading constricting fiscal responsibility for the greater good of their national population.

Chapter 2: Dispelling the Fears Associated With Universal Healthcare

As I discussed in chapter one, none of the universal healthcare systems explored alleviated all of the problems associated with healthcare access, quality, and cost. In 'fact' some universal healthcare systems exacerbated issues such as extensive wait times/lists, lack of physician choice, increased rationing, lack of access to biotechnology and pharmaceuticals, lowered physician income, and an overall decrease in access to healthcare. In light of this, I wondered whether the implementation of the Affordable Care Act would expose Americans to some of the drawbacks of universal healthcare and address the quality and access problems already faced in the United States.

Rationing and Access to Drugs and Technology

In 2009, an article came out by Mary Vanac stating that older Americans' fear that medical care rationing would result from healthcare reform (Vanac 2009). This is a very legitimate fear seeing that in Germany and Great Britain, older citizens have been denied care due to budgetary constraints coupled with expensive cost of special procedures. Also, there is justifiable fear that access to drugs and technology will be limited due to the regulations imposed upon pharmaceutical and medical technology companies by organizations like the National Institute for Health and Clinical Excellence in Great Britain, and that the general cost restrictions that exist among all of the universal healthcare systems explored in chapter one will inevitably materialize. It was not only

older Americans who had reservations about the Affordable Care Act, as pharmaceutical and medical technology companies were also initially tentative about the Affordable Care Act. This was particularly reflected in reports issued from the IMS Health Inc. saying, “Obamacare may shave 30% from drug sales” and came from the fear of having British level regulation (Edney 2013).

However, these organizations have voiced their support for the Affordable Care Act in more recent times as the terms of the Affordable Care Act have been revealed, as was indicated by the statement made by Pharmaceutical Research and Manufacturer’s of America (PhRMA),

We believe comprehensive health care reform will benefit patients and the future of America. That’s why we have been involved in this important public policy debate for more than a year and why we supported the final health care reform bill and the amendments found in the reconciliation legislation.... But throughout this long process, we have been guided by a belief that all Americans should have access to high-quality, affordable health care coverage and services...” (PhRMA 2010)

These companies began to support healthcare reform since the Affordable Care Act does not fundamentally change the major payment schemes that existed prior to healthcare reform. In fact, medical industry companies serve to make even more money due to the Affordable Care Act and have a guarantee from the federal government that prevent some cost contracts, which would serve to reduce costs for pharmaceutical products. Also, bringing more *customers* into the healthcare system will increase the need for drugs and medical technology. The lack of rigid cost regulation within medical industries

coupled with the increased need for medical products in the United States, will enable enough provisions for the population's expanding need and higher profitability for medical industries.

Medical Professional Deficit

Another side effect of healthcare reform, as exemplified particularly in Great Britain and Germany, has been the major wait times and wait lists that negatively impact healthcare outcomes for patients. These wait times/lists result mainly from the budgetary constraints and medical professional deficits. As was seen in Great Britain, the cost cutting contracts negotiated with primary care physicians served to cut down on physician hours, but led to decreased access to primary care physicians and increased wait times. This side effect becomes more concerning in an American context considering the addition of between 9 million and 14 million new Americans to the healthcare system under the Affordable Care Act (Schlesinger 2014). This begs the question: With the addition of so many Americans to the healthcare system, will there be a medical professional deficit? To quote Dr. Watson, a first generation American and general practitioner practicing in Atlanta, Georgia:

Yes [there will be a medical professional deficit], but it existed long before Obama became president...The US stopped building medical schools. The American Medical Association came out with a report saying there were going to be too many doctors, and the US stopped building medical schools. Then, ten years later there's going to be a shortage. (Watson 2014)

Despite the medical professional deficit that existed prior to the Affordable Care Act, it is very unlikely that Americans will be subjected to the wait times and lists seen in Great Britain. The reason for this is that relative to the other industrialized nations with universal healthcare examined in chapter one, the United States has more physicians per capita than many European nations, or as Dr. Watson says:

We have healthcare institutions in this country like we have McDonalds. Europe may have one center that does hip replacements for an entire region. It's like apples and oranges. When you add up medical facilities per capita compared to other countries, it's astronomical... For example, Florence, South Carolina, a town of 25,000 people has three hospitals! In Europe, one hospital will supply an entire region. (Watson 2014)

Although there is a large number of hospitals and practices in the United States, they are not restricted by the same strict budgetary constraints of medical institutions as some universal healthcare systems. Even though hospitals in the United States used to be mostly charitable organizations that were run mainly by churches, they are mainly for-profit institutions—even if they are classified as not-for-profit (Bennett 2014). Therefore, the majority of Americans should not have problems accessing care with the relative immediacy that existed prior to the Affordable Care Act.

An additional side effect of universal healthcare systems such as is the case in Germany, France and Great Britain were decreased reimbursement rates paid to physicians. These reduced reimbursement rates would be highly unlikely

in the American context, since the Affordable Care Act, like Switzerland, set up a managed competition model. As was seen in Switzerland, due to the individual insurance mandate, individuals pay for private insurance. Facilitating easier access to obtaining health insurance does not change the cost for medical services—as was done in Switzerland and now in the US under the Affordable Care Act. Health insurance just provides the populace with a coupon card for medical services, so that these costs do not have to be paid entirely out-of-pocket (Bream 2014). Therefore, medical professionals should not see a change in income since the reimbursement rates did not change. In ‘fact’ it is possible that physician incomes may increase for general practitioners as a result of incentivizing the specialty to achieve overall better health outcomes for patients, and the increased volume of patients under private insurance should facilitate access to more patients with higher reimbursement rates.

Access and Quality of Care

Although individuals will most likely not be subjected to wait lists because of the number of physicians/hospitals per capita, this measure does not fully take into account the disproportionate access to care in the United States.

D.C. has [one of] the highest ratios of doctor-to-people living there and yet some of the worst outcomes. How do you make sense out of that? Well, maybe they [the physicians] are all in the suburbs... Underserved communities, people of color don't get [equal] care and get a different quality. (Morrison 2014)

As Dr. Morrison, a University of Pennsylvania nursing professor with a public health background, pointed this out, certain populations have a disproportionate medical deficit. Previously, these populations were seen as unattractive because of the lack of health insurance, or Medicaid status. Treating these types of patients is usually attended by financial loss for physicians. According to the Affordable Care Act, the individual mandate and the Medicaid expansion should solve this problem by providing insurance coverage to a larger amount of the population. However, the reality is that providing insurance most likely will not solve the disproportionate access to healthcare because it does not seem to appropriately compensate for the underlying issues that are inhibiting healthcare access and that diminish quality of care. For example, take the experience of Dr. Thomas, a general practitioner in a moderately low-income region of Philadelphia:

Philadelphia has more physicians per square mile and more per person than anywhere else in the country... We're ten miles from the nearest hospital and our population can't get an appointment...If you called and said some code words they'll give you an appointment...Call and give a stutter, and respond in an uneducated way and specifically ask for an appointment...Nobody wants somebody like that in [his or her] practice. (Thomas 2014)

The signal expressions Dr. Thomas was talking about in the above quote were words such as, Keystone first, Health Partners, or Aetna Better Health. These words evoke the association of Medicaid, which as previously mentioned for physicians and hospitals is a money losing service in a very profit-based market.

In addition, patients on Medicaid tend to be difficult to treat because of the social, political, and economic factors that prevent healthier lifestyles. As such, people on Medicaid are still denied the quality treatment they deserve, regardless of their insurance status.

To combat the egregious gap in care given to different populations, the Affordable Care Act instituted quality metrics to hold physicians accountable for lower quality treatment. According to the legislation, physicians will be paid on the basis of quality outcomes. In addition, cost regulation will be imposed on hospitals and physicians, which has the intent of reducing frivolous use of information technology (Sochalski 2014). One of these quality metrics is Medicare's Hospital Value-Based Purchasing Program (VBP), which is a pay-for-performance approach (Davis 2012). The goal of the quality metrics is to reduce hospital readmission rates, prevent procedural errors, and links payment to the patient's experience. By linking payments to the overall health outcome and to patient's experiences, the hope is to invest all players in the healthcare experience and promote efficient and effective treatment at a high level for all patients. The incentive behind this is the payment scheme, in which "achieving the specified quality measures will receive higher payments, while those that fail to meet the standards will see payment reductions" (Davis 2012). Despite the good intentions, the physicians I talked to did not appreciate the metric. Dr. Watson called it an "asinine policy." This policy is viewed as silly because it does not take into

account the difficulty in treating a patient in an underserved area. For instance, Dr. Watson illustrated to me the caveat to this policy:

I treat patients of very high socioeconomic situations. [When] they come in with high blood pressure, I prescribe them medicine, and they'll take their medicine diligently and their blood pressure will go down. A person who is of lower socioeconomic status and has social issues... I have to work four times as hard to get that person's blood pressure down, but I get credit for the easy one. That's just a stupid policy that has no application in medicine. I could just say forget it, I could just stop treating the hard people. (Watson 2014)

Another example Dr. Watson uses is with diabetes hemoglobin A1C, a marker of diabetes control. He discusses the ridiculousness of another physician being considered a better physician based upon numbers. If a person of low socioeconomic status with multiple social influencing factors came into Dr. Watson's office with an A1C of 14, and Dr. Watson was able to get the value down to a 10, which is a significant improvement but still reflective of uncontrolled diabetes, he would be considered a bad doctor, compared to the physician who took on a patient with an A1C of 8.5 and got it down to a 7, the acceptable level of A1C. Instead of incentivizing the physician to practice better quality medicine, the legislation has backfired and reduced the incentive to treat medically marginalized patients.

Quality metrics have also served to demonize physicians by quantifying medical treatments and associating lower metrics with practicing bad medicine, when these low metrics may truly be a result of treating a patient with multiple

social factors that complicate health outcomes—such as the decreased access to healthy, but more expensive foods and decreased access to a gym with a trainer for a person of low socioeconomic status with high blood pressure and/or diabetes. As a result, some physicians have even made the choice to cut back on hours, or to sell their practices (Bream 2014). Prior to the Affordable Care Act, some physicians already did not accept Medicaid, this number could increase because of these metrics that de-incentivize care for fear of penalization. If enough physicians react like this, a significant medical professional deficit could be on the horizon, particularly for populations that already have decreased access and quality of healthcare.

Incentivizing the General Practitioner

One way the Affordable Care Act has tried to compensate for the disparities in healthcare is by promoting the primary care physician. To help promote the importance of the primary care physician, the Affordable Care Act has expanded Medicare reimbursement rates by 10% and added more insured people to the healthcare system. For physicians, the Affordable Care Act has provided scholarships, loan repayment, and demonstration programs to invest in primary care (Abrams, et al. 2011). Despite these legislative changes, Dr. Thomas was particularly skeptical of these measures incentivizing primary care physicians:

There's a hope it will emphasize primary care. That's a faith-based statement... They don't really have a mechanism. The hope is that if you

reimburse general practitioners at a higher percent than specialized care you'll promote primary care...Primary care is our solution to cost, but the lobbies outside of primary care are very strong. We've learned this in multiple states and this exact issue with medical assistance. They could've increased general practitioner reimbursement by \$3 or they could have increased hip replacement by \$1000. [They] looked at the tradeoff and chose hip replacement. It was thousands of dollars underpriced instead of \$40...A bunch of people in primary care are starting to work like plumbers, a shift on and a shift off. It changes the level of professionalism, when you treat people like cogs in a machine, it turns out they respond like cogs in an industrial wheel. (Thomas 2014)

Dr. Thomas's statement is evidence of the difficulty in promoting primary care.

The Affordable Care Act may have instituted some broad measures like increasing access to health insurance and quality metrics to promote primary care, but portions of the quality metrics legislation serves to undermine the intent. As well, politics and lobby groups are a major factor in determining whether primary care will become the most valued specialty. It takes more than just paying physicians a bit more or providing modest scholarships. It is about changing the perspectives in the medical profession about primary care. Dr.

Watson shed light on the difficulty in promoting primary care as well:

It's about the heart, identifying people before medical school. If it were up to me, I would make an effort to accept more people from primary care than those who are not. Several of the major medical schools in this country discourage the brightest students from going into primary care. "You did great on your boards, why do you want to go into primary care? You could be a cardiologist!" (Watson 2014)

The difficulty in changing this mentality is that the United States is a capitalistic country. There is still the higher incentive to be in a higher paying environment, and a moderate increase in general practitioner incomes will not necessarily

promote the importance of primary care, particularly in underserved areas, as it is still more profitable and more revered to be a specialist.

Changing Quality

The Affordable Care Act's attempt to promote primary care is fundamentally a step in the right direction, since promoting maintenance of good health prior to a catastrophic medical event—e.g. stroke and heart attack—is a more cost effective approach than paying for treatment for a catastrophic medical event. However, the legislation was not written with an understanding of treating people of low socioeconomic status, who would benefit the most from these doctor-patient interactions while serving to cut the cost of emergency visits that these uninsured individuals disproportionately accrue during catastrophic health events.

Low-income populations are much more difficult to deal with because of the structural violence—institutionalized prevention of meeting one's needs based upon discrimination—they face as a result of their societal status. American culture is built off of the premise that working hard will produce results financially, and if one is not working hard, one will suffer the consequences—capitalist mentality. Unfortunately, this does not take into account the societal barriers—e.g. educational quality barriers, the lack of social capital and limited networks for good professional positions or schools—certain populations face, or the history of disenfranchisement of certain peoples—racism. The combination of structural violence, historical disenfranchisement, and American capitalist mentality has ultimately led to making people of low socioeconomic status unattractive in a healthcare setting. Their unattractive status furthers their inability to be involved in capital making activities

because of poor health outcomes, which further serves to perpetuate their low-income status.

Moreover, healthcare is quite complicated. It takes a certain level of education and know-how to navigate the system and use it to one's best personal value. Unfortunately due to the historical lack of access in certain areas, low-income populations do not have the social capital to navigate the complex healthcare system. As Dr. Watson pointed out,

The thing is healthcare is very complicated. If I think something is wrong with me, I'm not going to just get off the couch and go to the doctor, and I haven't been to the doctor in years. I don't know how to find a doctor. If I can go to the doctor, how much it will cost me? So, I'll sit here and suffer until I can't suffer anymore and then run to the emergency room. Education is the key and preventative health is the key to adjust those numbers. That's going to be a ten-year project not a tomorrow project. (Watson 2014)

Changing the quality of care for those who currently receive a lower level of care relative to the rest of society probably is going to require a sweeping campaign on the level of the medical professional, the community, and the media. This overhaul requires more than just legislative regulations, as Dr. Morrison suggests as she discussed the vital role of medical professionals outside the physician in reaching underserved populations:

Home health aids, community health workers, doulas are an enormous untapped resource. Professional arrogance gets in the way; they're in those homes everyday...while I was a practicing nurse, the health home aid...was more important than anyone...She was always right and she was high school trained...We're still delivering a lot of white man care; we could change that if we had more minority people. (Morrison 2014)

Dr. Watson also emphasized the importance of utilizing the resources that already exist to promote healthcare in underserved communities.

Utilize media, Internet, TV. We need to utilize a Madison like plan to promote health. Pharmaceutical companies advertise drugs; the government should do the same thing. They should do the same elaborate productions that get people motivated to take care of themselves. If they spend money on that, they'll spend a lot less money on the back end. These little low-end promotional type stuff is not going to be effective. You have to have vibrant commercials about prenatal care, checking your blood pressure, checking your blood sugar, checking your cholesterol, signs of dementia...Outreach is there, tell people what the signs are and where to be assessed. Give the people information so they can actually go do it. (Watson 2014)

The points Dr. Morrison and Dr. Watson both raised are the importance of empowering the individual. By first acknowledging that there is a disparity, and developing a remedy that caters to the populations where the disparity exists is the way to solve a medical access and quality issue. Although the Affordable Care Act attempts to compensate for disparities in healthcare, affecting change will most likely not be successful by only promoting a top-down legislative approach. The top-down approach often serves to demonize physicians, de-incentivize providing care to underserved areas, while not positively impacting the intended communities. The key seems to be involving medical professionals within communities, in order to achieve access to good quality care, better health outcomes, and overall reducing the United States' healthcare costs.

Chapter 3: Partisan Politics And Its Effects On The Affordable Care Act

The Affordable Care Act put into place legislation that was meant to address the major problems associated with disparities in quality of care and access to care, and its careful crafting avoids the known pitfalls of other universal healthcare systems. However, the legislation does not seem to solve some of the pre-reform problems in practice. In order to understand how some parts of the legislations seemed to fail in practice, I asked medical professionals their perspectives on the Affordable Care Act.

As I sat in the office of Dr. Watson, with a beautiful skyline view of downtown Atlanta I asked the question “How do you feel about the program [Affordable Care Act]?” There was a pause and look of wishful hoping, but realistic concern as he answered,

[The] spirit was in the right place but the administration and structure of it...a lot of improvement is going to be needed. I don't think they had the right people involved in structuring of the program. From what I understand, physicians were hardly involved in the process at all. It was mostly “Washingtonians” or people who write books about healthcare and have never treated a patient in their life, health policy people, not people on the ground that actually know the practical aspects of healthcare and know about treating patients. (Watson 2014)

With many of the other medical professionals I interviewed expressing similar views, the significance of the lack of involvement of the healthcare workforce was juxtaposed with the nature of hyper-partisan politics in the creation of the Affordable Care Act.

To contextualize the role of hyper-partisan politics in hampering healthcare reform, Theodore Roosevelt first introduced the idea of universal healthcare in the

United States in the early twentieth century, and not until 2010 was the United States able to pass any comparable legislation—that is over 100 years (The Washington Post Staff 2010). As mentioned in the introduction, the Clinton administration tried vehemently to pass a healthcare reform bill that miserably failed in 1993. Like many presidents prior to him, Democrat and Republican, who had illuminated universal healthcare as something the USA should have, Clinton was unable to successfully get any legislation through. In fact, the Affordable Care Act is the only recent healthcare legislation to pass since the Medicare/Medicaid legislation in 1965 (The Washington Post Staff 2010).

Passing the Affordable Care Act

Power of the Lobbyists

A significant contribution to the failure of healthcare reform under the Clinton administration was the influence of lobby groups. Like the Clinton administrations attempt for healthcare reform, passing the Affordable Care Act was significantly impeded by the involvement of lobby groups that fund hyper-partisan politics and the Democrat's resolute posture in determining the contents of the healthcare legislation. The market-oriented system that existed prior to healthcare reform has made insurance companies, hospitals, physicians, and other health organizations very wealthy, and they would like to maintain this trend of profitability. As such, they were resistant to the possible changes that would be instituted by healthcare reform, mainly fearful of the governmental regulations that they would be subjected to in order to control cost. To appease these lobbyists, a

model had to be constructed that would not destroy the fundamental structure of healthcare in the United States prior to the Affordable Care Act. Accordingly, a mainly managed competition style of healthcare emerged from the Affordable Care Act. Despite efforts to cut down on partisanship, ultimately healthcare reform required two bills, the Patient Protection and Affordable Care Act (ACA) and Health Care and Education Reconciliation Act (HCERA) (Cannan 2013). The contentious nature of the debate can be further seen by the actions of Democrats and Republicans throughout the formulation and passing of healthcare reform. Dr. Thomas, the primary care physician that caters to a community of lower socioeconomic status in Philadelphia pointed this out very succinctly:

The law [ACA] only passed through a committee procedural trick that hasn't been used in any other law. [The] people of Massachusetts, who are the barometer of the US, elected someone who was against Obamacare because a senator died. A democratic state elected a republican. [That's a] big message, maybe we shouldn't be pushing this. There was still this little trick but instead they ignored it ... Instead of listening, partisanship in DC went into their frenzy and republicans and democrats pushed it through without compromise. Neither side was compromising. You look at the presidential elections it's 50-50. We keep pretending one side is 100% right. (Thomas 2014)

I nodded in profuse agreement as Dr. Thomas said this with such conviction. After hearing this statement and recollecting the numerous unsupportive news headlines about healthcare reform in my junior year of high school, I wondered exactly why it was that the Affordable Care Act seemed to be such a peculiar case in legislation. After a bit of perusing the online news articles and seeing titles like "Republicans renew fight against Obamacare as Sebelius resigns" a *Fox News* article written in April of 2014, I stumbled upon an extensive, but very comprehensible article by

John Cannan called “A Legislative History of Affordable Care Act: How Legislative Procedure Shapes Legislative History” (Cannan 2013).

As Cannan discussed in his article, President Obama identified broad principles he wished to achieve in a healthcare bill, but left it up to the House and Senate to fill in the details (Herszenhorn and Calmes 2009). Historically, legislation is compiled in Congress using the markup process in which the bill is discussed, amended, and eventually voted on. Due to the increased availability to these public discourses facilitated by news broadcasts and online outlets on the subject, the markup process has been somewhat abandoned and discussions often take place in private (Cannan 2013). This is what occurred with the bill that ultimately evolved into the Affordable Care Act. The privately formulated Bill 3200, as it was called in its preliminary stages, was presented to the House where the minority (Republicans) in the House immediately attempted to gut Bill 3200; their attempts were ultimately voted down. However, the Conservative Democrats were very unhappy with the high cost and the size of the bill and were able to hold back their votes in order to lobby for the changes they wanted in the bill. Three versions of Bill 3200 were presented to the House floor with varied levels of inclusion of the lobbyists changes, and two weeks later Bill 3296 came into being (Cannan 2013).

Unlike its predecessor (Bill 3200), Bill 3296 did not follow the traditional track of legislation and instead jumped to consideration within two weeks of being drafted without being given to a committee for any review. This jumping of the bill was conducted in order to avoid direct votes on measures that might be controversial and thus might delay the legislative process; this method was mainly

applied to avoid the contentious abortion discussions (Cannan 2013). For the most part, many of the most important portions of Bill 3200 were maintained in Bill 3296 such as the healthcare mandate, public options, surcharges on high incomes, Medicaid/Medicare expansion etc. (Pear and Herszenhorn 2009). Due to this special rule, Bill 3296 was debated for an hour before being passed on to the Senate (Canaan 2013).

Although seemingly smooth in the House, this was not the case in the Senate. The Senate had also composed their own personal version of the healthcare bill during the summer of 2009—different from the healthcare bill proposed by the House, which included the mandate of the uninsured to buy their insurance through state exchanges or make payments to the government, and subsidies for lower to middle class income brackets for purchasing policies. No public options were included in this proposal. The proposed bill was assessed to cost the government \$1 trillion and would provide insurance for 16 million people. After this cost quote, the bill was amended about 500 times within a month. Throughout this process some of the Senators were negotiating with industries in order to gain their support. For instance, Democratic Finance Chairman Senator Baucus negotiated an \$80 billion deal with pharmaceutical companies to make medications more affordable for the elderly. The real purpose behind this negotiation was to reduce the cost of healthcare reform (Reuters 2009). Pharmaceutical companies agreed to this negotiation with the promise that the government would not institute negotiated prices for medications and with the promise that pharmaceuticals could not be imported from Canada (Kirkpatrick 2009). In essence, this negotiation allowed

pharmaceutical companies to maintain their pre-Affordable Care Act prices.

Senator Baucus (D) was not the only person or entity to make negotiations of this nature, the White House also negotiated with hospital associations for \$155 billion (Herszenhorn, Democrats Divide over a Proposal to Tax Health Benefits 2009).

After getting various medical industries on board, in October of 2009 Senate Majority Leader Senator Reid (D) led the campaign to pass a single bill. Unlike in the House, there are limited regulations that can speed up the process of debate or amendment in the Senate; correspondingly, there are no limits on the length of debates or the amendments that can be opposed. The result of this is that Senators, individuals or groups, can significantly slow down the ratification process, almost to a complete halt (Cannan 2013). To further add to the administrative challenges in passing the bill, Senator Reid (D) was going to have to rely on the votes of all 48 Democrats and 2 Independents due to the united Republican opposition to the bill (Herszenhorn 2009). This was even further complicated since the Democrats and Independents had varying opinions on portions of the bill. Senator Reid's bill was less restrictive about abortions and included taxes on elective cosmetic surgeries, expensive healthcare plans, and fees on insurance companies, pharmaceutical companies, and medical technology companies. In addition, Reid's bill delayed the implementation of the bill by a year, until January 2014, compared to the House's version, and costs had been cut to \$801 billion compared to the House's proposed \$1 trillion (Canaan 2013).

Ultimately, the Senate did not debate House Bill 3296 and instead opted to review one of the less controversial bills drafted in the House, Bill 3590, along with

Senator Reid's Amendment 2786. Both Democrats and Republicans had major issues with the bill. Despite this, the bill made it past the first round because Republicans actively and unanimously decided to undermine the Democratic image by presenting a cooperative Republican party that was not impeding the speed of the political process in juxtaposition with a Democratic party that would indiscriminately settle for any form of healthcare reform (Oleszek and Oleszek 2012). Under uniform consent, Senators picked specific non-controversial amendments to debate and vote on, and successfully passed many amendments by mid-December of 2009 with the condition that passing an amendment would take sixty votes (Canaan 2013). However, on December 16, 2009, the hyper-partisan antics began. Senator Coburn (R) insisted on a time-delaying tactic that resulted in the Senator Sanders (I) reading a public options amendment on the floor, which took hours. Despite this, by the end of December, everything seemed to be on track until Senator Kennedy (D) died and Massachusetts elected Senator Brown (R) (Murray 2010). As previously mentioned, Senator Reid (D) needed all Democrats and Independents to vote in favor of the bill and the amendments. Additionally, Republicans were staunchly against the proposed bill, as was the incoming Senator Brown (R).

In order to solve this dilemma, Democrats decided to use *Reconciliation*. Reconciliation is a legislative process that allows Congress to get around the required sixty votes to kill the minority party's delay in coming to a vote, in favor of a simple majority vote of 51. This process can be used when the bill is heavily contested or controversial (VoteTocracy 2014). Under reconciliation both the

House and the Senate would have to pass the bill in order for it to become a law. However, this was quite convoluted since the House Democrats would not pass the bill composed by the Senate and the Senate Democrats would not be able to muster enough votes to pass the bill. In order to skirt around this issue, a solution was proposed. First the House would pass the bill proposed by the Senate and then the House would pass an amendment for Bill 3590 (Herszenhorn and Pear 2009). Like Bill 3200, the reconciliation Bill 4872 (the House's amendment for Bill 2590) was negotiated in private, this time between the White House and House Democrats (Cannan 2013). Much of the amendment was related to Medicare/Medicaid. By March of 2010 the bill was passed, but there was continued bickering and proposed amendments even after signing the legislation into law, which still continues to this day.

Medicaid Expansion

To further illustrate the presence of the staunch dislike of portions of the Affordable Care Act by Republicans, we can see the refusal of many Republican governors from their initial rejection of the Health Insurance Exchange and in rejection of the Medicaid expansion to cover more people as is indicated in Figure 1. All of the 21 states that have decided not to expand Medicaid coverage have Republican governors. To explain the choice of non-expansion, I will compare Georgia and Pennsylvania, the two states in which I conducted my interviews. Originally Republican Governors of Pennsylvania, Governor Tom Corbett, and Georgia, Governor Nathan Deal, rejected the Medicare expansion available through the Affordable Care Act (Young 2013). Ultimately Pennsylvania's Governor Tom

Corbett drafted a health reform package that would improve access to Medicaid recipients through a premium assistance model—a model in which public funds are used to purchase private coverage, but Governor Nathan Deal has stayed unwavering in his disapproval of the Medicaid expansion (The Advisory Board Company 2014).

Georgia and Pennsylvania were not unique, which begs the underlying question of why would numerous states around the country reject the expansion. Is it a lack of care for low-income populations? What legitimized the continued marginalization of communities with a high health burden continuing to fall through the gap? I asked these questions of two Pennsylvanian medical professionals Dr. Morrison, a nursing professor at the University of Pennsylvania with a background in public health who also worked on Clinton’s healthcare reform proposal, and the previously aforementioned Dr. Thomas. Dr. Morrison was absolute with her response as she discussed the state’s refusal of money by rejecting the Medicaid expansion, “Pennsylvania is staring down a billion dollars on what? Politics?” (2014). My suspicions had been proved correct, or so I thought. Then the motivating factors began to unfold as Dr. Thomas fittingly said, “the expansion of medical assistance is a double edged sword.” I looked at Dr. Thomas to expand more on what he meant,

Although the government will pay for the expansion for the first two years, after that the State will have to pay for the Medicare expansion with an already broke medical assistance program. They will have to cut benefits from something else...which means somebody will lose. Historically, the unattractive patient loses. In Pennsylvania’s Special Pharmacy Program and differential access to medical assistance. If you have schizophrenia or HIV you can get medical assistance if you earn 250% of federal poverty line. If you have a uterus that can reproduce you can get medical assistance at 175%

of poverty line. If you have a uterus that can't reproduce and breasts you can get it at 125% poverty line. If you're just poor, until you make 47% you can't get it. If you're poor or uneducated you can't get medical assistance, but if you're ill you can. Medicaid expansion covers people up to 400% poverty; they can get subsidized medical assistance. Well they're going to have to take that money from somewhere. They can take it from the schools, but the governor is already getting beat up about that. They can sell the turnpike and that will solve it for four years or however long that money lasts, but then after that there's no turnpike to sell and no revenues. Or we can take it from some magical fund that I don't know where it exists, or we can take it from people who already have care and historically when we take it, we take it from the poor unattractive patient... The truth is that people lose at 50% poverty so that the people at 300% poverty can gain. (Thomas 2014)

Initially, I was a bit resistant to this theory, as the Affordable Care Act makes a provision for the federal government to cover Medicaid expansion fully for the first three years and subsequently cover a minimum of 90% thereafter (Scott 2013).

However as Dr. Morrison, the nursing professor at Penn, pointed out, there is a history of the federal government making promises about revenue, which they have not delivered on (2014). In that light, Dr. Thomas's assessment was a very real dilemma that could and most likely would be faced within the next five years. Like Pennsylvania, Georgia would be put in a very similar situation. As Dr. Patterson, a first generation American and primary care physician in the *suburbs* of Atlanta said, "The Georgia system is already flooded. I don't know if they can handle more payouts. I think it's already strapped" (2014).

Granted, Medicaid expansion could place states under extreme financial pressure if the government does not continue to pay for the expansion; however, these states will be losing out on billions of dollars while paying for other states' expanded coverage. As the Commonwealth Fund explains,

Federal funds that pay for state Medicaid programs are raised through federal general revenue collection—taxes paid by residents in all states—

whether or not they participate in the program. Therefore, taxpayers in states not participating in the Medicaid expansion will bear a share of the overall cost, without benefitting from the program. (Scott 2013)

The biggest losers of the non-expansion will therefore be the traditionally Republican states that have chosen not to accept the Medicare expansion, such as Texas at \$9.2 billion, Florida at \$5 billion, *Georgia* at \$2.9 billion, Virginia at \$2.8 billion, and North Carolina at \$2.6 billion (Scott 2013). In these states millions of the most vulnerable residents will be unable to obtain health insurance (Scott 2013).

Beyond the millions of people who will be losing out on the ability to access health insurance, the hospitals in these non-expansion states might run into some issues. As Dr. Morrison pointed out, under the Emergency Medical Treatment and Active Labor Act hospitals cannot turn individuals away from the emergency room. Previously, hospitals that used to cater to lower-income populations received special payments from the federal government to compensate for the cost. With the expansion of Medicare, these hospitals should no longer need this special payment anymore since essentially everyone should be covered by health insurance, and those who are not will be fined. This means that the states that do not take the expansion will have a portion of the population who will still not have access to insurance, and when they continue to use the emergency room for healthcare, the hospitals are not going to be paid by the government for their services. Moreover, low-income individuals will not be able to afford the penalty that was designed to address such gaps. Accordingly, hospitals may face large financial burdens in caring for these populations, thus creating an incentive for the further degradation of

quality of care provided to these patients in order to dissuade them from coming in to the hospital—ultimately working in direct opposition to the ethos of the Affordable Care Act.

Universal Healthcare?

The words of Dr. Thomas and Dr. Watson rung in my head. It was clear that passing the bill became a business negotiation between Washington politicians and medical lobbyists, and to use the words of Dr. Watson, “the people on the ground” were left out (2014). As a result, the United States healthcare reform was forced to eliminate a major cost cutting measure, negotiated priced medications, which ultimately eliminated the bargaining capacity that makes healthcare most valuable. In addition to trying to appease lobbyists in the medical industry, a lot of manipulation occurred within the House and the Senate to pass the bill. There was clear disregard for the opinions offered by Republican voices, as they were not included in the drafting process. In this context, it is understandable that Republicans would try to hold up the ratification process if their inputs were not being valued. Furthermore, their valid claims, such as those related to the Medicaid expansion, perhaps could have been thought out better and a proper solution proposed to dissuade a heavy financial toll on states. As a result, the Affordable Care Act evolved into a skewed opinion of how a very small set of people—who have an extensive knowledge base but may not have an appreciation for the nuances of grass-root insights—think access to healthcare comes about, an insurance mandate. The consequence of these partisan politics has still left thirty million Americans

uninsured such as illegal immigrants, individuals who receive special exemptions from the insurance mandate, those in non-expansion Medicaid states who would be covered by the expansion, and those who opt to pay the penalty over purchasing health insurance. Although it is commendable that the Affordable Care Act has provided access to reasonably priced healthcare for an estimated fourteen million Americans through the insurance mandate, the truth is that the Affordable Care Act did not create universal healthcare.

Conclusion: Foot in the door

“Nobody remembers well those who stand in the way of America’s progress of our people. And that’s what the Affordable Care Act represents. As messy as it’s been sometimes, as contentious as it’s been sometimes, it is progress. It is making sure that we are not the only advanced country on Earth that doesn’t make sure everyone has basic healthcare” (Obama 2014)

As Obama so fittingly states April 1, 2014, in the White House Garden, the intent of the Affordable Care Act was to achieve basic healthcare for everyone like the many other industrialized nations who have had universal healthcare programs for decades. As Dr. Patterson, the immigrant general practitioner in the suburbs of Atlanta of chapter three stated,

“The Affordable Care Act was devised to provide a gap for the uninsured and those that are insured in order for them to give them access to healthcare... [and] to help remove some obstacles, such as pre-existing conditions, some people had to getting care.” (Patterson 2014)

By these expectations, the Affordable Care Act appears to be marginally successful in its intent, since it made insurance more accessible to the average American through the marketplace, Medicare/Medicaid expansion, and insurance subsidies. As I have discussed, it will continue to require a significant amount of bartering, iterative learning, and money to create effective healthcare reform in America. Clearly, in its current state, America’s reformed healthcare system is by no means a perfect system. Dr. Morrison, the University of Pennsylvania nursing professor, very aptly assessed the numerous contexts that culminated to create the Affordable Care Act:

[The Affordable Care Act] went as far as it could in putting into it not just the provision of health insurance. It put in place a pretty good amount; I would have liked to have seen more provisions that help us reshape how we deliver care. So financing it differently and pushing harder. It did a lot on primary care prevention, more than in the past. What we've given people access to, healthcare, is not the best it ought to be and there still is a lot of inappropriate unnecessary care that drives up the cost of care and doesn't provide good quality, but it put a lot of things in there...[It was] a good first step for a country that had to be brought there screaming and kicking... [It is] built on top of a system that is more costly than it should be because we want to maintain private insurance...I have confidence it won't look like that in ten years. (Morrison 2014)

Other medical care professionals that I interviewed also expressed a similar sentiment. The Affordable Care Act is the beginning of an *attempt* at universal healthcare in the United States. It has been a long time coming and will continue to evolve until legislators figure out what works best for Americans. Unfortunately, its progress was halted by the strong presence of lobbyists who became involved in every aspect of creating the Affordable Care Act. Ultimately, the Affordable Care Act may have satisfied democratic politicians, but the partisan politics and continued widespread criticism are only indicative of a few of the major problems—there are many others yet to be discovered since the Affordable Care Act is a work in progress. Many of the Affordable Care Act's current problems were already an inherent part of American healthcare prior to healthcare reform.

Among its other outstanding problems, the Affordable Care Act fails to deal with adverse selection of certain populations in healthcare (Bream 2014). Although, quality metrics and general advocacy around the importance of the primary care physician were instituted to increase access and quality of care, particularly for

people of low socioeconomic status, the policies instituted have seemingly only served to ostracize physicians and further de-incentivize the treatment of low socioeconomic populations. Limited physician involvement in the creation of the Affordable Care Act is a major proponent of what many have called a very misguided policy. Quality metrics have worked positively in other contexts and countries, particularly in Switzerland where it worked to increase health outcomes of patients. However in the American context, the Affordable Care Act is going to require an adjustment of mindset by American medical professionals, the legal system, and the American general populace on the use of malpractice suits, and a cooperative effort between the American political community and medical professionals to create a compromise that is beneficial to all involved in the healthcare process.

Secondly, the Affordable Care Act fails to truly cater to the low socioeconomic population that is most disenfranchised by the American healthcare system. The political mindset behind the Affordable Care Act was concerned with appeasing the medical industry and the American majority. For this reason, middle and upper class Americans still have pre-reform health insurance schemes, since their access and quality of care were never in question. Taking on the mentality of pleasing those who do not need change in their healthcare experience minimized the task of creating change in low socioeconomic communities interaction with the healthcare system. An example of this pleasing the American majority mentality is providing the healthcare marketplace online. Low socioeconomic populations have a significantly reduced capacity in accessing a computer due to financial disadvantage and in some cases lack the knowledge in how to maneuver the marketplace to

receive the best value (Bennett 2014). In addition, the Affordable Care Act is set up on the premise that providing insurance to individuals is equated with access to care. As Dr. Watson, the Atlanta general practitioner with a varying socioeconomic patient base, pointed out in chapter two, participating in healthcare is complex (2014). If an individual is only interacting with the medical community minimally prior to insurance, his or her perspective on when it is appropriate to seek care does not automatically change. Effecting change in the low socioeconomic persons healthcare behavior requires legislators as well as medical professionals to understand the structural barriers that prevent access to care and compensate for those barriers through relatable campaigns and a relatable medical professional presence in the community—not just top down legislation that is hopefully supposed to promote healthcare.

Thirdly, the Affordable Care Act fails to address the major cost at all levels in the healthcare system. In order to appease the lobbyists, the Affordable Care Act was built on the pre-reform healthcare system that is more expensive than it should be. The same cost practices prior to healthcare reform still exist post “reform”. US lobbying groups made sure that the cost cutting measures that were instituted in Switzerland were eliminated as cost cutting measures in the American system. Although the Affordable Care Act did attempt to make insurance more attainable for people of lower socioeconomic status, the result is that people at up to four times the poverty line are favored over those below the poverty line. According to the Affordable Care Act and as Dr. Watson explained, “they’re [individuals below the poverty line are] too poor to get help [subsidies].” That fundamentally is counter-

intuitive. Additionally, the economic responsibility imposed upon the State and individuals who are not considered to have low socioeconomic status, but are still struggling, has increased. Medicaid expansion is going to place a heavy financial burden on all Americans through taxes and add more strain to already financially strapped states (Bream 2014). Also, people who are currently just getting by are now finding themselves under even more strain. Now they will need to eke out even more money out of their already strapped budgets to pay for the compulsory insurance (Fields 2014).

Finally, and perhaps most importantly, the Affordable Care Act fails to accomplish universal healthcare. There are millions of Americans who are still left out of the system including special exemptions, illegal immigrants, and those who would rather pay the uninsured penalty than pay for actual healthcare coverage.

Due to the fundamental inequalities that exist under American capitalism—and perhaps all societies for that matter—and the increasing income disparities, perhaps the reality is that equality in healthcare is an unattainable task. The wealthy will always have better and faster access to medical care.

Perhaps the key to raising the quality of care and access to care for those who are medically marginalized is to first understand the complexities of their social, political, and economic situations. If these disparities are acknowledged, it appears to me that the United States should embrace the concept of using the majority to pay for the minority. This ‘fact’ is something the creators of the Affordable Care Act began to realize as they imposed taxes on elective cosmetic surgeries and expensive healthcare plans. However, to make the Medicaid expansion more financially

feasible there will need to be a more extensive and sustainable source of revenue. This may mean Americans will have to sacrifice more of their salaries to taxes, as is already done in other industrialized nations like Germany, France, and Great Britain, in the interest of the greater good—the right to healthcare. The reality is that in a nation that promotes neoliberal and capitalist concepts on every sector of its economy and attempts to promote these same concepts on a global scale, raising taxes for malign entitlements is highly unlikely. It is fundamentally un-American. The United States has overcome a major hurdle by passing extensive healthcare reform, but it is the continuing discourses of how the system can be further improved considering all of the variables, that will help Americans figure out what works best for them.

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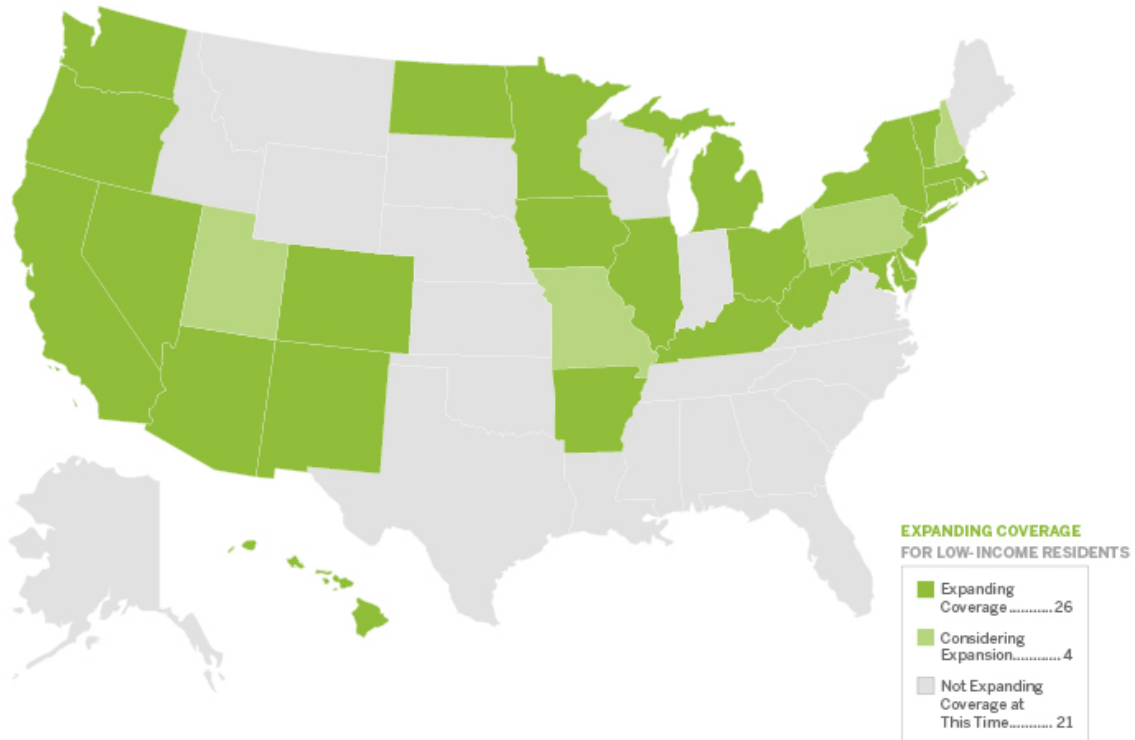
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Figures

Where the States Stand on Medicaid Expansion 25 states, DC, Expanding Medicaid—February 7, 2014



Notes: Based on literature review as of 2/7/14. All policies subject to change without notice.
HHS has announced that states can obtain a waiver to use federal funds to shift Medicaid-eligible residents into private health plans.
The District of Columbia plans to participate in Medicaid expansion and will operate its own exchange.



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Figure 1. (The Advisory Board Company 2014)

Tables

WHO Ranking vs. Percent of Gross Domestic Product Related to Healthcare

Nation	WHO ranking for healthcare	% Of GDP related to healthcare 2011(OECD)
France	1	11.6%
Switzerland	20	11.0%
Germany	25	11.3%
United Kingdom	18	9.4%
United States	37	17.7%

Table 1. (WHO 2010) (OECD 2011)