

# How Can We **SOLVE** Our **SOCIAL** **PROBLEMS?**

THIRD EDITION



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# 10

## How Can We Solve the Problem of Health Care?

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**H**ealth care is an immensely difficult problem in our society. Every industrialized country except the United States provides national health care for all of its citizens (Kerbo, 2012). Until the passage of the Affordable Health Care Act, there were 50 million American citizens, that is, roughly 1 of every 6 Americans, who had no health care insurance coverage.<sup>1</sup> So, this means that when people who did not have health care insurance became sick or had a toothache, it would cost them a lot more money to see a doctor or dentist than it would cost those people who do have health care insurance. As a result, they would be more likely to put off going to the doctor or dentist or not get any medical help at all.<sup>2</sup>

Employers that helped pay health care costs for their employees were finding that, because of rising health care costs, they were less competitive than (1) U.S. companies that did not provide coverage and (2) foreign companies that did not provide health care benefits (Durbin, 2005; Maynard, 2006; Reid, 2009). Because the costs of health care insurance have been increasing, more and more employers have been finding that they cannot afford to provide health care coverage for their employees (Reid, 2009). As a consequence, all through the late 20th century and into the 21st century, employees have been having a harder time finding and paying for their health care.

Until the Affordable Care Act was passed, many retired people living on moderate to lower incomes needed to use more and more of their retirement incomes to pay for prescription drugs (Carroll, 2003). Also, another problem

we have had is that poor people who were on Medicaid (the government health care program for the poor) still might not receive health care due to low reimbursement rates provided to doctors. (Yetter, 2005).

In short, we have had many problems with our past health care system. Let us look at our past problems, then see where we are today, and then see where we could go in the future to create an excellent health care system for all Americans.

## Consequences of Our Problem

For many decades, our country has resisted going to a health care system that includes all Americans, beginning with President Harry Truman who tried and failed to create such a health care system (Espo, 2009). The result has been that millions of Americans have gone without any health insurance and hence have put off going to doctors and dentists until their situations were so serious that they could not do so any longer. The consequences for these sick individuals have been that (1) they were in much worse health, (2) they endured needless pain and discomfort, and (3) many of them, over 20,000 Americans, died each year from treatable diseases but had no health insurance and therefore could not afford to go to the doctor (Reid, 2009). Adults missed work and lost pay while their employers lost profit. Students of all ages missed school days, were in danger of getting lower grades, and could not participate in school activities. A sad example of this occurred in the state of Kentucky in 2005 where 338,000 Kentucky children never saw a dentist that year (Yetter, 2005, pp. A1–A2).

There are a number of reasons why these children did not receive dental care. First, more than half of the dentists in Kentucky did not treat people who were on Medicaid because the dentists believed that they did not get reimbursed enough from Medicaid to cover their expenses (Yetter, 2005). Second, because parents on Medicaid are poor, many times they did not have the means of transportation to get to those dentists who are willing to treat their children (Yetter, 2005). Third, many parents worked at jobs in which it was difficult to get time off from work, or they were not permitted to leave work in order to take their children to the dentist (Yetter, 2005). Fourth, even in those cases where parents were allowed to take time off from work, many times they would lose pay that they could not afford to lose, especially when they made low wages (Yetter, 2005).

Without a health care system that covers all Americans, there have also been negative consequences for the elderly in our country. The elderly, especially those who had moderate to lower incomes, needed to use a considerable

portion of what little Social Security income and retirement income they had to pay for monthly prescription drugs, which meant that they had less money left over to pay for food, rent, transportation, and other expenses (Carroll, 2003). Due to the high cost of drugs in the United States, a number of Americans have purchased drugs from Canada through Internet sites.<sup>3</sup> As you can see, there has been a serious conflict of vested interests (see our theory and causal model in Chapter 1) between the elderly who need prescription drugs at lower prices because these prices take so much of their retirement incomes and the drug companies who argue that they need to charge higher prices because of the cost of doing research on new drugs.<sup>4</sup>

There have also been consequences for many U.S. companies due to our lack of a comprehensive health care system that covered all Americans. By paying for health coverage of their employees, companies have had to add on to the prices of their products, making their products less competitive in the marketplace, especially compared with foreign companies that did not have to pay for health insurance because their governments paid for such coverage.<sup>5</sup> For example, it was estimated that General Motors needed to add \$1,500 to the price of each car to pay for its employees' health care coverage.<sup>6</sup> Also, because of rapidly rising health care costs, American corporations had to cut back jobs. For example, General Motors announced in November 2005 that it was cutting 30,000 jobs in North America by 2008 (Durbin, 2005; Maynard, 2006). The result has been that American corporations have been less competitive, and American workers have lost jobs due, in part, to health insurance costs. Consequently, for a number of different groups in our society—the poor, children of the poor, the elderly with moderate to lower retirement incomes, employees in companies with no health care, and corporations who have tried to provide health care—there have been many unfortunate consequences of our health care system.

There has also been, as you might well predict, a relationship among one's income, one's health, and one's health care coverage. Kerbo (2012) asserted that "good health is to some degree unequally distributed through the stratification system" because "adequate health care is unequally distributed" (p. 40).<sup>7</sup> Once again, we see how one social problem, such as much inequality of money, power, and prestige (see Chapter 3) is connected to another social problem such as little or no access to health care. As we can find ways to decrease the social problem of much inequality, we can also address another social problem such as the health care of people.

A final consequence of the health care system of the 20th and early 21st century was that Americans faced the constant pressure of rising health care costs. Although this affected everyone, it affected Americans with less



income more harshly. For example, from 2004 through 2009, yearly health care costs always increased more than the yearly rate of inflation (see Table 10.1). Notice that in column 3, yearly health insurance premiums (what people pay for health insurance) always rose faster than column 2, yearly inflation rates. Also, notice in column 4 that the premiums increased from at least 1.2 times the inflation rate to 9.9 times the inflation. So, the health insurance companies were always increasing their prices more than the inflation rate. With regard to the implementation of the Affordable Care Act, by 2014, the exchanges were up and running. Data in Table 10.1 suggests that, in 2014, the yearly premiums were increasing at a rate of only 3%; so, the premiums were only 1.9 times the inflation rate for that year. This is data for only one year, but if these statistics continue, then the rise in premiums could be less as the Affordable Care Act gets more established.

**Table 10.1** Health Insurance Premium Increases Always Higher Than Yearly Inflation Rates (2004–2014)

Year	Inflation Rate (%)	Yearly Premium (%)	Times the Premiums Are More Than Inflation Rates
2004	2.68%	9.7%	3.6 times
2005	3.39%	9.3%	2.7 times
2006	3.24%	5.5%	1.7 times
2007	2.85%	5.5%	1.9 times
2008	3.85%	4.7%	1.2 times
2009	−.62%	5.5%	9.9 times
2010	1.6%	3.0%	1.9 times
2011	3.2%	9.5%	3.0 times
2012	2.1%	4.5%	2.1 times
2013	1.5%	3.8%	2.5 times
2014	1.6%	3.0%	1.9 times

*Source:* Compiled from “Current U.S. Inflation Rates: 2005–2015” (2015) and “Premiums and Worker Contributions Among Workers Covered by Employer Sponsored Coverage, 1999–2014” (2015).

## Why Don't We Have a Health Care System That Covers All Citizens Like All Other Industrial Nations?

There are a number of reasons why we do not have a health care system for all Americans. The main reasons seem to boil down to the following: (a) the vested interests of maintaining the current health system, (b) the desire to maintain political power, (c) the ideology of individualism that we have created in our country (again, refer back to our theory and causal model of conflict and social change in Chapter 1), (d) the fact that many Americans currently have access to excellent health care, and (e) the fact that most Americans do not know much about possible alternatives to our current system.

### Vested Interests

Doctors, dentists, drug companies, hospitals, and health insurance companies want to make money. The current health care system results in doctors and dentists earning high incomes and health insurance companies, drug companies, and hospitals making profit. Vested interests—that is, what benefits a certain group of people—can be an extremely strong barrier to almost any kind of social change. T. R. Reid (2009) notes, “The vested interests that are doing well in the health business now—insurance companies, hospital chains, pharmaceutical companies—have blocked significant restructuring of our system” (p. 22). Or, as Daniels, Light, and Caplan (1996) put it, “The failure of national health care lies in the fact that comprehensive reform threatens powerful, wealthy interests” (p. 17).<sup>8</sup>

Let us take the example of drug companies versus the elderly and the price of prescription drugs. Due to the high cost of drugs produced in the United States, more and more Americans have been buying their drugs from Canadian companies. Moreover, a national poll found that 70% of respondents agreed that “it should be legal for Americans to buy prescription drugs outside the United States” (Lester, 2003, p. A5). U.S. drug companies have been fighting to keep the importation of prescription drugs from other countries illegal, arguing that U.S. drug companies need to recover the costs of doing research to create new drugs, and that drugs from other countries could be “unsafe” (Carroll, 2003, p. A7). The “unsafe” argument is probably not a valid one given that “Canadian authorities subject all drugs sold in the country, including those made in the United States, to testing similar to that conducted by the FDA [U.S. Food and Drug Administration]” (p. A7). As you might expect, there is disagreement over whether and how much money

drug companies need to be able to do research on new drugs and how much profit they make. The drug companies say that the average cost to do research on a drug is \$800 million (Carroll, 2003). Hence, they say they need the higher prices on their drugs to make up for expensive research. Anne Northup, a former Republican congresswoman from Kentucky who supported the importation of prescription drugs to decrease drug costs for Americans said that, on the contrary, drug companies are making 18% profit after paying their taxes—“a breathtaking amount of profit” (Carroll, 2003, p. A7). From a profit point of view, why would drug companies want to change the American health care system as long as they are making that much money?<sup>9</sup>

Assuming that this situation is a key barrier to any change in the health care system, we will need to address this impediment in some kind of equitable and fair way such as decrease the costs for drugs but provide reasonable compensation to drug companies.

In addition to the profit concerns of drug companies, the income concerns of doctors under a possible national health care system would also need to be addressed. For example, evidence from a study conducted on Canadian physicians found that when these physicians are paid well, they are less resistant to a national health care system (Globerman, 1990). Reaching an equitable and fair situation with doctors will also require considerable national discussion in our country. Most Americans highly regard doctors and dentists and medical personnel in general because of their years of training and education, their expertise, and their ability to decrease the pain and suffering in the rest of us and the ability to cure many of us. So, for most Americans, we want to compensate these medical personnel appropriately.

Another huge vested interest has to do with American health insurance companies. They are for-profit companies that make a lot of money selling health insurance to the rest of us. Consequently, they have a huge vested interest in not wanting the American health care system to change if it means that health insurance companies no longer get to make big profits. Furthermore, they definitely do not want to have a health care system that provides health care for all Americans but is run and paid for by the government through taxes, which would cut them out altogether from being in business and making a profit. So, either a government run or a nonprofit insurance company run health care system could be much cheaper and could include all Americans; this would cut out profit making for insurance companies. Hence, the health insurance companies would not want such a change. Moreover, given that they can give a lot of money to members of the U.S. Congress to vote against any health care system that becomes a nonprofit system and given that they can spend millions of dollars on television and

newspaper ads being against any government-run or nonprofit run health care system, this means, or has meant so far, that the alternatives of either a government-run system or a nonprofit-run insurance system have not been considered (for an extended discussion, see Brill, 2015).

## Political Power

Fear of losing one's political power is another barrier to creating a comprehensive health care system for all Americans. Presidents and members of Congress attain their positions of power in government, in part, through the large contributions of wealthy and powerful health insurance and drug companies. As you might predict, the more this relationship occurs, the less these politicians want to "bite the hand that feeds them," that is, the less they want to risk losing contributions and therefore risk losing their political office (again, see Brill, 2015, for an extended discussion of the politics and political power that go into the making of an American health care system).

People who want to be in Congress or be President or members of Congress who want to remain in Congress need lots of money to get elected and re-elected. As Weber ([1914]1968) and Marx and Engels ([1848]1992) noted, more than 100 to 150 years ago, money and power tend to be closely related. In the cases of Congress and the President (as well as state offices such as the governor, state senator, and state representative offices), substantial money is needed to gain and retain office and therefore political power. Some of the people and organizations with a lot of money in our country are doctors, dentists, drug companies, hospitals, and health insurance companies. Doctors and dentists can make \$300,000, \$400,000, and \$500,000 per year and drug companies, hospitals, and health insurance companies can make millions of dollars, hundreds of millions of dollars, or even billions of dollars per year. Hence, these individuals and organizations can have a big influence on who gets to be in political positions and have political power in our country. Hence, they influence legislation that is favorable to their vested interests. As a result, money, political power, and the kinds of laws and social policies that we have can be, and many times are, closely tied to each other—that is, money, leading to political power, leading to certain laws and certain social policy.

## Ideology

To understand the third reason why we do not have a health care system for all Americans—ideology—we need to refer back to the beginning of our country. Historically, our early American ancestors did not want monarchies



to rule us, they did not want governments to grow too big and intrude into our lives, and they did not want a feudal caste system in which people could not move up and down the social class system (however, our country did institutionalize such a caste system for African Americans in the form of slavery and later in the form of legalized segregation and discrimination, and we also accepted many traditions of Europe where males ruled and did not allow women to be upwardly mobile). Our ancestors began to construct a new social reality<sup>10</sup> that tended to emphasize more individualism, getting ahead, having the chance to be upwardly mobile, being more industrialized, being more urban, and being a more capitalistic nation. Such a view of life has meant that we have been slower to accept government programs and services than have people in European countries. This belief system where we emphasize more individualism and less reliance on the government has been a significant barrier to our having a health care system for everyone. People in European countries and elsewhere have grown up relying more on their respective governments and therefore have more easily accepted and viewed some kind of a national health care system as normal and to be taken for granted. We can therefore see how ideology can play a significant role in creating laws and social policy and, hence, in solving our social problems.

### Excellent Care

A fourth reason we do not have a health care system that covers every American is that many Americans already have health care. Many of us have nice homes and cars, we live in nice neighborhoods, we send our children to good schools, we take nice vacations, we have enough money to pay our bills, we have plenty of food, we have all kinds of options for recreation and leisure activities, we can go to shopping malls that are filled with all kinds of things to buy, we can purchase new technological innovations that are continually coming onto the consumer market, and so on. In other words, many Americans live a very good lifestyle. Moreover, many of us have excellent health care coverage provided by our employers and our own monthly payments. Given such an ideal situation, why would we be concerned about health care? We have excellent health care. Like other problems, if we are not personally bothered by them, we tend to take less interest in them—whether the problem is poverty, inequality, discrimination, or lack of health care.

### Lack of Knowledge

Finally, a fifth reason we do not have health care for everyone is a lack of knowledge. That is, we Americans do not know much about how health care

systems work in other industrialized countries. Other than hearing a little about Canada having lower prices on prescription drugs than the United States, we know little or nothing about other health care systems with which to compare and discuss various options. Many times, when people do not know much about something, they fear the unknown. Instead of being able to seriously consider various health care options based on knowledge, we base our decision making on how we benefit from our healthcare system but do not know how we might benefit from other healthcare systems, for example, being accepted for health care even if we have a pre-existing health condition, always having access to health care even when we move from one job to another job or have no job or regardless of how serious and expensive our illness is, we do not go into debt—all of these benefits that people in other industrialized countries have had, but we in America have not had.

If Americans can acquire knowledge about elements of health care systems from other industrialized countries, such as Germany, Canada, and Great Britain, and then can discuss the pros and cons of these elements, we would have knowledge that could relieve our fears about the unknown, and this knowledge could help us consider new ways of having a more comprehensive and yet less costly health care system. Until we have this knowledge, we will be ambivalent about trying anything new and different and hence will conclude, “It is better to stay with the known”—even though the known may not be the best for us.

In short, the vested interests of wanting to make much money, the desire to maintain political power, the ideology of individualism and the belief that we should not rely on the government (or should rely on it as little as possible), the fact that many Americans already have excellent health care, and limited knowledge about other ways we could have a health care system together present formidable barriers to our having a good health care system for all Americans. However, if we can overcome these barriers, we may have a chance to create a health care system that covers all Americans and yet is less costly.

### **Criteria for Health Care System for All Americans**

No one knows exactly what an American health care system that covers all Americans would look like. Assuming that we create such a system, it would be unique. It could take on elements from other countries, such as Germany, Canada, and Great Britain (more about these countries later). Because these nations are also democratic, are predominantly capitalistic, and have high standards of living, and because they already have health care systems that

cover all of their citizens, we could borrow various elements of their health care systems to create our own unique system.

Although no one knows what such a health care system would look like, we can develop criteria that we might want in a new system and discuss how we might implement these criteria:

1. Americans will receive health care based on their health care *needs* instead of their *ability to pay* for health care.<sup>11</sup>
2. All Americans will be covered by this new health care system.<sup>12</sup>
3. All Americans will receive good-quality care.
4. All Americans will receive care in a timely way.
5. An integral part of the health care system will be an emphasis on preventing illness by creating incentives and providing education for people to live healthier day-to-day lives, thereby decreasing the cost of the health care system.<sup>13</sup>
6. An integral part of the health care system will be an emphasis on preventing illness by providing periodic checkups so that potential illnesses can be caught early, thereby decreasing the cost of the health care system.
7. Americans live not only healthier day-to-day lives but also happier day-to-day lives.
8. Doctors, dentists, nurses, and other health care personnel are reasonably paid for their education, training, and expertise.
9. Drug companies are reasonably paid for their products and the research required to create these products.
10. Health insurance companies that could be harmed by the loss of business resulting from a new health care system will be reasonably compensated so that they can move into other areas of insurance or other areas of business.<sup>14</sup>
11. For-profit hospitals and hospital chains can choose to run their hospitals for a reasonable amount of compensation from the government or to sell their hospitals to the government for a reasonable amount of compensation.
12. Americans create a health care system where the costs are comparable to the costs that occur in other industrialized countries.

## How We Could Implement These Criteria

Given the preceding criteria that we would want to have in a health care system that meets the health care needs of all Americans, let us now discuss how we might implement these criteria.

## Buy in Bulk and Use Competitive Bidding

One element of our current health care system that could be used nationwide is what the Department of Veterans Affairs (VA) is currently doing with millions of American veterans of military service (Pear & Bogdanich, 2003; Weigel, 2006). The VA saves a lot of money in buying its drugs for our veterans “through bulk purchasing arrangements—using generic drugs where possible—and competitive bidding” (Pear & Bogdanich, 2003, p. A7). That is, instead of veterans buying drugs at high prices in drugstores, the VA has drug companies bid on which companies will provide particular drugs at the lowest prices. The VA buys these drugs at much lower prices and, in turn, provides these drugs to the veterans who “pay just \$7 for up to a 30-day prescription” (Pear & Bogdanich, 2003,). If we used this same strategy for all Americans where the federal government (1) bought drugs in bulk, (2) used generic drugs where possible, and (3) had the drug companies bid on drug contracts, the costs to the federal government would be less and taxes would be less. The drug companies selling the drugs would still make a profit—although not as much profit as they do in the current health care system. By using this strategy, we could satisfy some of our criteria, such as (Criterion 9) allowing drug companies to earn a reasonable profit and yet (Criterion 12) decrease the cost of our health care system.

## Create Social Conditions That Promote Healthy Lives

Another key element of an effective health care system is to get people to live healthier lives. This alone could save taxpayers a lot of money in that there would not be as much expense for chronic or emergency care, hence addressing Criterion 12 of lowering the cost of our health care system and addressing Criteria 5, 6, and 7 of living both healthier and happier lives.

One way to promote healthier lifestyles is to give Americans tax breaks if they achieve certain health care goals throughout the year. For example, if, on examination, people are designated as being overweight, they can get an increasing tax break as they lose a certain amount of weight. The same principle could be applied to people who have high levels of cholesterol and blood pressure and other measurable indicators of health. Also, if we could invent a way to measure the amount of exercise people do over the course of a year, we could give people a higher or lower tax break depending on how much exercise they did in a year. Likewise, if we could measure and report the healthy intake of food (for example, fruits, vegetables, grains) and measure the amount of rest needed for good health, these measurements could also be factors going into decreasing people’s taxes. Such a system

could address Criterion 5: prevent illness by educating people to live healthier lives; Criterion 7: help Americans live healthier and happier lives; and Criterion 12: decrease the cost of our health care system.

A second way to promote healthy lifestyles is to provide early education and more education on how to live a healthy lifestyle. From the first grade onward, students can be taught about eating the right kinds of foods and getting sufficient exercise and rest. Part of a health care system would be to allocate more money to school systems to teach children about living healthier lifestyles and to mandate that all public schools provide only food that is part of a healthy diet and that any unhealthy food (for example, soda, pizza, burgers, fries) cannot be provided at the schools. Such early education about how to live a healthy lifestyle would address Criterion 5 of preventing illness through education and Criterion 12 of decreasing the cost of our health care system.

This health care system could provide for all Americans to have periodic exams—medical and dental. There are a number of reasons for these exams. First, any problems will be discovered early so that there is a better chance to cure people. Second, early detection and cure will mean that Americans will endure fewer catastrophic illnesses that are so costly, thereby decreasing the costs of our health care system. Third, the early detection and cure will mean that people will be in less pain for a shorter amount of time. Periodic exams will therefore satisfy Criterion 6 (prevent illness through periodic checkups), Criterion 7 (people live happier lifestyles), and Criterion 12 (decrease the overall cost of our health care system).

Besides these direct measures that will help people live healthier lifestyles, an indirect action that will help people live healthier lives is decreasing economic inequality in our society (see Chapter 3 on how we can decrease inequality). Budrys (2003) noted that there is a correlation between one's social class and one's health. She reported, "Accumulated evidence tells us that social class must be a more important factor than anyone previously realized" (p. 211). She adds, "The association between social inequality and poor health is consistent and powerful" (p. 211). She concludes that if we want to have better health in our country, we need to decrease inequality. Hence, as we work to decrease inequality, we will also help to decrease the health problems in our country and, in so doing, decrease our health care costs (Criterion 12).

### Institute a Progressive Federal Income Tax to Pay for the New Health Care System

To have a health care system that covers all Americans (Criterion 2) with good-quality care (Criterion 3) in a timely way (Criterion 4), we will need



enough money to pay for it. Because the new health care system could be one national system, probably the most realistic way of procuring the money in the United States would be to get the money at the federal level via a progressive income tax.

The additional money needed might not be that much more and may even be less than we are currently spending for health care. Currently, we are paying taxes for Medicare to help retired people have health care and for Medicaid to help poor people have health care. We are also paying taxes to pay the health care system for our veterans. Besides these three government programs, there are many employers paying insurance companies to insure many of us who work. Finally, most of us, who have health insurance plans with our employers, also contribute from our salaries and wages to our health insurance plans. As we would change to one health care system, we could abolish Medicare, Medicaid, the Veterans system, employer costs, and employee costs and instead pay one cost through our income taxes to the federal government.

Which system—our current system of many systems or one new health care system—will cost us more? I do not know. We would need to have experts consider all of the variables and analyze how the costs of the current and new systems compare. We could find that once we subtract (a) the costs of Medicare, (b) the costs of Medicaid, (c) the costs of the Veterans system, (d) the costs of more than 50 bureaucracies that serve Medicare, Medicaid, and Veterans programs, (e) the costs to employers to insure their employees, (f) the costs to employers that lose business because they are less competitive in the marketplace, and (g) the costs to employees to help pay for their own health insurance, the difference between the costs of the current system of many programs and many bureaucracies and the costs of one comprehensive system may be substantial. Other countries have fewer systems or one system, and their health care costs are lower (Reid, 2009). Given that all other industrialized countries are able to cover all of their citizens and yet pay for health care at less of a cost—sometimes almost one half the cost—compared to what we pay in our country (Reid, 2009), it seems that considering one health care system that covers all Americans could be in order.

By having a progressive income tax that brings in sufficient revenue to pay for our health care system, we will be able to pay doctors, dentists, and other health care professionals reasonably (Criterion 8), pay drug companies reasonably (Criterion 9), compensate health insurance companies and hospitals sufficiently (Criteria 10 and 11), and decrease the overall cost of our health care system (Criterion 12) and yet serve all Americans (Criterion 2). Such a strategy would help to reduce the opposition of health care professionals, drug companies, and health insurance companies that have vested interests in the current health care system.

## Institute One Health Care System

In Canada, although each province and territory creates its own health care system, each system must meet minimum standards set by the federal government (Health Canada, n.d.b). Both the federal and provincial governments contribute to paying for their health care system with both federal and provincial taxes. We, in the United States, could go in the same direction, but because our states are strapped for raising tax revenue, we might choose to have the federal government pay for the health care system and have one system that is standard throughout the country. Some advantages of this kind of system is that when people move to other areas of the country, as many Americans do, they would not need to go through the process of dropping one system and signing up for another system, they would not need to fulfill any waiting period for being on the new system,<sup>15</sup> and they would know what the specific benefits are because the benefits would not change from state to state. If we went in the direction of having one national system, we would know that not only all citizens would be covered but also all citizens would be covered all of the time (Criterion 2).

## Ensure That Medical Care Is Geographically Dispersed

The new health care system would need to make sure that all Americans can get to medical care within a reasonable amount of time (Criterion 4). We need to ask, “Is there reasonable access to medical care in rural areas of our society, in inner cities, and on reservations?” If not, we would need to plan our new health care system to achieve not only Criterion 3 (good-quality care) but also Criterion 4 (receive care in a timely way). The problem of geographic access is a bigger problem for poor people because they are less likely to have their own means of transportation<sup>16</sup> to get to medical care. To provide access to all Americans, we may need to give doctors, dentists, and nurses financial incentives to live in geographic areas where there are currently disproportionately fewer medical personnel.

## Use Public Education: Teach Diet, Cooking, and Exercise

The public school system, from kindergarten through the twelfth grade, can be given sufficient funding to teach students (a) what food to eat and not eat, (b) how to cook nutritious food to make it taste delicious, and (c) how to get healthy exercise.

To achieve these three goals, we could create a new major in college, called *healthy lifestyles*. A student who majors in healthy lifestyles would

learn how to have the best diet possible, how to cook the most nutritious meals possible, and how to get the healthiest exercise possible. Once students in this major learn these three areas, they would then learn how to teach these three areas of healthy living to others, especially elementary, middle, and high school students. Public schools would incorporate these new kinds of teachers and courses into their classrooms. Also, corporations could be given tax breaks if they hired people who have degrees in healthy lifestyles to teach courses to employees.

As a part of this action, public school systems could be required to serve only nutritious food and could be prohibited from serving food that has high saturated fat, a lot of sodium, high cholesterol, many calories, and high sugar content.<sup>17</sup> Foods such as pizza, burgers, fries, cake, cookies, and soft drinks would not be served. Diets at the schools would be made up of foods such as fresh fruit and vegetables; baked and grilled chicken, turkey, and fish; and water, low-fat milk, and tea.

Carrying out this recommendation will address Criterion 5 (providing education for people to live healthy day-to-day lifestyles) and Criterion 7 (living healthier lifestyles that lead to more enjoyable day-to-day lives). By having such an educational system in place, we would prevent many serious illnesses from occurring (Criterion 5) and would cut the overall costs of our health care system (Criterion 12). By instituting such a health care system in our country, we will (1) be proactive with respect to our health, (2) live healthier and happier lives, and (3) decrease the cost of our health care system.

### Try Out the New Health Care System in a Select Number of States

Before we switch the entire country to a new health care system that covers all Americans, we could select a few states that would like to be a part of this initial stage to carry out the new system. By doing this, we could benefit in two ways. First, we could “work out the bugs” before we went nationwide with the new health care system. Second, we could show the rest of the nation that the system could work and how it could work. Canada unintentionally did this during the late 1940s and early 1950s, when four provinces began health care plans, thereby demonstrating to the rest of the Canadian population that, yes, such a system could work in Canada (Graig, 1999, p. 125). If a few states showed the American people that such a comprehensive health care system could work and how it could work, Americans who were dubious might be more inclined to give such a system a try.

Before we go to the next section of this chapter, I want to mention a few historical points. First, as far back as 1916, Congressman Meyer London of New York called for a national health care system (Walker, 1969, p. 299). A few years before his call, labor unions, state legislatures, the American Medical Association, the American Pharmaceutical Association, and the American Hospital Association voiced concerns over the lack of health care in our country and called for and carried out various studies. At the time, there were a number of state legislatures that were seriously considering creating state health care plans. So, consideration of a comprehensive health care system has been around in our country for nearly 100 years. Once we get used to the pros and cons of the Affordable Care Act, we may want to take the next step of creating one excellent health care system that covers all Americans, is less costly than the multiple systems we have now, and addresses all of the criteria discussed above.

## Advantages of Health Care for all Americans

There will be a number of advantages if and when we have one comprehensive health care system that meets the criteria outlined. One advantage is that many poor people who were on Medicaid but will be on the new health care system will finally be treated by all doctors and all hospitals. As we noted previously, currently a number of doctors will not treat poor people on Medicaid because they believe that they do not get paid enough from Medicaid to cover the expense of treatment. Likewise, hospitals do not always get reimbursed for the services they provide because the people who are served either cannot pay for the medical services or are on Medicaid and Medicaid, which do not always reimburse hospitals enough to cover their costs (Daniels et al., 1996, p. 5). One comprehensive health care system would provide health care to poor people and reimburse doctors and hospitals sufficiently to cover their expenses.

The working poor, who have no coverage through their employers but who are not poor enough to be eligible for Medicaid, will also benefit from one health care system that includes all Americans. This would mean that up to 50 million people in the United States who have not had health coverage would finally get coverage (Zaldivar & Espo, 2009). Once the working poor could get access to health care, they would not only live healthier lives but would also experience less absenteeism from work where it has been estimated that they would make 10% to 30% more income per year and thereby increase tax revenues to various levels of government (Budrys, 2003, p. 233). So, having a healthier workforce would help both corporate profits and government revenues.

The elderly, by having access to a national health care system, will immediately have a higher standard of living because they will not need to use portions of their Social Security and retirement incomes to pay for prescription drugs. Hence, they would no longer need to choose between paying for their pills and paying for their food. They could live a healthier and happier lifestyle.

In addition to helping the preceding groups, corporations would benefit. Corporations would benefit because they would no longer need to pay for health coverage for their employees. This would immediately make American businesses more competitive in the world marketplace. For example, General Motors reported that it had to add \$1,500 to the cost of each car just to pay for the health care coverage of its current and former employees.<sup>18</sup> Even though foreign car companies also pay health insurance premiums, “because those foreign health care systems cost so much less to run than ours, foreign competitors pay far less for health coverage than American companies do” (Reid, 2009, p. 25), thus putting American companies at a competitive disadvantage. One comprehensive health care system could immediately cut the costs for American companies and therefore put these companies in a much better competitive situation relative to companies in other countries. This change alone could prove to be a major stimulus to our economy or what sociologists call a latent function, that is, a consequence that is not intended but unintentionally increases the survival of a social system.

Another key benefit that would come from having health care for all Americans is that there could be just one bureaucracy administering this system versus the many bureaucracies administering the current health care systems. Currently, we have one bureaucracy administering the Medicare system for the elderly and 50 state bureaucracies administering the Medicaid system for the poor.<sup>19</sup> We also have a completely different health care system and bureaucracy for veterans. Then we have many health insurance companies with their respective bureaucracies for people who get their health insurance from their employers. Moreover, if a person changes jobs, then he or she has to join a new health care system and new bureaucracy. So, as you can readily see, we have many health insurance systems with many bureaucracies with many different rules. All of this is very complicated and really not needed. But that is what we have in this country, so far.

If we had one health care system for all Americans administered by one bureaucracy with one set of rules, we could get rid of more than 50 bureaucracies (states, veterans, Medicare, Medicaid, and employers) with different sets of rules and create a system with one bureaucracy with one set of rules that would benefit all Americans. One bureaucracy focusing on



one health care system with one set of rules would be (1) more efficient, (2) less costly than many bureaucracies constantly creating different rules and procedures, and (3) more understandable for American citizens. Having one system with one set of rules that makes things much more understandable for the everyday American citizen—this alone would be a huge improvement in our country.

Moreover, although libertarians wish to have hardly any government (except for the defense of the country),<sup>20</sup> and conservatives do not want big government with many bureaucracies (Fine & Shulman, 2003, pp. 9–11), it would seem that most libertarians and conservatives would opt for one system that has one bureaucracy and one set of rules versus the current fifty-some government bureaucracies with fifty-some sets of rules. Also, one system with one bureaucracy that would be more organized could cut costs of health care—another advantage that almost all Americans—libertarians, conservatives, and liberals would like. As Reid (2009) asserted, “In fact, a better-organized system, covering everybody, would almost certainly cut our health care costs—after all, every other rich nation’s health care system is cheaper than ours” (p. 25).

A related advantage to having one government bureaucracy is the fact that doctors and dentists, under one health care system would not have “the huge cost and time burden of processing insurance forms and negotiating with insurers regarding clinical decisions for their patients” (Daniels et al., 1996, p. 5). Doctors and dentists would deal with one bureaucracy rather than fifty-some bureaucracies and one set of rules versus many sets of rules. This should greatly relieve the headaches of office personnel in doctors’ and dentists’ offices who currently need to work with all of these bureaucratic entities. More simplicity, more efficiency, less cost, and more understanding of one system would all be a part of this one system.

Another advantage of having one health care system that serves all Americans is that wherever people move in the United States and whether or not they have a job, they will still be covered. Currently, as Americans move from one job to another job, they typically do not have health insurance that moves with them. So, once they get to their new job, they have to sign up for new and different health insurance with new and different rules and regulations. Also, as Americans get laid off from their jobs or get downsized, they lose their health coverage, putting all members of their families at risk. With one health care system covering all Americans, wherever they live in the United States and whatever their circumstance—job, no job, new job, elderly, poor, and so on—they will be covered. People will also know what their benefits are. Their benefits will not change from job to job. Such a situation will take away much stress that occurs now when people lose

their jobs or move to other parts of the country. They will no longer need to worry about the health care part of their lives. It will be constant, consistent, and much clearer than past and current health care systems.

Another advantage of having one comprehensive health care system that covers all Americans has to do with the current situation of health maintenance organizations (HMOs) that provide health coverage for people. HMOs charge a flat fee to those who join. The people joining HMOs know that they do not need to pay any more money to receive health care. That sounds good for these people. There are, however, two problems with this system. HMOs, knowing that they will get a flat fee, will want to include only healthy people in their plans so that health care costs will remain low, and the HMOs will make more profit. They will not want to sign up people who have serious illnesses that will cost a huge amount of money to treat and that will decrease the profit the HMOs make.<sup>21</sup> So, seriously ill people or typically healthy people who have had to have medical care in the recent past can be turned down for coverage by HMOs. So, HMOs do not provide coverage for all Americans.

A second problem with the HMO system is that HMOs are not required to disclose the treatments they offer and the conditions under which they are offered, consequently making it next to impossible for people to know whether or not they will receive coverage. On the other hand, a comprehensive health care system would include all Americans (Criterion 2) and spell out specifically what kind of care they will receive (Criteria 3 and 4).

## Disadvantages of Health Care for All Americans

One disadvantage of health care for all Americans would affect the executives of companies. In many current situations, executives of companies currently pay the same premiums for health care coverage as do their employees. Although the premiums can take a considerable chunk of employees' wages and salaries, they take a much smaller fraction from the salaries of executives. In essence, the current system of paying monthly premiums is regressive on employees. That is, employees pay a higher proportion of their incomes on health care coverage than do executives. In this way, the past and current systems work to the advantage of executives. In 1990, the ratio of worker pay to top corporate executive pay was 40 to 1, but by 1998, the ratio increased to 419 to 1 (Kerbo, 2009, p. 23). With executive pay increasing disproportionately to worker pay, this means that the monthly health insurance premiums that workers pay have become more regressive than ever.

However, if a health care system for all Americans was put in place, it could be that the way to pay for this new system would be through a more progressive income tax. That is, as people make more money, they pay more tax, and as people make less money, they pay less tax. If such a tax were instituted to pay for the new health care system, executives who paid rather a small part of their salaries to pay for health care would pay more for their health care. So, a new health care system that included all Americans and was paid for by a progressive tax system would be a disadvantage to corporate executives.

On the other hand, if the new health care system was paid for via a more progressive tax, the executives of various companies would benefit in that their respective companies would no longer have to pay for company health care systems, which, as we have noted before, would place companies in a better competitive position vis-à-vis their foreign competitors. So, even though individual executives would be at a disadvantage by paying a higher progressive income tax, their respective companies would be in a better competitive situation relative to their foreign competitors, hence making for greater survival and more profit for these American companies.

Another disadvantage will affect the drug and insurance companies. If the federal government will request competitive bids from these companies to see which companies can offer the lowest prices on drugs and services and purchase drugs and services in bulk, these companies will not make as much profit as they are currently making. Consequently, their executive salaries and employee wages will not be as much as they are now. These companies will still make reasonable profits and compensation, but they might not make the 18% profits that have been previously reported. And as you and I might predict, drug and insurance companies will attempt to discredit a health care system for all Americans if they believe they will make less profit. Given that the drug and insurance companies have “deep pockets” with which to mount a negative campaign against a health care system for all Americans that results in their making smaller profits, we, as sociologists, would predict that there is a high likelihood of advertisements on television and in newspapers and magazines and on the internet vilifying a health care system that covers all Americans. We should also predict that some members of Congress who receive significant amounts of campaign contributions from these companies will wax indignant about the perils of going down the path toward a “socialistic system.” Such terms and phrases as *socialism*, *communism*, *not a real American*, *not the American way*, and so on would be a key part of the advertising in opposition to a health care system for all Americans.

Consequently, we, as sociologists, should predict that drug and insurance companies will, in all likelihood, succeed at slowing down the progress

toward a health care system that includes all Americans. Whether their efforts result in halting or even stopping the movement toward a comprehensive health care system or whether they merely slow down the process, we should predict that a major barrier to getting such a health care system will be the actions of the drug and insurance companies—unless these companies can be assured of reasonable profits and compensation within the new system. As we mentioned before under criteria for a health care system that includes all Americans, drug companies (Criterion 9) and insurance companies (Criterion 10) would be reasonably paid and compensated.

### What Other Countries Include in Their National Health Care Systems

Before we conclude this chapter, let us see what other industrialized countries—Germany, Canada, Great Britain, and Japan—include in their health care systems so that we can get an idea of what we in the United States could do. As T. R. Reid (2009) notes, “If we could import these common principles from the other rich countries, our health care system would work better for patients, providers, payers, and the American economy” (p. 23). We could take the best from each of these health care systems and create our own excellent system.

#### Germany

Germany was the first country to have a national health care system, which was created during the late 1800s by Otto Von Bismarck. Graig (1999) notes that the German health care system “is among the most comprehensive in the world” (p. 50); the German system covers the following areas:

Medical, dental, in-patient hospital care, prescription drugs, preventive care, and even rehabilitative treatments at health spas are covered. Patients do not pay deductibles, though there are minimal copayments for eyeglasses, dentures, prescription drugs, and the first fourteen days of a hospital stay. . . . Another measure of the breadth of German national health insurance is in the area of income replacement. Generous maternity benefits provide full pay during the period six weeks before birth through eight weeks after birth. (p. 50)

People below a certain income must be a part of this system (this includes approximately 75% of the population), and those above this income can choose to be a part of this system (Graig, 1999). Two thirds of the people

who are above this income level and who have a choice as to whether or not to be part of the national health care program choose to be a part of it (Graig, 1999). This means that another 17% along with 75%, or altogether about 92%, of all Germans are included or choose to be within this system.

The German health care system, though expensive, is still cheaper than the American system (the American system is the most expensive in the world spending 15.3% of GDP—gross domestic product— whereas the German system is two thirds that of the American system, spending 10.7% of GDP [Reid, 2009]). Reid (2009) notes the following differences between the German and American health care systems:

First and foremost, the sickness funds are nonprofit entities; they exist to pay people's medical bills, not to pay dividends to shareholders. Thus, they don't have the same incentive that the U.S. insurance industry has to limit the people they cover or deny claims; in fact, the German insurance plans are required to accept all applicants and to pay any claims submitted by a recognized doctor or hospital. They don't have to pad their premiums to pay for a claims-review bureaucracy or to allow for profit. The result: The sickness funds have about one-third the administrative expenses that are normal in American health insurance. That makes the whole German insurance system much cheaper. (p. 75)

Moreover, when German workers lose their jobs, they do not lose their health coverage, because the government unemployment benefits will cover the workers—another key difference between the German and the American health care systems (Reid, 2009, p. 75).

To pay for the German health care system, employers and employees pay an equivalent amount into the system, based on the employees' incomes (Graig, 1999). The German system provides "the same benefits to the unemployed as to the employed" (Graig, 1999, p. 53). Unlike the current U.S. system, if German workers lose their jobs, they are still covered (Graig, 1999). Patients can choose the doctors they want (Graig, 1999). Doctors get paid based on negotiations between doctors' associations and the associations that run the national health care system.<sup>22</sup>

## Canada

The idea of a national health care system in Canada began to take hold during the 1940s when a Gallup poll found that 80% of Canadians favored a national health care system, and that the Canadian Medical Association, representing the doctors in Canada, also supported the creation of such a system (Graig, 1999). Canada's health care system is actually 12 systems representing 10 provinces and 2 territories (Graig, 1999). Doctors have private independent



practices and are paid fees for their services each month, but these fees have already been negotiated between the government and the doctors. Hospitals are mainly private nonprofit organizations (Graig, 1999). Each provincial and territorial health care system needs to meet four criteria set down by the federal government. First, each plan is comprehensive, so that many services are offered. Second, each plan is administered publicly, that is, by an agency of the provincial government. Third, each plan is available to all people in the province; so, there are no pre-existing conditions that prevent patients from getting care. Fourth, people from one province, when visiting another province, can get medical service (called *portability*) (Graig, 1999). In the process, a province can even buy out private health insurance buildings, computers, and employees (Graig, 1999). Hospitals have remained private nonprofit organizations, but instead of being reimbursed by an insurance company, they are reimbursed by the government. Consequently, Canadian citizens, instead of paying doctors and hospitals directly or paying insurance companies to pay the doctors and hospitals, pay taxes to the government, which pays the doctors and hospitals (Graig, 1999), which is about one half of what Americans pay in premiums to private insurance companies in the United States (Reid, 2009). Graig (1999) described the Canadian system this way:

Preventing a two-tier system of health care made up of those who could pay and those who could not was a high priority. The federal government determined that the best way to avoid such a two-tier system was to take the dramatic step of outlawing private insurance coverage for any services covered under the provincial plans. Provincial universal hospital and medical plans thus took the place of all the various forms of insurance—private, not-for-profit, and public—that had existed up to that point. The provincial governments became the single purchasers of publicly insured hospital and medical care services. . . . By the mid-1970's, 95 percent of all costs of hospital and medical care services were paid through the provincial health plans and 0 percent of the population had private comprehensive health insurance coverage. (p. 128)

Graig (1999) also pointed out that Canadians go to the doctors of their choice and present a health card. As such, they do not need to fill out any forms, pay any copayments, or pay a deductible. A *deductible* is a certain amount of money that the patient needs to pay for health care first before the rest is paid for by the patient's insurance.

As you might predict, there has been and continues to be conflict between the doctors' associations and the provincial governments as to how much doctors will be paid for the services they render. A number of Canadian doctors feel that they are not paid enough. They are paid about one half of

what American doctors are paid (Reid, 2009). Hence, there is not as much financial incentive for Canadians to become doctors. As a consequence, Canadians feel that their health care system is “underdoctored,” which leads to the problem of longer waiting times to see doctors as compared to the United States. Provincial governments try to hold down rising medical costs, whereas doctors want to get a higher return on the services they provide. Hence, the negotiations are continually difficult. Some doctors—approximately 1%—have left Canada as a result of these contentious disagreements (Graig, 1999).

As you can see, even with a national health care system, there will be built-in conflicts of interest. So, even if we go to one comprehensive health care system in the United States and achieve the goal of meeting everyone’s medical needs, our system, like other national health care systems in other countries, will, in all probability, be in a continual process of conflict, negotiation, and change. These are the kinds of conflicts that will need to be hammered out if we in the United States go toward a health care system that covers all Americans.

It seems that the people of Canada, all in all, are glad to have their health care system. As Reid (2009) notes, the Canadian National Health Insurance system “records high levels of satisfaction” (p. 127). Reid adds that it is Canada’s “most popular social program” (p. 127). Canadians like the fact that all Canadians can get care regardless of income. So, no one can be denied because of pre-existing conditions, and no one can go bankrupt due to excessive medical expenses, such as has occurred in the United States. Canada comes out ahead of the United States on longer life expectancy and lower rates of infant mortality and yet costs about half that of the U.S. system. The key complaint of the Canadian system, however, is the long wait for care in nonurgent situations. Reid notes that “if your medical problem is not urgent enough to require immediate treatment, Canada will almost always keep you waiting” (p. 128). This is one area in which Canadians would like to improve their system.

### Great Britain

Great Britain has what is called the National Health Service (NHS), which “the entire British population depends on” (Graig, 1999, p. 151) for its health care needs. The central government plays the key role, more so than in the United States, Germany, Canada, or Japan. That is, the government finances and runs the health care system (Graig, 1999). When people who are against government health care systems such as Medicare, Medicaid, and Veterans Affairs, and call all of these kinds of health care systems

“socialism,” they are often thinking of the British health care system (Reid, 2009). The British health care system “provides essentially cradle-to-grave care, regardless of one’s ability to pay, and is free to the patient at the point of service” (p. 154). The phrase “free to the patient” means that patients do not pay money when they go to the doctor, but they pay the federal government in taxes and the government, in turn, pays doctors and hospitals. In 1997, the government spent 6.7% of gross domestic product (GDP) on health care, whereas the United States spent 13.6% of GDP (or roughly twice as much money) on health care, yet various health indicators, such as infant mortality and life expectancy rates, were similar in the two countries.

The British health care system costs less than half what the American system costs, but the British system has two key problems that the American system does not: longer waiting lists to get medical service and shortages in technology (Graig, 1999). Until the Affordable Care Act was passed, 1 out of 6 Americans did not have health care coverage, whereas all citizens of Great Britain have been covered. Prescription drugs, which have been a political “hot potato” in the United States and have been and are very costly, are nearly free in Great Britain. That is, some people need to give copayments, but 80% of prescribed drugs are dispensed free of charge (Graig, 1999). Yet, Reid (2009) suggests that, all in all, “the people who provide care in the NHS are enormously proud of their system and . . . the people who receive care from the NHS are among the most satisfied medical customers on earth” (p. 104).

Any health care system seems to struggle with the problem of keeping costs down as new technologies increase costs and as vested interests, such as doctors who want higher incomes, work to increase costs. Reid (2009) suggests that the British health care system does an excellent job of keeping down costs and “is a model for any country that wants to provide quality care at low cost” (p. 112).

With any national health care system in any country, there will be conflicts of vested interests, continual desire for more or less of something depending on the interest groups, and so on. Great Britain is no different. Although Great Britain has been able to keep its health care costs relatively low, the British people want more services (Graig, 1999). Also, the British population, like the American population, is aging, and hence there will be more elderly people requiring more services. Also, although the waiting time to see a doctor or get medical service has not increased in Great Britain since the 1960s, the number of people on waiting lists has increased (Graig, 1999). So, an aging population, a demand for more services, more people on waiting lists, and an ever-changing economy make for continual change within the British health care system. Vested interests of patients, taxpayers,

doctors, hospitals, and the government all work to put pressures on any national health care system. So, we in the United States, like the people in Great Britain and other countries, whatever health care system we could eventually create, will need to change our health care system as different variables change. This seems to be what happens in other countries and will probably happen in our country.

## Japan

Except for the United States, as in other countries, Japan's insurance companies are nonprofit companies. Unlike American insurance companies, the Japanese health insurance companies "exist to pay medical bills, not to earn a profit for investors" (Reid, 2009, p. 90). This is a key reason why the Japanese health care system is one half the cost of the American system. Another reason that the Japanese health care system is much cheaper than the American one—the American cost is 15.3% of GDP while the Japanese cost is 8% of GDP (Reid, 2009)—is that the government under the Ministry of Health and Welfare negotiates with doctors and hospitals, and the results of these negotiations apply to all doctors and hospitals in Japan (Reid, 2009). These negotiations mean that "the system squeezes cost by sharply limiting the income of medical providers—doctors, nurses, hospitals, labs, drug makers" (Reid, 2009, p. 86). This is unheard of in the United States where many doctors make \$300,000 a year or more, hospitals make millions of dollars, and drug companies and insurance companies make profit of millions, hundreds of millions, or even billions. Another way of keeping costs down is that every Japanese citizen is required to sign up for health care through his or her employer; the premium is split between the employer and employee (Reid, 2009). That way, the cost is spread over many people. For those who are unemployed or too poor to pay a premium, local governments cover their health care costs, with the result that "coverage never lapses" (Reid, 2009, p. 88).

The Japanese health care system has a number of advantages for patients. Japanese patients pick their doctors and hospitals. The insurance plans in Japan must accept people with pre-existing conditions—unlike the U.S. system until the Affordable Care Act was passed. The insurance plans "must pay every bill submitted by a physician or a hospital" (Reid, 2009). Also, the Japanese system has little or no waiting to get to see a doctor, and yet Japanese patients go to the doctor three times more often than Americans do (Reid, 2009). Also, Japanese doctors make house calls, something long gone in the United States.

## The Future: What Could Happen?

No one knows what will happen in the near future.<sup>23</sup> However, I have some ideas given recent trends in our country. The recent trends are that health care costs have increased substantially, making more people aware of this growing problem. Another trend is that more corporations and nonprofit organizations are decreasing or eliminating coverage for their employees because health insurance costs so much. For example, 69% of American corporations provided health care coverage for their employees in 2000, but only 60% provided coverage in 2006. One implication of this decrease in coverage is that members of the middle class have been threatened with a decrease or loss of health care coverage (Beauchamp, 1996). Such a trend will get the influential middle class more concerned about the problem of health care in our country. Another trend has been that prescription drug costs have continued to climb at such a rate that elderly people must use more and more of their Social Security and retirement incomes to buy the prescription drugs that they need. This has decreased their standard of living to the point that many retirees have experienced more financial stress during their retirement years. Another trend that occurred in the late 1990s and early 2000s was that the number of uninsured in our country increased from 44 million in 1999 to 46 million in 2006 to 50 million in 2009.<sup>24</sup> Another trend that has occurred is that Medicare for the elderly and Medicaid for poor people were being cut back, making it more difficult for the elderly and poor people to get health care.<sup>25</sup> Another trend that has occurred, especially in the 2000s is that the health care problem has continually been in the news, with the result that Americans have become more aware of this problem and have wanted to do something about it. For example, a front-page article titled “Support Swells for Universal Health Care” in the *Louisville Courier-Journal* on January 30, 2006, was typical for readers wanting to learn more about the health care problem (Unger, 2006). A few weeks later, an editorial titled “Ailing Health System Needs More Than a Few Band-Aids” in the *Indianapolis Star* on February 21, 2006, was another early example (Feldman, 2006). Since 2006, there has been a growing number of newspaper articles and editorials; in the spring, summer, and fall of 2009, news articles and editorials appeared almost daily in the newspapers as numerous committees in Congress worked on a new health care system and President Obama pushed hard for a new system (see for example, Elliott, 2009; Hiatt, 2009; Marcus, 2009; Werner, 2009b; ; Zaldivar, 2009b; Zaldivar & Espo, 2009).

Consequently, we are focusing more and more on this problem. This leads me to predict that unless something unforeseen happens, such as another



war or natural catastrophe that would divert our attention and resources, we, as Americans, will increasingly work to improve our health care system. As to where this process will eventually end, I do not know, but let me share with you what happened in our country prior to our passing the Affordable Care Act, or as some people call it, *Obamacare*.

## Summer and Fall 2009 and Winter 2010: Finally, Serious Debate

More than 65 years ago, President Harry Truman began the preliminary discussion on health care for Americans (Reid, 2009, p. 11). Discussion over this issue has come and gone, but nothing comprehensive has been done for all Americans. Partial steps have been taken, however. Medicare and Medicaid were created in 1965; Medicare protected people over 65 (Reid, 2009, p. 38) while Medicaid protected those who were poor. As of 2005, Medicare covered 40 million Americans or 14% of the U.S. population, while Medicaid covered 38 million Americans or 13% of the population (Macionis, 2008, p. 560). Yet, by 2005, 47 million Americans still had no health insurance or approximately one out of six Americans; moreover, most of these 47 million Americans (78%) were working, but their employers did not provide health coverage (Macionis, 2008, p. 561).

As of winter, 2010, 1 of 6 Americans still did not have health insurance to protect them when they became sick or needed checkups or preventive care. There were three main reasons why these Americans had no health insurance. One reason was that employers could not afford to provide health care for their employees. A second reason was that many of these uninsured Americans could not afford to buy health insurance on their own—it was too expensive relative to the low incomes that they had. A third reason was that if someone already had an illness, called a “pre-existing condition,” the insurance companies did not have to insure these people. So, they typically did not insure these people because they would lose profit on these individuals. Many of these people with pre-existing conditions who could not get health insurance could not pay the huge costs of treating their illnesses on their own; so, they would either go without treatment and therefore live lives filled with pain and continued sickness or die sooner since they had no treatment (Reid, 2009, pp. 1–3). If they chose to get treatment and paid thousands, hundreds of thousands, or even millions of dollars, they and their families would typically lose their life savings, any investments that they had, their homes, and would end up living in poverty for years, and in many instances, for the rest of their lives. Reid (2009) asked a revealing question:

How many people went bankrupt (due to medical bills) in other countries compared to how many people went bankrupt due to medical bills in the United States?

In Britain, zero. In France, zero. In Japan, Germany, the Netherlands, Canada, Switzerland: zero. In the United States, according to a joint study by Harvard Law School and Harvard Medical School, the annual figure is around 700,000. (Reid, 2009, p. 31)

In the spring of 2009, Congress, at the behest of President Obama, once again took up the issue of health care in America. When President Obama was elected in November 2008, there was an air of seriousness about addressing our health care problems. Polls conducted during the 2008 election found that 79% of those polled wanted either “‘fundamental change’ or ‘a complete overhaul’” (Reid, 2009, pp. 10–11). The President, the Congress, and the American people, it appeared, were finally ready to move toward a better health care system.

Many things occurred in the summer, fall, and early winter of 2009. In a sense, it was a raucous time for our Congress. Three committees in the House of Representatives and two committees in the Senate began to formulate plans for health care reform. It seemed that all summer and all fall and even to the end of 2009, the Congress and many American people were concentrating on this one issue and were even “caught up” in this whole affair.

August is a time that the Congress takes the month off for vacation. But many members of Congress went back to their home states and congressional districts and held what are known as “town halls,” that is, meetings where citizens could air their views (Gerth and Rose, 2009). In many of these town hall meetings, there was considerable tension between more conservative citizens who did not want the government to take over the health care system because, from their perspective, they did not want more “big government” and more taxes and liberals, who on the other hand, believed that the state of affairs in our country with respect to health care was, to say the least, deplorable (Adams, 2009). They noted that unlike any other industrialized nation, our country did not cover the health care of all of its citizens. Moreover, many Americans were not allowed to get health care coverage because they had pre-existing health problems and therefore, health insurance companies, who were in business to make profit, did not accept these people who would be a great expense to the insurance companies. So, as you might expect, there were different views expressed at these town hall meetings where moments of tensions arose.

By the time the Congress reconvened in September, the main issues of the health care debate were coming more clearly into focus (Alonso-Zaldivar, 2009a; Highlights of the Plan, 2009). Yes, there were huge differences in philosophy (Groppe, 2009). Conservatives were generally of the opinion that small government, low taxes, and private enterprise should take care of health care, while liberals were generally of the opinion that all Americans should be covered, pre-existing conditions should not be allowed as a criterion for not providing coverage, and competition should be introduced into health care by creating a public option (that is, a government health care option, as a means of introducing competition into the market, with the intent of controlling spiraling health care costs caused by private health insurance companies that are in business to make profit). Given this large gap in philosophy, as you might predict, politics entered into the debate (Milbank, 2009; Obama's Chance to Recast Debate, 2009). The Republicans did not want the newly elected Democratic president, Barack Obama, to have a big victory by passing health care reform (Babington, 2009). Likewise, the Democrats wanted a big victory for their new president. Hence, all through the summer, the fall, and into December 2009, differences in philosophy and the playing of politics took center stage during the health care debate (Alonso-Zaldivar, 2009b; Zaldivar, 2009a). As you might suspect, such conditions made for a highly emotional time, with daily displays of drama, innuendo, and outright accusations.

Finally, in November and December, the Democratically controlled House passed a health care bill that included a public option while the Senate, also Democratically controlled, passed a bill without a public option (Alonso-Zaldivar, 2009c; Babington & Loven, 2009; Werner, 2009a). In winter 2010, members of the House and the Senate met to "iron out" differences in their respective bills to see if they could create a health care bill that would be voted on by both houses of Congress and sent to President Obama to sign.

There were many questions to be answered at that time. Will the final bill include a public option that will create more competition and hence control health care costs? Will insurance companies have to insure people who have pre-existing conditions? Will insurance companies accept people with pre-existing conditions but charge a lot more for their health insurance? How many more Americans out of the 45 to 50 million who were not insured will actually end up getting health care coverage? And if the bill passes and is signed into law by President Obama, when will it take effect—immediately or 1, 2, 3, or 4 years from now? Will the United States no longer be *the only* industrialized country in the world not to provide health care for all of its citizens, or will we continue to be the only industrialized country not to cover all of its citizens? In other words, are we on the road to solving

this social problem of 50 million Americans not having health care and the United States having the most expensive health care system in the world, or are we not?

### **March 21, 2010: Health Care Reform Passes Congress**

The setting: the House of Representatives of the United States Congress. The date and time: Sunday, March 21, 2010, at 10:30 p.m. Individual Republican and Democratic members have been speaking for or against the bill all day and well into this evening. Finally, the last person to speak about the bill is Nancy Pelosi, the Speaker of the House. She notes that our country has discussed the problem of lack of health care for Americans for over 100 years. She states further that we are now about to make history by finally providing the American people with health care. She finishes her speech and is applauded loudly with a standing ovation by her fellow Democrats while the Republicans sit and watch. Within minutes, the gavel goes down, and the voting begins. Everything comes down to this moment. Will we finally have health care for more Americans or will we not?

For the next 15 minutes, voting takes place. National television networks cover this extraordinary session; so, millions of Americans are watching this event unfold. All Republicans vote no. Some Democrats vote no. But the vote, yes, for health care reform begins to mount. What is needed are 216 yes votes—a majority in the House. Slowly, over the next 15 minutes, the yes vote begins to grow. Now, it is 180—now, 190. Will the House reach 216 votes and pass health care reform or not? It is 10:43 p.m., and the count is up to 210. Can the Democrats get the last 6 votes? At this moment, it is very suspenseful both in the House chamber and for many Americans watching on television. I looked at my watch and at 10:45 p.m., the 216th vote was cast, and a loud and joyous sound burst out in the chamber. Health care reform, in the United States—after 100 years of serious consideration—passed.

In essence, what did this mean? What changed? In a nutshell, this is what happened:

1. An additional 32 million people will be insured. This will mean that about 94 percent of all Americans will be insured.
2. Insurance companies can no longer deny Americans with pre-existing conditions.
3. Insurance companies can no longer cancel a policy once one of their clients gets sick.

4. Insurance companies can no longer place a lifetime limit on an insured person.
5. Insurance companies can no longer deny children with pre-existing conditions.
6. Insurance companies can no longer charge women more for insurance.
7. To pay for the added obligations for insurance companies, people “with incomes above the federal poverty level must enroll in coverage or face a penalty” (O’Donnell and Ungar, February 2, 2015, 1B) and the penalty for 2014 is \$95 per person or 1% of household income, whichever is higher and the penalty for 2015 is \$325 per person or 2% of household income, whichever is higher and the penalty for 2016 is \$696 per person or 2.5% of household income, whichever is higher (O’Donnell and Ungar, February 2, 2015, p. 1B).
8. Medicaid will be expanded to cover more lower-income people.
9. For people who make money from investing and for individuals who make \$200,000 or more per year, they will be taxed more to help pay for health care reform.
10. The so-called “donut hole” (where people on Medicare are covered, then not covered, and then covered again, for the cost of their prescription drugs) will decrease each year and will disappear by 2020 where all of their prescription drugs will be paid for, eliminating the “donut hole,” thus making life more financially stable for the elderly.
11. Small companies, the self-employed, and the uninsured can choose an insurance plan from what will be called “exchanges” where a number of insurance companies will offer plans, increasing the competition and thus containing costs.
12. There is no government run health care program (known as the “public option”). For-profit health insurance companies will still be where most Americans (except for the poor on Medicaid, the elderly on Medicare, and veterans on veterans health care) will choose their health care.
13. Any government taxes cannot be used to pay for abortion. Furthermore, no health care plan is required to offer abortion insurance. Also, in health care plans where abortion insurance is offered, policyholders will have to pay for this insurance separately. Finally, states can ban abortion coverage in insurance plans.
14. The new health care reform will mainly begin in 2014 but some changes will begin immediately such as (1) people with pre-existing conditions can now buy insurance, (2) sick children cannot now be denied coverage, (3) insurance companies now no longer have a lifetime limit on what they pay, (4) there are now no co-payments for preventive care and vaccines, (5) parents can now cover their children up to age 26 (was 23), and (6) the



donut hole will start to be closed with a \$250 tax rebate to those on Medicare (phone communication with the office of Congressman Baron Hill, March 22, 2010).

(“The Final Bill at a Glance,” Louisville Courier–Journal, March 23, 2010, p. A4 [Numbers 1–6 and 8–13]):

So, with the passage of this bill in the Senate and in the House and with the signing of this bill by President Obama, we in the United States came closer to providing health care for all Americans. Although we did not provide all Americans with health care, we did provide millions of more Americans with health coverage with the expansion of Medicaid to cover more lower-income Americans and with 10 million Americans signing up for health insurance in 2014 and 11.4 million signing up in 2015 (O’Donnell and Ungar, February 19, 2015; Rudavsky, January 15, 2015).

Where we go next in our country is unknown. Many Republicans want to do away with the law and have introduced many bills in Congress to do just that. All have failed so far. Many Democrats want to keep the new law, which allows millions of more Americans to have access to health care, either through expanded Medicaid for low-income people or through exchanges that provide people some choice as to how much they can afford to pay. Still others hope that we will go further and finally provide health care for all Americans at a more reasonable cost by either having nonprofit insurance companies provide care and cut out the cost of making a profit or taxing Americans and having the government manage health care at probably one half the cost of what it is today. Republicans and conservatives, due to their philosophical beliefs, typically do not want another government program even though it would cover all Americans and cost less. So, this is where we are today. With the Affordable Care Act, or as some call it, *Obamacare*, we are closer to having health care for all Americans but not there yet. The final chapter of this social problem is yet to be written—possibly during the lifetime of those college students who are reading this.

### Questions for Discussion

1. Should we have a health care system based on people's *ability to pay* for health care or on their *need* for health care?
2. If we created a health care system for all Americans, what, in addition to the things discussed in this chapter, would you put in an American health care system? Why?

3. What suggestions in this chapter would you drop? Why?
  4. If the American people had a chance to read this chapter, what do you think their thoughts would be? Where would they agree, and where would they disagree? Why?
  5. Will we someday have a health care system that covers all Americans and is not so expensive? Why, or why not?
  6. How could we move toward a more preventive philosophy in health care?
  7. Are we becoming a healthier or unhealthy society? What is your reasoning?
  8. What one step do you think Americans could take to have much healthier lifestyles?
  9. How healthy are the lifestyles of college students? Why is this the case?
  10. How could college students live healthier lifestyles?
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