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Chapter 1 : The U.S. Health Care System: An International Perspective â€" DPEAFLCIO

The industry that we are imagining here, the health care industry that costs half as much of GDP while returning much better health, is wildly different from the health care industry of today. It is as different as a Toyota Prius is from a Willys truck.

This is a critical aspect of having an efficient government and political system. In this post, we will continue to look at the true story behind health care in the U. Being that Canada is right on our northern border, whenever the discussion of health care comes up people immediately begin to compare what we have to what they have in Canada. And this is a good starting point but given that almost all other developed countries have a universal coverage health system, there are a lot of examples for us to use as a model. Canadians pay about half of what we pay for health coverage, which is in line with most other systems. Out of 11 industrial countries, a study by the Commonwealth Fund ranked Canada just above the U. So, Canada is not the best country to use as a benchmark for a system to copy but it is still better and much cheaper than ours. It will serve as a good starting comparison. Some key points about the Canadian system are summarized in the follow points: There is no need for persons to be involved in billing. There are no deductibles and co-pays are extremely low or non-existent. There are no lifetime limits. Costs are paid through funding from income taxes. Virtually all essential basic care is covered. Coverage not impacted by pre-existing conditions or changing jobs. It does not cover prescription drugs or dental care. Most Canadians pay for these out-of-pocket or through private insurance. General practitioners are chosen by individuals. Canada has a record number of doctors and may be heading toward an excess. One issue that is often brought up by detractors is the wait times in Canada, in particular to see specialists. However, this is not due to the system. It is reported that the Canadians have made a conscious decision to hold down cost by limiting supply, which can create wait times. The wait time issue could be overcome by paying more but they have decided that they would rather have lower costs. A poll conducted in in Canada apparently the last one conducted shows that And back when the poll was conducted, seven in ten Canadians thought President Obama was right in pursing health reform. When you look at what Canadians pay for their health care compared to what we pay, the difference is shocking. Data from two sources in and correspond and indicate that in the U. As a percent of GDP the ratios are about the same; we still pay about twice. If we went to a Canadian system in the U. In the next post, I will look in more detail at the programs in Europe which are even better than those in Canada and in some cases cost even less. The goal is to educate everyone about what we are doing in this country regarding our health system. We can no longer allow ideology to make our decisions for us when facts and data prove that it is costing us so much money. Health Care Compared to Europe About the author.

Chapter 2 : Same cancer, worse results and twice the cost in the US - CNN

The industry that we are imagining here, the health care industry that costs half as much of GDP while returning much better health, is wildly different from the health care industry of today. It is as different as a Toyota Prius from a Willys truck.

Sierra Leone ranks last with a life expectancy of just over 50 years. Monaco is first on this list of , with an average life expectancy of Chad is last with Aa National Research Council study stated that, when considered as one of 17 high-income countries , the United States was at or near the top in infant mortality , heart and lung disease, sexually transmitted infections , adolescent pregnancies , injuries , homicides , and rates of disability. Together, such issues place the U. As of , U. For women, the percentages are different. Medical centers in the United States In the U. As of , there were 5, registered hospitals in the United States. There were 4, community hospitals, which are defined as nonfederal, short-term general, or specialty hospitals. The Hill-Burton Act was passed in , which provided federal funding for hospitals in exchange for treating poor patients. Department of Defense operates field hospitals as well as permanent hospitals via the Military Health System to provide military-funded care to active military personnel. These facilities, plus tribal facilities and privately contracted services funded by IHS to increase system capacity and capabilities, provide medical care to tribespeople beyond what can be paid for by any private insurance or other government programs. Hospitals provide some outpatient care in their emergency rooms and specialty clinics, but primarily exist to provide inpatient care. Hospital emergency departments and urgent care centers are sources of sporadic problem-focused care. Surgicenters are examples of specialty clinics. Hospice services for the terminally ill who are expected to live six months or less are most commonly subsidized by charities and government. Prenatal, family planning , and dysplasia clinics are government-funded obstetric and gynecologic specialty clinics respectively, and are usually staffed by nurse practitioners. Besides government and private health care facilities, there are also registered free clinics in the United States that provide limited medical services. They are considered to be part of the social safety net for those who lack health insurance. Their services may range from more acute care i. STDs, injuries, respiratory diseases to long term care i. Physician in the United States Physicians in the U. The first step of the USMLE tests whether medical students both understand and are capable of applying the basic scientific foundations to medicine after the second year of medical school. The step 3 is done after the first year of residency. It tests whether students can apply medical knowledge to the unsupervised practice of medicine. Medical products, research and development[edit] As in most other countries, the manufacture and production of pharmaceuticals and medical devices is carried out by private companies. The research and development of medical devices and pharmaceuticals is supported by both public and private sources of funding. Please help improve it by rewriting it in an encyclopedic style. April Learn how and when to remove this template message A large demographic shift in the United States is putting pressure on the medical system as "baby boomers" reach retirement age. The expenditure on health services for people over 45 years old is 8. All of these factors put pressure on wages and working conditions, [74] with the majority of healthcare jobs seeing salary reductions between and These treatments are defined as therapies generally not taught in medical school nor available in hospitals. They include herbs, massages, energy healing, homeopathy, and more. A national survey found that from to , the use of at least one alternative therapy has increased from Their reasons for seeking these alternative approaches included improving their well-being, engaging in a transformational experience, gaining more control over their own health, or finding a better way to relieve symptoms caused by chronic disease. They aim to treat not just physical illness but fix its underlying nutritional, social, emotional, and spiritual causes. Health care spending in the United States U. American Board of Medical Specialties , United States Medical Licensing Examination , and National Association of Insurance Commissioners Involved organizations and institutions[edit] Healthcare is subject to extensive regulation at both the federal and the state level , much of which "arose haphazardly". Essential regulation includes the licensure of health care providers at the state level and the testing and approval of pharmaceuticals and medical devices by the U. These regulations are designed to protect consumers from

ineffective or fraudulent healthcare. Additionally, states regulate the health insurance market and they often have laws which require that health insurance companies cover certain procedures, [85] although state mandates generally do not apply to the self-funded health care plans offered by large employers, which exempt from state laws under preemption clause of the Employee Retirement Income Security Act. In , the Patient Protection and Affordable Care Act PPACA was signed by President Barack Obama and includes various new regulations, with one of the most notable being a health insurance mandate which requires all citizens to purchase health insurance. While not regulation per se, the federal government also has a major influence on the healthcare market through its payments to providers under Medicare and Medicaid, which in some cases are used as a reference point in the negotiations between medical providers and insurance companies. Department of Health and Human Services oversees the various federal agencies involved in health care. The health agencies are a part of the U. Public Health Service , and include the Food and Drug Administration, which certifies the safety of food, effectiveness of drugs and medical products, the Centers for Disease Prevention, which prevents disease, premature death, and disability, the Agency of Health Care Research and Quality, the Agency Toxic Substances and Disease Registry, which regulates hazardous spills of toxic substances, and the National Institutes of Health , which conducts medical research. Regulations of a state board may have executive and police strength to enforce state health laws. In some states, all members of state boards must be health care professionals. Members of state boards may be assigned by the governor or elected by the state committee. Members of local boards may be elected by the mayor council. The McCarranâ€”Ferguson Act, which cedes regulation to the states, does not itself regulate insurance, nor does it mandate that states regulate insurance. By contrast, most other federal laws will not apply to insurance whether the states regulate in that area or not. Providers also undergo testing to obtain board certification attesting to their skills. A report issued by Public Citizen in April found that, for the third year in a row, the number of serious disciplinary actions against physicians by state medical boards declined from to , and called for more oversight of the boards. An even bigger problem may be that the doctors are paid for procedures instead of results. For example, in , 36 states banned or restricted midwifery even though it delivers equally safe care to that by doctors. Emergency Medical Treatment and Active Labor Act EMTALA, enacted by the federal government in , requires that hospital emergency departments treat emergency conditions of all patients regardless of their ability to pay and is considered a critical element in the "safety net" for the uninsured, but established no direct payment mechanism for such care. Indirect payments and reimbursements through federal and state government programs have never fully compensated public and private hospitals for the full cost of care mandated by EMTALA. More than half of all emergency care in the U. According to the Institute of Medicine , between and , emergency room visits in the U. In accordance with EMTALA, mentally ill patients who enter emergency rooms are evaluated for emergency medical conditions. Once mentally ill patients are medically stable, regional mental health agencies are contacted to evaluate them. Patients are evaluated as to whether they are a danger to themselves or others. Those meeting this criterion are admitted to a mental health facility to be further evaluated by a psychiatrist. Typically, mentally ill patients can be held for up to 72 hours, after which a court order is required. Hospital Quality Incentive Demonstration Health care quality assurance consists of the "activities and programs intended to assure or improve the quality of care in either a defined medical setting or a program. The concept includes the assessment or evaluation of the quality of care; identification of problems or shortcomings in the delivery of care; designing activities to overcome these deficiencies; and follow-up monitoring to ensure effectiveness of corrective steps. However, there is "no consistent evidence that the public release of performance data changes consumer behaviour or improves care. In order to monitor and evaluate system effectiveness, researchers and policy makers track system measures and trends over time. The dashboard captures the access, quality and cost of care; overall population health; and health system dynamics e.

Chapter 3 : Health Costs: How the U.S. Compares With Other Countries | PBS NewsHour

BETTER HEALTH CARE AT HALF THE COST Fifty Years Of Medical Progress: An Insider's View ARNDT VON HIPPEL, M. D.

Not extra or wasted care. Not red tape or a half-dozen other frequently blamed factors. Ashish Jha of the Harvard T. Chan School of Public Health. American nurses make considerably more than elsewhere, too. Jha says he hopes the new study will spur "a more honest conversation about what drives much higher health spending in the U. But the stark fact remains that the U. Hospitalization for heart attacks, mental illness, pneumonia and chronic lung disease is middling among wealthy nations. Other countries have higher rates of total hip replacements and hysterectomies. And in fact, the U. The exception is Canada. Thus excess care, the Harvard researchers say, "did not appear to explain a large part of the higher spending in the United States. In fact, the U. But the new analysis shows that U. The new study does note that the U. Why Should We Care? So far, the past decade of national debate over expanding access to health care has barely touched on what to do about controlling costs. Ezekiel Emanuel, of the University of Pennsylvania, in an editorial accompanying the new paper. Emanuel notes that last year Medicaid, the state-federal program for lower-income citizens, consumed 29 percent of state budgets â€" up nearly 10 percentage points over the past decade. Meanwhile, elementary and secondary education has been declining, to less than 20 percent currently. Nobody can accuse Germany of stinting on care or technology. As the new analysis found, Germany still has more doctors and nurses per capita than we do, about the same number of MRI and CT machines and considerably more hospital beds. Yet it spends half of what the U. But it is certainly the most expensive way.

Chapter 4 : Better Health Care at Half the Cost - Joe Flower Healthcare Futurist

It covers health-related topics ranging from the economy, the medical-industrial complex, taxation and outsourced jobs, to inexpensive remedies for gout, coronary artery inflammation, and declining sexual potency.

Especially if the Affordable Care Act is repealed. This trend, though, is not new. Even as more Americans gained health insurance under Obamacare, many people found that in some cases it was cheaper to pay out-of-pocket for care south of the border. That says something about the Mexican healthcare system. It also says a lot about the United States, which struggles with rising healthcare costs and a steadily shifting insurance marketplace. But this is only part of the story. Mexico has a mix of public health insurance programs, employer-provided health insurance and private out-of-pocket care. And a number of disconnected social security institutes that provide care. Achieving universal health coverage The World Health Organization WHO defines universal health coverage as a program that ensures all people in a country receive the high-quality health services they need â€" without suffering financially as a result. This includes providing people with a full range of health services, including prevention, treatment, rehabilitation, and palliative care. That kind of system is unsustainable. This was meant to improve access for poor families to health services, and prevent them from suffering financially due to illness. According to the World Bank , before this program only about half of Mexicans carried health insurance, mainly through their employers. Low income families without insurance paid for much of their healthcare out-of-pocket. Public health programs existed, but there was no essential set of free health services for this segment of the population. Seguro Popular provides unemployed and poor Mexicans with access to preventative healthcare services such as diabetes screening and vaccinations, as well as treatment for chronic and severe illnesses. The program is supported by a mix of federal and state funds â€" similar to how the Medicaid program for low-income Americans is funded. The poorest families pay nothing to join Seguro Popular. The rest pay a premium based on their income. By , the number of enrollees in Seguro Popular had grown to 55 million â€" helping the country achieve universal health coverage. This is roughly the same number of Americans who were enrolled in Medicaid before states expanded the program under Obamacare. That number is currently 74 million. Obamacare â€" including the Medicaid expansion â€" was supposed to reduce the number of uninsured in the United States. It is based on the death rates for 32 diseases that can usually be treated easily, including heart disease, diabetes, maternal and infant diseases, as well as diseases that can be prevented with vaccinations. The average for all countries was Andorra topped the list that year at A report last year by the Organisation for Economic Cooperation and Development OECD highlighted some of the specific successes of the Mexican healthcare system and also areas that still need work. But a CDC survey found that in , 16 percent of Americans under 65 years old were parts of families that had trouble paying their medical bills. Between and , infant mortality in Mexico also dropped, falling 38 percent to 13 deaths per 1, live births. In , the U. Another OECD report found that deaths from heart disease and stroke in Mexico have declined, as well â€" now at deaths per , people. This is a 50 percent decline since , but these diseases are still the leading cause of death in the United States. In spite of its gains in some areas, Mexico still struggles with other health-related issues. The country has the second highest rate of adult obesity after the United States. And the situation is worsening. In , 71 percent of Mexicans were overweight or obese, according to the OECD report â€" up from 62 percent in In the United States, more than 70 percent of Americans are overweight or obese. Diabetes is also common among Mexicans â€" 16 percent of adults. The persistence of these and other diseases has increased the life expectancy gap between Mexico and other OECD countries from four years to six years. Mexicans born in can expect to live to be 74 years old on average. Life expectancy at birth in the United States is 78 years. One problem is that care is provided by a number of social security institutes that are not connected. If Mexicans lose their jobs, they may have to switch doctors, which disrupts the continuity of their care. This also happens in the United States, where private health insurance â€" as well as Medicare and Medicaid â€" have preferred provider networks. In Mexico spent 3. Medicaid accounted for 17 percent of this total. The United States spends more per person on healthcare than every other country in the world, but it still has a lower life expectancy than some

lower-spending countries. Even with the introduction of Seguro Popular, the OECD reports that overall out-of-pocket spending on health services in Mexico remains high â€" 45 percent. For families, this translates to 4 percent of their household expenses. CMS reports that overall, Americans pay only 11 percent out-of-pocket. But healthcare costs in the United States are higher than in Mexico, which is one reason Americans continue to cross the border for medical care. Health disparities remain In spite of the work that still needs to be done to improve the Mexican healthcare system, some recent research suggests that Seguro Popular is achieving some of its goals. A study published in The Lancet earlier this year found that Seguro Popular reduced catastrophic spending on health services â€" more than 30 percent of household income â€" by 23 percent among enrollees. The effect was stronger for poorer households. The program also reduced out-of-pocket spending for inpatient and outpatient medical care, both overall and for poor families. However, there was no reduced out-of-pocket spending on medication or medical devices. Overall they rated the program 7. Many Americans traveling to Mexico for medical care are pleased with the care they receive â€" and the lower cost compared with care back home. But their experiences may not reflect the situation for all Mexicans. There continues to be differences in the healthcare received by different groups in Mexico â€" such as for people in rural vs urban areas, or household income and wealth. The United States, even with its high spending on healthcare, is not immune from these kinds of health disparities. For the richest third, it was 12 percent. Chile and Portugal were the only two countries with a larger income-based gap in the health of their citizens. Mexico was not included in this study. But the results show that spending more on healthcare is no guarantee that everyone in the country will fare equally well. Still, even as debates over healthcare continue in the United States, Mexico is already into its second decade of universal healthcare. Written by Shawn Radcliffe on July 13, related stories.

Chapter 5 : The Health System - The Health Section

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Why is health care in the US so expensive? The patients had similar diagnoses, levels of education, financial situations and other demographics that commonly affect health outcomes and mortality. Some of their ages were different, but the biggest difference between them is on which side of the border they live. Using data from hospitals, Dr. The 5 most expensive drugs in the United States Care varied slightly for the two groups. American doctors ordered chemotherapy more often than the Canadian doctors did, but that may have been because the US patients were a little younger as a group than the Canadian patients, Yezefski said. Read More American patients in western Washington with advanced colorectal cancer survived about This survival time is consistent with this kind of cancer. The research has its limitations, he noted. It is based on a small number of patients -- 1, in Canada and in Washington -- and looks only at one kind of disease, but Yezefski believes there is a larger lesson here. Medicare drug prices soar at 10 times rate of inflation, report says "The one thing we think we can take from this is that the government sets the prices for what they pay for chemotherapy and for the drugs involved in this treatment in British Columbia," he said. We think if Medicare, being the largest payer for medication, could negotiate drugs prices, the cost could go down overall, even for what private insurance pays. President Donald Trump has repeatedly criticized the policy, and most Americans want it changed, according to a recent poll. He did not work on the new research but has undertaken similar scholarship. He added that the results are consistent with other research into why Americans pay so much more. One is a lack of price transparency. Prices at hospitals vary wildly, sometimes even in the same ZIP code. If patients knew what things cost, they might shop around for a better price, and that might encourage hospitals to charge less. Canadian hospitals get a lump-sum budget that covers the costs of care. Unless there is a major overhaul of the economic health care system, government projections show , the high costs of care in the US will only get higher.

Chapter 6 : Health care in the United States - Wikipedia

Title: Better Health Care At Half The calendrierdelascience.com Author: Book PDF Subject: Free Download Better Health Care At Half The Cost Book PDF Keywords: Free DownloadBetter Health Care At Half The Cost Book PDF, read, reading book, free, download, book, ebook, books, ebooks, manual.

Then we instituted cost controls. By or , we may be back to costing the same as any other country â€" half the current cost in GDP. Historical charts of the comparative cost of health care in different countries show a startling and obvious pattern. The trend lines of the leading economies form a fairly tight pack, drifting slowly upward from around 5 percent of GDP in to 8 percent to 10 percent in recent years â€" except for one. Around , the U. This happened over the very period that Medicare, followed by private health plans, instituted increasingly stringent and widespread unit cost controls. I draw two conclusions from this: The notion that U. And there is no evidence that unit cost controls actually control system costs. In fact, through a series of complex feedback mechanisms, it may well be that controlling unit costs pushes up system costs, as members of the system find ways to increase their prices and the numbers and acuity of their utilization patterns despite the caps on reimbursements for individual items. One analysis that I saw broke out all the various costs, and how much they contribute to health care inflation, but never mentioned pharmaceuticals. It turned out drug costs were subsumed within physician costs, hospital costs and so on. The survey was, of course, paid for by the pharmaceutical sector. But you know the drill: We tend to use more of the more expensive items. We waste vast amounts on unnecessary uses. Our dysfunctional malpractice system pushes doctors into defensive medicine, which means more unnecessary care. All of the various causes of the high cost of U. The fact that the cause is structural suggests that no amount of per-unit cost controls is ever going to fundamentally change the situation. Health care paid for this way will always cost too much, and return too little. What to pay attention to. Because the cause is structural, look to structural changes in the funding of the health care market for the big leverages. But these are not the real show. They will not fundamentally change the relationship between the buyers and sellers of health care. Any mechanism that pays for outcomes, for the health of populations, anything that even partially spreads the financial risk for those outcomes from the payers alone to the users and the providers will fundamentally change the interactions between the buyers and sellers. Shift the financial risk, and you shift everything. So to see the future, follow the risk. These large and small shifts in risk are already having their effect on the market. Across the country we are seeing hospitals merge into larger systems that are more capable of bearing financial risk and of bearing the heavier data and management cost of mitigating that risk. Suddenly it seems that they will do better financially if they can keep people out of the hospital. This is just the beginning. We are approaching a tipping point. The recent substantial drop in health care inflation is not just a cyclical reflection of the recession. It is, at least in part, the leading edge of the effects of the systemic, structural and therefore permanent and growing shift in risks across health care. The growing evidence that employers and health plans can drive costs down through such shifts in risk, accompanied by aggressive prevention efforts, incentivized wellness programs, and targeted intensive management of chronic disease, is already percolating through the broad community of payers. Self-funded employers half of small employers, up to 90 percent of large employers , especially, have both the flexibility and the direct, bottom-line incentive to get much more heavily involved in directing the health care of their employees. Both employers and health plans are increasingly willing and determined to try new ways. The Next Health Care When that happens â€" and I believe we will cross that tipping point fairly soon over the next few years â€" we will see a rapid and chaotic shift across health care. The Next Health Care will be fiercely driven by data, analysis and strongly directive management. Health care organizations will compete strongly. The scoreboard of this competition will not be, as it has been, who can provide the most reimbursable services, but who can provide the measurably best health and health care both to defined populations that they serve. The industry that we are imagining here, the health care industry that costs half as much of GDP while returning much better health, is wildly different from the health care industry of today. It is as different as a Toyota Prius from a Willys truck. Because communities are very attached to them, hospitals

have somewhat more built-in resilience than computer companies. The creative destruction in the computer industry in the s and s approximates the scale and depth of change that we can contemplate for this industry over the next decade at least. The Next Health Care is a tough fit for hospitals as we have traditionally conceived them â€" loosely organized, focused on the reimbursement for the reimbursable, paid for action rather than results. The strong tendency will be for hospitals to be increasingly cut out of more and more of the market, specifically all parts of the market that can be made to pay under the new risk-bearing regimes â€" unless they are smart, nimble and aggressive in re-shaping themselves. We are likely to see entirely new players entering local and regional marketplaces, new risk-bearing structures designed specifically to keep the people they serve out of your EDs, your surgical suites and your hospital beds. Your competitors at Major Memorial will increasingly not be St. Dealing with the end of cost-shifting. The functional result of working in a health care economy that is mixed between risk-bearing and fee-for-service structures will be that cost-shifting, not only between payers but between departments and product lines, will become much more difficult. The Next Health Care will in effect demand that every product and product line bear its own real costs. This is dire news, the most difficult dynamic in the Next Health Care for hospitals, particularly hospitals that continue to have a heavy burden of uninsured â€" usually the same hospitals bearing the heaviest burden for emergency and trauma. As cities and states pare back other services and programs, EDs increasingly become not only the first responders for stroke and AMIs and diabetic shock, but at the same time dumping grounds for the mentally ill, the painkiller addicts, the violent, the drunks, the police problems. Communities desperately need and are deeply attached to competent emergency services, but are not really willing to pay for them. The Next Health Care will make that much more difficult to do. Stemming the emergency department tide. In response, hospitals and health systems that do not want to simply abandon their communities will be forced to become extremely creative and aggressive at paring back the burden of the populations that surge into the ED. Make psychological triage a normal part of the ED intake process. Find someone other than a trauma specialist physician to do that. Mental health services are generally far cheaper than the medical and surgical services they can supplant. Identify and track problem users, especially those just seeking narcotics. Use biometrics if necessary. Establish pro-active Camden-style clinician groups to seek out such problem users and help them. If someone is showing up in your ED every three weeks with multiple chronic problems, you will spend far less money if someone goes to their house and helps them vigorously and intensively before they show up again. Seek new sources of funding from states and municipalities, such as direct contracts for emergency services, and direct revenue streams from sales taxes and property taxes. The current mania for never taxing anything and drowning government in its bathtub will run its course. It will be possible to make the case to municipalities and states that the people need to pay for the services that the people demand. Campaign for state and federal legislation to cover the un-coverable. Upgrade your cost analysis. The technically most difficult part of managing this transition is simply continually computing your real costs, not per reimbursed procedure but per benefit provided. But if you have a contract for a set amount for every aching back referred from, say, all the warehouse workers at the airport, then you have a different and much more complex analysis to make: What are the average costs of fixing all those aching backs, some of which may need surgery, but most may not? Suppose you have a comprehensive risk contract for all the back care for all the warehouse workers, whether they have aching backs or not? Then you have a further element to your analysis: What can you do to prevent chronic back aches in this population? But in the Next Health Care, it is even more important to stop doing unnecessary procedures. Put an implanted defibrillator in someone who does not need it, and you get paid. Under a risk-based contract like an AQC, waste is waste. Do something expensive, unnecessary and risky for the patient, and it costs your bottom line. There is no doubt that everything coming your way will be easier and cheaper to deal with if you can get to it sooner. At the same time, you will need to become world class in tracking, characterizing and understanding your customers and potential customers. This is miles beyond marketing research. All of this is new, and there will be an extraordinary premium on getting it right. Campaign for legal reform. There are significant legal barriers that get in the way of hospitals competing effectively in the Next Health Care. These barriers are found especially in the federal Stark laws and anti-kickback legislation which can be interpreted to prohibit or inhibit many of

the kinds of risk-sharing structures that this shift calls for. State scope of practice laws often, in effect, mandate the inefficient use of health care resources, demanding, for example, that a physician give a subcutaneous vaccination that could just as easily be given by a pharmacist. The efficiencies of the Next Health Care will need all clinicians to be operating at the top of their license and at the full extent of their training. In the Next Health Care, these laws will tend to disadvantage hospitals and health systems, because the new-style competitors will be more nimble and well situated to find ways around them. Hospitals and health networks will need changes in the laws not only not to be disadvantaged, but to be able to make use of these new entities as allies and partners. Re-Invent Yourself The economy of the Next Health Care, emerging over just the coming few years, will re-apportion financial risk for the health outcomes from the payers to the providers and the users, driving the entire industry to a smaller, leaner, more efficient and effective model. Such a shift is an existential threat to hospitals and health systems. To survive and thrive will take insight, unprecedented flexibility and creativity, strong leadership, and courage.

Chapter 7 : Health Care in Canada â€“ Better and Half the Cost â€“ Human Efficiency

[6f35f9] - Better Health Care At Half The Cost in health care in the united states took no more of a bite out of the economy than it did in any other developed country then we instituted cost.

Nationally, Americans use preventive services at about half the recommended rate. Cost-sharing such as deductibles, co-insurance, or copayments also reduce the likelihood that preventive services will be used. These chronic diseases can be largely preventable through close partnership with your healthcare team, or can be detected through appropriate screenings, when treatment works best. Are you a writer or producer working on a current TV or film project? Contact the program for technical assistance. Eating healthy, exercising regularly, avoiding tobacco, and receiving preventive services such as cancer screenings, preventive visits and vaccinations are just a few examples of ways people can stay healthy. The right preventive care at every stage of life helps all Americans stay healthy, avoid or delay the onset of disease, keep diseases they already have from becoming worse or debilitating, lead productive lives, and reduce costs. And yet, despite the benefits of many preventive health services, too many Americans go without needed preventive care, often because of financial barriers. Even families with insurance may be deterred by copayments and deductibles from getting cancer screenings, immunizations for their children and themselves, and well-baby check-ups that they need to keep their families healthy. The Affordable Care Act ACA makes preventive care affordable and accessible by requiring certain private health plans to cover certain recommended preventive services without charging a deductible, copayment, co-insurance, or other cost sharing. Under this new requirement, those services including well-woman visits, support for breastfeeding equipment, domestic violence screening and counseling, became more broadly available without cost sharing. More information on the requirement that insurers cover cost-free preventive care is available at: Opportunities for prevention impact all Americans, regardless of age, income, or perceived health status. Each year, potentially preventable chronic diseases e. The five leading causes of death in the U. Because health problems impact productivity, health problems are a major drain on the economy, resulting in 69 million workers reporting missed days due to illness each year. Although most Americans underuse preventive services, individuals experiencing social, economic, or environmental disadvantages are even less likely to use these services. Examples of obstacles include lack of access to quality and affordable health care, lack of access to healthy food choices, unsafe environments, and a lack of educational and employment opportunities. Can It Be Prevented? When we invest in prevention, the benefits are broadly shared. Children grow up in communities, homes, and families that nurture their healthy development, and adults are productive and healthy, both inside and outside the workplace. Businesses benefit because a healthier workforce reduces long term health care costs and increases stability and productivity. Furthermore, communities that offer a healthy, productive, stable workforce can be more attractive places for families to live and for businesses to locate. Further discussion of these benefits is available in the National Prevention Strategy at: The ACA has already helped women in private plans with cost-sharing, like waiving coinsurance or deductibles for certain preventive services such as mammograms, cholesterol screenings, and flu shots, amongst other benefits. The Bottom Line for Consumers Eliminating cost-sharing e. The government is making strides to broaden private health plan access to recommended preventive services with no cost or low cost-sharing. You may have no insurance copays or other out-of-pocket costs for certain visits and preventive screenings to detect disease in the early stages, when it is most treatable. Preventing disease before it starts is critical to helping people live longer, healthier lives and keeping health care costs down. Preventive services can also help those with early stages of disease keep from getting sicker. Counseling on such topics as quitting smoking, losing weight, eating better, treating depression, and reducing alcohol use can improve health and reduce costs by preventing illness. Counseling, screening, wellness visits, prenatal care, etc. Increasing the use of proven preventive services can encourage greater workplace productivity. Case Examples Joe Smith always considered himself to be a healthy individual. As far as he was concerned, he ate the right foods and exercised enough. As a result of the ACA, Joe learned that his health care insurance plan was now offering free diabetes screenings. As a result of the test, Joe met with his health care provider and

learned about the types of foods he should be eating, as well as suggestions for improving his exercise regimen. After five months of the new diet and exercise program, Joe was able to lose 24 pounds and reduce his blood sugar so that he is no longer considered pre-diabetic. Judy Davis, an independent consultant was living a fast-paced life. As a single mother with two small children, she focused all of her energy on her work and family. Although her kids ate well-balanced meals, she relied on coffee and cigarettes. Her only exercise was running after her kids. As a result of the ACA, Judy learned that she was eligible for free preventive services with her private health care plan. This included screenings for breast cancer. After a Mammogram, her doctor told her that there was a sizable lump in her breast and recommended a biopsy. Results confirmed that Judy had breast cancer. After a lumpectomy and many months of radiation, Judy decided to change her lifestyle to make sure she would be around to watch her children grow up. Judy quit smoking, began eating healthy, and started exercising. As a result of catching her cancer early, when it was more easily treatable, Judy has a new lease on life and is now cancer-free.

Chapter 8 : Book:Better Health Care at Half the Cost - TextbookRevolution

But the stark fact remains that the U.S. does not have better measurable health outcomes. explain America's world-beating health costs. half of what the U.S. does on health care per capita.

This is a critical aspect of having an efficient government and political system. In this post, we will continue to look at the true story behind health care in the U. All we need to do is pick out the best system being used elsewhere and copy it. Most of the best systems are in Europe. Each one is somewhat different. And picking any one of them would be an improvement over what we have. They are all ranked as being better than the U. Looking into this, it was surprising to me how different the European systems are even though they all accomplish the same purpose. There are a lot of public and private combinations. France and the UK have a state-run portion and a private sector portion. France has both religious and social welfare hospitals and clinics. Germany has about state sickness funds from which people can select to provide coverage, with rates shown on-line. In Germany about a third of people are covered by social or local funds. The UK is ranked to have one of the best health care systems actually four, one for each country in the UK. The Europeans have unemployed and low income individuals just as the U. As was noted in a previous post, in the U. However, here it is a chaotic system. And the inability to pay medical bills is the biggest reason for personal bankruptcies in the U. In summary, there are quite a few reasons why we pay about double for our health care in the U. These include an inefficient system where fees are constantly being negotiated, bankruptcy costs, insurance company profits in the billions, higher drug prices, higher medical test prices, and higher physician fees. Many of these people do pay other taxes like Social Security taxes. The point is that our health care costs could be cut in half compared to what we pay now no matter how we pay for it, taxes or otherwise. But we pay for it in an inefficient manner. The goal of these posts is to educate everyone about what we are doing in this country regarding our health system. We can no longer allow ideology to make our decisions for us when facts and data prove that it is costing us so much more money. The Jobs Issue in the U.

Chapter 9 : Health Care in Europe â€“ Even Better and Half the Cost â€“ Human Efficiency

Counseling, screening, wellness visits, prenatal care, etc., can improve health and reduce costs by preventing illness. Health problems are a major drain on the economy, resulting in 69 million workers reporting missed days due to illness each year, and reducing economic output by $ billion per year.

An International Perspective The U. Rather than operating a national health service, a single-payer national health insurance system, or a multi-payer universal health insurance fund, the U. In , 48 percent of U. The federal government accounted for 28 percent of spending while state and local governments accounted for 17 percent. Among the insured, In , nearly It will then outline some common methods used in other countries to lower health care costs, examine the German health care system as a model for non-centralized universal care, and put the quality of U. Of the member states, the U. In North America, Canada and Mexico spent respectively On a per capita basis, the U. Prohibitively high cost is the primary reason Americans give for problems accessing health care. Americans with below-average incomes are much more likely than their counterparts in other countries to report not: The first is the cost of new technologies and prescription drugs. Nationally, health care costs for chronic diseases contribute huge proportions to health care costs, particularly during end of life care. Their findings suggest that this holds true even when controlling for socio-economic disparity. Further, the government outsources some of its administrative needs to private firms. The aim is to improve administrative efficiency by allowing doctors and hospitals to bundle billing for an episode of care rather than the current ad hoc method. Uneven Coverage While the majority of U. Average annual premiums for family coverage increased 11 percent between and , but have since leveled off to increase five percent per year between and Between and , single coverage deductibles have risen 67 percent. The lack of health insurance coverage has a profound impact on the U. The Center for American Progress estimated in that the lack of health insurance in the U. While the low end of the estimate represents just the cost of the shorter lifespans of those without insurance, the high end represents both the cost of shortened lifespans and the loss of productivity due to the reduced health of the uninsured. Forty million workers, nearly two out of every five, do not have access to paid sick leave. Experts suggest that the economic pressure to go to work even when sick can prolong pandemics, reduce productivity, and drive up health care costs. Experts attribute this sharp decline in the uninsured to the full implementation of the ACA in Firms with higher proportions of low-wage workers are less likely to provide access to health insurance than those with low-proportions of low-wage workers. However, the percentage of part-time workers without insurance was The uninsured rate among those who had not worked at least one week also decreased from Among all small firms workers in , only 56 percent offered health coverage, compared to 98 percent of large firms. Beginning in , the Affordable Care Act banned this practice, as well as denying coverage for pre-existing conditions. From to , average annual health insurance premiums for family coverage increased 61 percent, while worker contributions to those plans increased 83 percent in the same period. Union workers are more likely than their nonunion counterparts to be covered by health insurance and paid sick leave. In March , 95 percent of union members in the civilian workforce had access to medical care benefits, compared with only 68 percent of nonunion members. In , 85 percent of union members in the civilian workforce had access to paid sick leave compared to 62 percent of nonunion workers. In the South, 41 percent of firms reported providing benefits for same-sex partners compared to 51 percent in the Northeast and 20 percent reported offering benefits to opposite-sex domestic partners compared to 46 percent in the Northeast. Provisions included in the ACA are intended to expand access to healthcare coverage, increase consumer protections, emphasizes prevention and wellness, and promote evidence- based treatment and administrative efficiency in an attempt to curb rising healthcare costs. Beginning in January , almost all Americans are required to have some form of health insurance from either their employer, an individual plan, or through a public program such as Medicaid or Medicare. Individuals with incomes between percent and percent of the federal poverty line would be eligible for advanceable premium tax credits to subsidize the cost of insurance. States have the option to create and administer their own exchanges or allow the federal government to do so. Currently, only 14 states operate their own

exchanges. A recent analysis by the Commonwealth Fund found that the number of insurers offering health insurance coverage through the marketplaces increased from to The analysis found only a modest increase in average premiums for the lowest cost plans from to As of November , 30 states have chosen to expand Medicaid. As of , adults with incomes at or below percent of the federal poverty line are now eligible for Medicaid in the states that have adopted the expansion. S healthcare system under the ACA, a number of challenges remain. The bulk of people in the coverage gap are concentrated in the South, with Texas , people , Florida , , Georgia , and North Carolina , having among the highest number of uninsured. The law banned lifetime monetary caps on insurance coverage for all new plans and prohibited plans from excluding children and most adults with preexisting conditions. Among them is the Independent Payment Advisory Board, which will provide recommendations to Congress and the President for controlling Medicare costs if the costs exceed a target growth rate. The administrative process for billing, transferring funds, and determining eligibility is being simplified by allowing doctors to bundle billing for an episode of care rather than the current ad hoc method. Additionally, changes were made to the Medicare Advantage program that would provide bonuses to high rated plans, incentivizing these privately-operated plans to improve quality and efficiency. Furthermore, hospitals with high readmission rates will see a reduction in Medicare payments while a new Innovation Center within the Centers for Medicare and Medicaid Services was created to test new program expenditure reduction methods. While methods range widely, other OECD countries generally have more effective and equitable health care systems that control health care costs and protect vulnerable segments of the population from falling through the cracks. Among the OECD countries and other advanced industrialized countries, there are three main types of health insurance programs: A national health service, where medical services are delivered via government-salaried physicians, in hospitals and clinics that are publicly owned and operatedâ€”financed by the government through tax payments. There are some private doctors but they have specific regulations on their medical practice and collect their fees from the government. Medical services are publicly financed but not publicly provided. Canada, Denmark, Taiwan, and Sweden have single-payer systems. This method is used in Germany, Japan, and France. Such a mandate eliminates the issue of paying the higher costs of the uninsured, especially for emergency services due to lack of preventative care. This has been effectively used by the U. Yet, it has been prohibited by law from traditional Medicare. Savings of up to five percent of total health care expenditures could result from the full adoption of these practices. How Germany Pays for Health Care Germany has one of the most successful health care systems in the world in terms of quality and cost. Some insurance providers collectively make up its public option. The average per-capita health care costs for this system are less than half of the cost in the U. The details of the system are instructive, as Germany does not rely on a centralized, Medicare-like health insurance plan, but rather relies on private, non-profit, or for-profit insurers that are tightly regulated to work toward socially desired endsâ€”an option that might have more traction in the U. Germans have no deductibles and low co-pays. However, they are tightly regulated. Groups of office-based physicians in every region negotiate with insurers to arrive at collective annual budgets. Doctors must remain in these budgets, as they do not receive additional funding if they go over. This helps keep health care costs in check and discourages unnecessarily expensive procedures. The average German doctor also makes about one-third less per year than in the U. Prior to reforms, drug companies set the price for new drugs and were not required to show that the new drug was an improvement over previously available prescription drugs. Pursuant to the reforms effective in , manufacturers could set the price for the first 12 months a new drug is on the market. New drugs without added benefits are available to patients, but the patient has to pay the price difference. For drugs with added benefit, a price will be negotiated between health insurers and the manufacturer. Health Care in an International Context U. However, treatment in the U. In terms of quality of care, the U. Despite the relatively high level of health expenditure, in the U. In , the U. Projections indicate that the U. Therefore, there are provisions in the legislation to increase the number of primary care physicians in the U. There is a significant spatial mismatch within the United States for physicians as well. This is the highest rate among OECD countries. The average for the OECD countries was