Health and Healthcare

With the shootings and poisons in our foods and failing environments, we need good healthcare, right? The U.S. has some of the best hospitals, doctors, medical research, pharmaceuticals and care anywhere. Wealthy folks from around the world often choose treatment by U.S. experts, because they can afford it and want the best specialized treatments available anywhere. At the same time, in 2018, 29 million U.S. people were uninsured for health care, up 1.4 million from 2016,577 excluded because they need care that would eat into profits, or because they can’t or will not afford it. Many U.S. people are not healthy.

The U.S. healthcare system is the most expensive in the world; its costs are rising faster than most; and its performance is worst compared with other developed Western nations.578 579 We spend $10,224 $10,224 per year per capita for health care, up from $146 per person in 1960,581 (a 6,903% increase) twice the average of other industrialized nations,582 more than any other nation as a percent of GDP, at 19%.583 We spend $3.3 trillion584 (328% of FADS) on healthcare in the U.S., 1 in every 6 dollars in the economy. That’s $1.9 trillion (164% of FADS) more than if we had healthcare like the other developed nations, almost two-thirds more than our Federal Government decides how to spend in a year. Daayam!

The U.S. healthcare system is the worst performing of developed nations overall, and for healthcare outcomes, access and equity.585 It has highest or near-highest rates of infant mortality, obesity, heart and lung diseases, STDs, and disability.586 It is 42nd in life expectancy, 48th in maternal mortality,587 a maternal mortality rate twice Canada’s, three times Italy’s.588 It’s last in most healthcare performance measures, compared to Australia, Canada, Germany, Holland, France, New Zealand, Norway, Sweden, Switzerland and the U.K.589 Half of U.S. adults have high blood pressure.590 The #3 cause of death in the U.S. (after heart disease and cancer) is something that happens to us in the U.S. healthcare system.591

Besides Mexico and Turkey, the U.S. is the only industrialized nation that doesn’t guarantee health care access for its people.592 It’s so unaffordable, 30 million people under 65 (10%) don’t have insurance.593 45,000 people a year in the U.S. die from lack of healthcare.594 In 2016, 114 million people in the U.S. (35%) didn’t have dental insurance,595 and many who do still can’t afford needed dental work. Veterans with physical, emotional and psychological problems often don’t get good medical support services.596

20% with health insurance still can’t pay, and 60% of those use most of their savings on medical bills.597 Medical debt is the #1 source of personal bankruptcy filings,598 part of half of personal bankruptcies.599 25% of senior citizens declare bankruptcy, and 40% mortgage or sell homes due to medical expenses.600 1 in 5 U.S. adults has big problems paying medical bills, more than 2X the next highest country’s rate.601 24 million (10% of) U.S. adults carry medical debt from the prior year.602 That makes medical problems?

31 million U.S. people are underinsured. They have policies with high deductibles and/or co-payments. That makes it more affordable to have health insurance to protect against catastrophic loss, which may result in bankruptcy, but it leads underinsured to forego medical exams and treatments to reduce out of pocket expenses for healthcare, and results in inadequate health care and poor healthcare outcomes.603

Those with good insurance are more likely to get lots of medical services, because it doesn’t cost more. Insurers reduce this through cost sharing tactics like co-pays and deductibles. If patients have to pay more out of pocket, they’re less likely to choose to get medical services. Those with higher deductibles or coinsurance rates consume less health care. That often leads to people to forego preventative care, to save money, leading to late diagnosis of easily treated diseases and more expensive problems later.
Healthcare system costs are crippling for many businesses and households, not affordable for too many. Because of that, many employers try to avoid paying for medical insurance for their employees. High employee medical insurance costs can be the difference between a viable and a non-viable business. Many people in the U.S. feel stuck in their jobs, because they’re afraid of losing their medical benefits. Many take jobs based in part on medical insurance coverage. Some choose desperately to commit crimes and be imprisoned, because that’s the only way they can get medical care. High medical insurance costs increase further with age, making those costs a huge deal for older and retired people.

Per capita, the U.S. spends the most on pharmaceuticals of any nation, by far. Drug companies charge extremely high “market” prices for drugs in the U.S. They claim that’s to recover high costs for R&D to discover and get approval for drugs, which is true; and to negotiate higher prices with lots of smaller insurance companies, which they do; all to make up for lower margins on drug sales in other countries where national systems negotiate lower prices, which those can and do. They’re also covering very high marketing and advertisement costs. The U.S. is one of two developed nations allowing costly direct-to-consumer prescription drug product ads in newspapers, magazines, and on the Internet and T.V.

U.S. drugs would not have such stratospheric prices unless drug companies were focused on maximizing profits for owners, exploiting monopoly intellectual property rights, doing things like raising a drug’s price 97,000% and bribing doctors to prescribe it, or charging $225,000 a year for heart medication. Our drug companies spent $3.9 billion in the last 20 years, more than any other industry, for lobbying, to influence government, for example, to stop single-payer health insurance, prevent insurers from negotiating lower drug prices, and reduce oversight trying to verify their drug efficacy and safety claims. They have big sales operations to seduce and convince doctors to promote and prescribe their wares. Their profit maximization motive often incents long-term symptom treatments over actual cures.

Doctors’ offices also focus on maximizing owner profits, with assembly line operations measuring time doctors spend with patients in small increments of minutes, since increased line rates increase profits. That gives doctors maybe 10 minutes to look at a patient history, interview and evaluate them, and prescribe a treatment, usually a drug focused on symptom relief. Effective treatments may not be used, because insurance companies may only pay for more profit-maximizing but less effective treatments.

Fortunately, the human body heals itself of most problems. How much money can healthcare providers get for services authorized by the insurance company while the body does that? Can they get away with expensive tests, to recover costs for expensive machines they bought, or to cover tails against litigation? Specialists charge even more for their services, because there’s less competition for them.

Patients with “good” (more expensive) insurance can get more and better services, doctors and drugs. So, good insurance often governs whether someone gets treatment that actually helps their problems. Those with good insurance may get excessive tests or treatments, because providers get paid for them, and to protect them from malpractice claims, because those with good insurance can get good lawyers. U.S. people get cancer screenings at much higher rates than people in other developed countries, and expensive MRI and CT scans at the highest rate of any OECD nation. Antibiotic prescriptions in the U.S. are 25% to 75% unnecessary, contributing to resistant super-bugs. That drives up costs.

There are so many insurance companies, providers, consultants and others in the healthcare system, and their operations and interactions are so different and complex, 25% to 30% of U.S. healthcare system costs go to administration, almost twice that of Canada’s nationalized, single-payer system.
Massive and growing numbers of healthcare industry employees are clerks and administrators who bill patients; track payments; correspond and negotiate with insurers, service providers and patients; “code” medical treatments in billing and administration systems; study complex insurance policies; create, authorize and deny services; manage and operate complex computer systems and networks to manage complex medical system functions; construct complex legal language; comply with regulations and medical recordkeeping requirements; dispute bills; and deal with litigation.

Healthcare providers and insurers negotiate privately. Prices often vary between providers and insurers for the same services. The variation in prices isn’t a result of quality of care, but of market leverage. Managing the myriad different deals in play greatly increases overall costs.

U.S. healthcare has lots of federal and state regulation, much of which arose haphazardly and reactively to curb abuses. That regulation requires all kinds of administrative record-keeping that is expensive, but much of the oversight of those rules is left to provider self-policing, or expensive litigation.

Health insurance coverage for large employers has the lowest administrative costs per person, maybe 9% of premiums, versus 11% of premiums for small groups, and 16% for individuals. Partly, that makes healthcare more affordable per person for those employed by large companies. Administrative costs by physicians, hospitals and other healthcare providers is often more than 20% of healthcare spending. 616

Drugs, expensive equipment, administration, inefficiency and profits are primary factors making U.S. healthcare so expensive. Patient care suffers, because doctors and nurses must spend increasing time and effort on administrative requirements. In some cases, nurses spend half as much time caring for patients as a few decades ago, or in other countries, because they spend so much time doing charting, doing medical coding, or in other administrative functions. Problems with health care coordination across the many parties affect about 40% of patients. 20% of doctors report having patients repeat tests because they can’t find test results during a scheduled visit. 617 Those inefficiencies raise costs.

People without insurance have no choice but to go to hospital emergency rooms for treatment when it gets really bad, where charges are outrageously expensive, $5,500 to sit there, $60 for ibuprofen, $143K to a 9-year-old for snakebite treatment, $40K for scorpion antivenom that’s $100 in Mexico. 619

That can bankrupt many quickly, creating ruin and homelessness. Hospitals must provide healthcare to all in emergency rooms, even if patients can’t pay. Half of U.S. emergency care is not compensated. 620 For patients bankrupted or determined unable to pay, costs are passed on to taxpayers, or passed to other patients in raised premiums and charges. That’s led to emergency room closures, to prevent loss.

So, the poorest get only basic care for only the most desperate emergencies, consuming all or most of their wealth, and leading to financial, emotional, psychological and social problems, which are ultimately paid by taxpayers and the medical services paying public, at the highest possible overall costs to society.

Because the U.S. is racially unjust in socioeconomic distributions, 621 with more people of color in poverty or near it, healthcare availability is unjust. Higher proportions of minorities don’t have adequate healthcare or insurance. 622 Blacks are 40% less likely to be given medication for pain than whites. 623

Health insurance is simple, conceptually. Individuals risk financial ruin from accidents and illnesses. If all pool together, putting relatively low amounts into a pot of money to pay costs for whoever needs care, each can get needed care without being ruined, reducing worry and stress.
At the end of the year, costs for all services are tallied up. If we paid too much, we get a refund. If we didn’t pay enough, premiums are increased to make up the difference. Everyone is covered; everyone is relieved from stress; and all prosper as a result. AAA is a good example of insurance working well.

However, in the U.S. most insurance companies are run for profit maximization, rather than just to enable the population to spread its risks and reduce its worries. Insurance companies use underwriting processes to determine who might actually need healthcare services and prevent them from joining the pool by denying them insurance coverage. To make profits, charge as much as possible and pay as little as possible. Accept those who are healthy and can pay, and exclude those who are unhealthy or can’t.

So, people with preexisting conditions, problems needing medical care, are excluded or only allowed insurance if they pay even higher premiums. Before Obamacare, 1 in 7 U.S. people were denied health insurance because of pre-existing conditions, serious things like arthritis, cancer or heart disease, but also common things like acne, being 20 pounds underweight, or old sports injuries. Many with easy to fix problems ended up with worse problems, even becoming disabled and unable to contribute, bankrupt and a financial burden on society, because they were excluded from medical coverage by profit-seeking insurance companies. Now, they aren’t, but many are trying to kill Obamacare.

The U.S. healthcare system performs poorly with mental illness, with repercussions rippling out through society and the economy. The U.S. Surgeon General found mental illnesses are the 2nd leading cause of disability in the U.S., affecting 20% of people. Less than half with mental illness get ongoing care. Most just get quick drug prescriptions. Social stigma fears keep many from seeking care. Many with mental illnesses self-medicate with street drugs, contributing to massive U.S. drug addiction problems. Many with mental illnesses land in the criminal justice system, where they cost far more to imprison and abuse than to treat their problems. 65% of non-metropolitan U.S. counties have no psychiatrists.

U.S. disability rates are high and growing, much related to stress. Back and neck pain, depression, musculoskeletal disorders and anxiety cause the most disability lost years. The healthcare system does a poor job with these problems, in part because it has little ability to reduce people’s stress, much of it socioeconomic. With 55% of its people in high stress, the U.S. ties for 4th place globally for high stress, with Albania, Iran and Sri Lanka. U.S. suicide rates increased 30% from 1999 to 2016. More since.

Healthcare is so inefficient and broken that mistakes are made daily. That creates opportunities for lawyers to sue healthcare providers and insurance companies, which happens daily, often seeking big punitive damages. The wealthy are more likely to succeed in these lawsuits, because they can afford better lawyers. The poor can’t sue, because they can’t afford the lawyers, unless the case is winnable enough for a lawyer to take it on speculation, being paid from the winnings. That is social inequity.

Suits are so rampant that healthcare providers are paranoid about them. That drives up costs, because they have to implement “cover your ass” procedures to protect against litigation and buy expensive insurance to cover them against litigation costs. All of that drives up costs hugely.

Doctors are systematically corrupted. It can take hundreds of thousands of dollars and many years to become licensed. It’s hard. Residency requirements force days of work with little sleep in hospitals. When it’s done, doctors need a lot of money to pay for expensive educations and malpractice insurance, and develop a sense of entitlement to make lots of money, and big egos, in some cases causing them to ignore or disparage the opinions of nurses who spend time with patients and provide patient care.
In general, U.S. healthcare is reactive. It’s designed to respond to business demand for treatment of illness and injury symptoms, while maximizing profits. There is little incentive to create programs to help people be healthy. 1/3 of adults[^632] and 1/5 of children[^633] are obese, which leads to diabetes and many other health problems. Little is done about that. There’s less money to make on healthy people.

An environment of guns, poisons, terrible food, unhealthy lifestyles and other illness producers is good for healthcare businesses. There’s little effort to reduce environmental problems, gun control, improve food, or incent healthy lifestyles, because no big money advocates for those with corrupt governments. There’s big money advocating for and protecting for-profit medical and healthcare insurance businesses. Politically, it seems to be almost impossible to improve health systems in the U.S., because anything that really improves health or reduces expense for healthcare harms some special interest’s profit prospects.

Federal, state, county and city governments own some U.S. facilities, but most of the health care system is privately owned. Special interest insurers, hospitals, doctors, pharma companies, medical billing and testing companies, software companies, and others devote big money, lobbying and manipulation efforts to keeping the system broken, so they can continue to exploit the brokenness to make money.

The complexity and chaos of the system leads to all kinds of problems. So does the proliferation of information, marketing and social media noise. People are confused about healthcare. Ads and all kinds of stuff on the Internet create anxiety and lead to real or imagined health problems. Trust in doctors and the healthcare system is compromised. One in four patients now believe their doctors have exposed them to unnecessary risks, based on things like self-help books and web posts[^634].

The U.S. healthcare system’s brokenness is obviously exceptional and harmful. It defies common sense. It hurts so many people. It is bankrupting our society. It is killing businesses. It is killing human beings. It must change, or it will eventually collapse society as it continues its cancerous growth.

Some of that’s on us, though. <1 in 3 in the U.S., 1 in 5 teenagers, meet U.S. physical fitness guidelines, achieved with 150 minutes of moderate-intensity aerobic and 2 sessions of muscle-strengthening activity per week for adults, and 1 hour of moderate-intensity aerobic activity per day and 3 sessions of muscle-strengthening per week for children. (Those guidelines were just eased by eliminating that physical activity should occur in 10-minute blocks, because people in the U.S. were having trouble doing 10 minutes of exercise at a time.)[^635] Really? 40% of adults and 19% of kids are epidemically obese.[^636]

It doesn’t make sense for our healthcare system to ruin us financially and cause healthcare problems. Share information about this problem! We each have the power to change our thoughts and behaviors. We can take charge of proactively producing and managing our own good health. Take more vacations! Eat healthy organic foods from quality permaculture operations! Drink healthy water! Exercise more! Get out in nature and develop a personal relationship with it! Find less stressful livelihoods! Feel good! Get out of polluted environments, and do what you can to clean up environments! Have more fun!

Write letters about this to government representatives, even if you think it won’t make a difference! Write to healthcare providers and insurers explaining why you will not be doing business with them! Stay out of the healthcare system as much as possible! Be your own advocate within the system! Reduce life stress and slow down! Join the gym, walk and run, and get massages! Get enough sleep! Share love and support with others in close, caring relationships and communities! Find real growth! Get away from screens! Find a way to be fulfilled! Don’t let bad healthcare create bad health! Change!
Endnotes

588 “Global Health Observatory (GHO) data: Maternal mortality ratio (per 100 000 live births), by WHO region, 2015”, World Health Organization, http://apps.who.int/gho/data/node.sdg.3.1-viz?lang=en
591 “The third-leading cause of death in US most doctors don’t want you to know about: A recent Johns Hopkins study claims more than 250,000 people in the U.S. die every year from medical errors. Other reports claim the numbers to be as high as 440,000.”, Ray Sipherd, CNBC.com, Updated February 28, 2018, https://www.cnbc.com/2018/02/22/medical-errors-third-leading-cause-death-in-america.html
594 “Yes, People Die When They Don’t Have Access To Health Care: One study in 2009 found 45,000 people died every year for lack of health insurance”, Arthur Delaney, May 8, 2017, The Huffington Post, https://www.huffingtonpost.com/entry/people-die-without-health-care_us_5910b4e8e4b0104c7351257b
598 “This is the No. 1 reason Americans file for bankruptcy”, Maurie Backman, The Motley Fool, USA Today, May 5, 2017, https://www.usatoday.com/story/money/personalfinance/2017/05/05/this-is-the-no-1-reason-americans-file-for-bankruptcy/101148136/
We Can Change Our Wicked Problems!

Source: www.WeCanChange.US

---


610 “Pfizer gets U.S. approval for $225,000 a year heart drug”, Michael Erman, Reuters, May 6, 2019, https://www.apple.news/A6PJRsZw2Q4O_XY42lILxug


618 I read 1,182 emergency room bills this year. Here’s what I learned. A $5,571 bill to sit in a waiting room, $238 eyedrops, and a $60 ibuprofen tell the story of how emergency room visits are squeezing patients”, Sarah Kliff, Vox, December 18, 2018, https://www.vox.com/health-care/2018/12/18/18134825/emergency-room-bills-health-care-costs-america


621 See the chapter on Income and Wealth Inequality

“Black Patients Are 40% Less Likely Than White Patients to Get Pain Meds From EMTs: EMTs and paramedics may be treating minority patients differently from the way they treat white patients, a new study suggests.”, Kristian Foden-Vencil, Oregon Public Broadcasting, Men’s Health, January 14, 2019, https://www.menshealth.com/health/a25893665/pain-meds-racial-bias-paramedics-emts-emergency-care/

“Before the ACA, 1 in 7 people were denied coverage because of pre-existing conditions. Today: none”, November 7th, 2015, HealthNetwork, https://healthnetwork.com/blog/before-the-aca-1-in-7-people-were-denied-coverage-because-of-pre-existing-conditions-today-none/


