Current Health Care System Policy for Vulnerability Reduction in the United States of America: A Personal Perspective

Edward J. Eckenfels
Rush Medical College, Chicago, Ill, USA

Aim. To raise questions about how the United States of America – which spends 1.3 trillion dollars on health care, conducts cutting-edge biomedical research, has the most advanced medical technology, and trains a cadre of highly competent health professionals – cares for the most vulnerable members of its population.

Methods. Relevant statistical data were extrapolated from the most current statistical sources and research reports, and assessed in terms of existing practices and policies.

Results. The data clearly demonstrated that particular population cohorts – the elderly, the poor, new immigrants, the homeless, the HIV-positive, and substance abusers – were especially vulnerable to illness and its consequences.

Conclusion. Since American medicine, despite all of its science, technology, and clinical competence, operates in a “non-system,” there is currently no efficacious approach to vulnerability reduction. To turn health care in the U.S. into a high quality, comprehensive, and cost-effective system, government officials, health care planners, and medical practitioners must address a series of fundamental social, economic, and political issues. What other countries, like those in South Eastern Europe, can learn from this is not to duplicate these mistakes.

Key words: academic medical centers; cost-benefit analysis; delivery of health care; health policy; health maintenance organizations; health services accessibility; insurance; health; poverty; public health; United States

Any attempt at proposing a policy for vulnerability reduction in the U.S. must address an initial question: How can the world’s wealthiest and most powerful nation – the United States of America – have anyone who is “vulnerable” when it a) spends 1.3 trillion dollars (US$4,400 per capita) annually on health care (1); b) has the National Institutes of Health with a budget of over 23 billion dollars annually to conduct biomedical research (2); c) has 125 academic health centers where doctors, nurses, and other allied health personnel are trained and the latest medical procedures performed on a routine basis (3); d) has 5,810 hospitals with 983,628 beds (almost three beds per person) (4); e) has approximately 777,000 physicians, over 2 million nurses, and over 10 million personnel in the health care workforce (5); and f) and has a government-sponsored public health system dispersed throughout the country (6)?

Categories of Vulnerability

Nonetheless, even with such an all-encompassing and costly health care system, it is still possible to identify particular groups that are most susceptible to illness on the basis of current statistical and research reports. The most prominent categories of vulnerability are the elderly, the poor, immigrants, the homeless, persons with acquired immunodeficiency syndrome (AIDS), and drug abusers.

The Elderly

The most rapidly growing population in the U.S. is the elderly – those 65 years of age and over (7). Currently, there are about 27 million people in this category that makes up about 12% of the total population. Sixty percent of them are women. There are 3.2 million who are 85 and older. With an aging population, there is an increase in vulnerability, especially with respect to heart diseases and cancer – the leading causes of death. The very old (over 85 years of age) are also vulnerable to falls and other kinds of physical accidents. As people grow old, they also become less mobile, and in many cases, they require home health care and placement in a long-term care setting.

The Poor

According to the census 2000, there were over 31 million people (11%) in the U.S. below or at the poverty line (8). A rough estimate of poverty threshold in the U.S. is about US$17,600 for a family of four. The poverty threshold is based upon the cost of a nutritionally adequate diet for a family of four, which is then multiplied by a factor of three, since it is estimated that a family spends about one-third of its total income on food. Poverty is concentrated among
ethnic minorities, women, and children. About one out of five African American or Latino American families is poor, and 41% of all families headed by women live in poverty. For immigrants, the figure is 16%. Over 17% of those in poverty are children and teenagers.

Immigrants
Since 1980, more than 18 million immigrants have come to the U.S. (9). That is more than “the great immigrant wave” that came at the turn of the last century. Most immigrants are from Southeast Asia, Central and South America, and Eastern Europe. There are an estimated 3-5 million illegal aliens; most come from Mexico and Central America, crossing the southern borders of the U.S. Although all immigrants cannot be characterized as vulnerable, new arrivals tend to be ignorant of how to use the complicated U.S. health care system. Furthermore, there is essentially no access to medical services for the indigent illegal aliens and for any health services they receive, they have to pay out-of-pocket.

The Homeless
The homeless in the U.S. live on the streets, beg for survival, and are susceptible to alcoholism and infectious diseases (10). A conservative estimate is that about 2 million people are homeless at some time each year, with 20% of them being children. On any given night, there are about 600,000 in homeless shelters or sleeping in the streets.

Persons with AIDS
The AIDS epidemic was first identified in the U.S. in the early 1980s (11). What started as primarily an illness concentrated among homosexual men spread to IV drug users, and now is transmitted heterosexually as well. There are between 750,000 and one million people in the U.S. who are HIV-positive. Over 400,000 have died of AIDS. Drug therapy is extremely expensive and costs around US$15,000 a year.

Drug Abusers
A national survey conducted in 1999 found that over 14 million people over 12 years of age (7%) had used some form of illegal drug within the past month (12). Hard drugs – cocaine, heroin, and crack – are easily accessible. The rates of addiction are higher among African Americans and Latino Americans. Treatment is sporadic, facilities are poorly funded, and the War on Drugs has turned abusers into criminals.

Causes of Vulnerability
But still, with such a highly sophisticated and technological health care system, how can anyone, even these groups, become vulnerable? A part of an answer to this question lies outside the health system per se and is in the economic, social, and political realm (13).

Costs
The average annual cost of health in the U.S. is around US$4,400 per person (1) and almost 90% is paid for by the employers of working families (14). Health insurance companies, over 300 of them, manage the payments to the health care providers, many of whom work in medical service settings called Health Maintenance Organizations (HMO). Retired people get most of their health care paid for by Medicare, the federal government’s Social Security fund that comes from joint contributions of the employer and employee (1). Medicaid, another government-funded program, is the primary source of health care provided for the poor (1). The result of this highly complicated and costly system is that over 40 million people are without health insurance (15). A large part of this group is what we call the working poor – they work at minimum wages or part time and do not get health insurance as a benefit of their job.

Access to Health Care
Not everyone in our health care system has equal access to health services (13). This circumstance is a function of a number of things. In rural areas, for example, you have to travel a great distance to get to a doctor or clinic, and the hospitals are small and not well equipped. If you do not have the appropriate insurance or the cash to pay for expensive treatments, you simply do not get them. In large urban areas like Chicago, there are some hospitals and clinics for the indigent – the poor who cannot afford to pay – but they are over-crowded and require long waits not only to have complicated technical procedures performed but to see the health care professional.

Quality of Health Care
Quality of care varies widely in the U.S. by region (e.g., North vs South), by state (e.g., Mississippi vs California), by type and size of community (e.g., large urban metropolis vs. small rural hamlet), and even within communities (e.g., inner-city ghetto vs affluent suburbs). The best health care professionals tend to work in the academic health centers and major hospitals. If you are well-insured, wealthy, and can afford the latest procedure or technical innovation (which is probably not covered by your insurance), then you can choose where you go for health care.

Public Health
Unfortunately, the public health system has some serious problems (6). Its major role in the private health care system is to serve as a “safety net” for those who slip through the cracks. Since the public health system is not a medical service or curative system, it focuses essentially on prevention, particularly in the area of immunization. But this also varies from state to state or region to region because the financial support of public health agencies is dependent more on state than on federal funds. One shameful result is that one out of every five children is not vaccinated (immunized) at the minimum requirement when they start school. Public health clinics have tried to have some impact on controlling chronic disease by offering free blood pressure measurements and medications, health education materials, and the like but without any really systematic approach. The U.S. Public Health Service does administer health care
programs for migrant workers and oversees the U.S. Indian Health Services, which was established to provide free health care for Native Americans. The health departments of each state and major cities are also responsible for sanitation control in terms of clean water, uncontaminated food, and sanitary restaurants. This is one of their major contributions to our health and welfare.

**Issues to Be Addressed**

The combination of all these factors presents the essential paradox of American medicine: all of our science, technology, and clinical competence operate in a "non-system." If we are to provide comprehensive, quality, and cost-effective care, then some major issues need to be addressed.

**Fragmentation**

The system is riddled with fragmentation (16). Not only is not everyone covered by health insurance, but services are fragmented as well. For example, mental health services are not funded except for psychosis or suicidal intent. Also, without the proper insurance coverage, many patients do not have access to tertiary care procedures, such as open-heart surgery. Fragmentation can be ended by instituting a system of universal health care that includes costs as well as services. There are many well thought-out proposals and well-documented studies that demonstrate the efficacy of such an approach. The U.S. is the only country in the West that does not have some form of universal health care.

**Cost-ineffectiveness**

The system is cost-ineffective (17). Some procedures are prohibited by high cost, and redundancy and duplication are rampant. Due to lawsuits and the high cost of malpractice insurance, many physicians practice defensive medicine by putting the patients through meaningless tests and uncomfortable procedures. The salaries of administrative executives are exorbitant – in some cases, in the millions. The salaries of specialists continue to rise at a higher rate than inflation (the norm for surgeons is over US$300,000), whereas those of primary care and family doctors remain well below the average (18).

Cost can be reduced dramatically by controlling duplication and redundancy. A fair and just tax system in which those with the highest incomes pay the highest rates can take the burden from the small business employer and spread costs around more equitably.

**Academic Health Centers**

Since all of the technology and highly-trained professionals are housed in the large academic health care centers, the patient has to go there to get that kind of health care (3). These institutions function as independent citadels of power and self-sufficiency. They operate primarily from a "supply-side" perspective; since they are driven by new knowledge and technology, their resulting need is to find patients to fit the interests and technical capabilities of the specialists and the equipment and services of the medical center. If the patient cannot afford this kind of care or does not have access, he or she is left out. "Demand-side" thinking, which concerns the patient and the health expectation, needs, and trends of communities, is de-emphasized.

The system must move from a supply-side orientation to a demand-side approach (19). The latter takes into account societal needs and creates a system that responds to those needs through concerted efforts by health professionals, politicians, and the public.

**Two-tiered System**

Such a system promotes two or more delivery systems – one for the have's and another for the have-nots, and no system at all for the truly disadvantaged (20). It is obvious where the best health care is provided. Some communities are without access to any health professionals or hospitals.

A single-tiered system should be established that gives access to comprehensive quality care to everyone, regardless of income, race, ethnicity, or country of origin. Along with social justice, equality is a fundamental principle of a democratic society. Again, there are strong social, economic, and moral arguments that suggest a single system would be more cost-effective, easier to administer, and less complicated to use.

**Market-driven Health Care System**

The system is run like a business and health care is considered a market commodity (13). Compassion and empathy are too often left out of the equation. Efficacy is measured in terms of how many patients you see (the more the better), how much time you spend with them (the shorter the better), and how much insurance coverage they have. The same approach applies to hospital care.

Health care in a democratic society, like public education and participation in the political process, is a right, and, as such, should not be treated like a market commodity.

**Medical Education**

A career in medicine has become very much an individualized profession. Your own needs – family, lifestyle, and status – come first; those of the patients come next. Personal achievements are emphasized over social responsibility. Future health professionals need to be made aware in the course of their education that they have an obligation and responsibility to serve as an agent of society, sponsored by society, to the society (21). This moral commitment does not mean that they have to forego their personal and private life. A sense of satisfaction and achievement in one’s work compliments one’s satisfaction in life (22, 23). As Freud said, Lieben und arbeiten, "to love and to work."

**Lessons to be Learned**

**Universal Health Care**

A fee-for-service, private system excludes people, especially the most vulnerable, from needed health care. Even with the best intentions, the most competent physicians will be drawn to a practice...
where they can make more money. Inevitably, this leads to a multileveled system, with those who can pay in and those who cannot out. The best guarantee is to make sure that all health professionals are adequately paid. To reach the people who live in more isolated areas or in the poorest sections of the cities, it is necessary to make sure that the resources – personnel, equipment, and materials – are distributed sufficiently with special attention paid to the neediest communities.

**Strong Public Health System**

The public health system needs to be reinforced with respect to immunization of children, the control of infectious diseases, and the monitoring of the physical environment. In addition, public health agencies need the legal and political authority to take action when the situation warrants it. Primary prevention should be integrated throughout the system with major campaigns directed at children when it comes to smoking and drugs. Also public health practitioners must teach each patient the importance of a healthy diet, exercise, and the need to adhere to the treatment plan.

**Integrated Managed Care**

It is imperative that an integrated managed care system be developed, one that includes primary care, specialty care, and hospital care. Such a system needs to work in harmony so if there are not enough family doctors, train more; if there are too many general surgeons, train fewer. The determination and projections of how many of what are needed must be based on carefully conducted epidemiological and demographic studies, so that the policy makers will have an empirical basis on which to make their decisions. The new disciplines of evidence-based medicine (24) and health services research (25) should become a required part of the medical school curriculum if future physicians are to become capable of assessing the system rationally.

**Social Responsibility**

Educators must reinforce the core values of compassion, empathy, and idealism among health professional students (26). Too much emphasis on technology and procedures have resulted in a detached and impersonal attitude among physicians in my country. A corollary consideration is to teach the students the importance of working as a team. They need to learn to think in terms of a health care system. There is an urgent need to develop, execute, and evaluate models of a system capable of providing comprehensive, cost-effective, and quality health care to all the people.

**Conclusion**

It would be remiss if something was not stated about the events of September 11, 2001, and their impact on the health care system in the U.S.

The anthrax scare and the fear of a smallpox epidemic have demonstrated how vulnerable our public health system is to bioterrorism. It was a wake-up call to reinforce our public health network. However, there were some negative reactions as well. The creation of new vaccines has been a financial windfall for the pharmaceutical industry, one of the greatest profit-making enterprises in the world (27). Along with Viagra and other comfort medications, this concern has become their highest priority while at the same time one out of five children is not being immunized. This is another example of what happens when market forces dictate what constitutes health care. Since that horrendous atrocity five months ago, close to 1.8 million workers have lost their jobs (28). For them and their families, this also includes a loss of health insurance. In other words, almost 2 million people are joining the ranks of the uninsured.

If there is one major lesson to be learned from all of this it is that we are all vulnerable – even those of us in the richest and most powerful country in the world. If we are all vulnerable, then as Dostoevsky says, "We are all responsible for all."

**References**


Received: January 2, 2002
Accepted: January 29, 2002

Correspondence to:
Edward J. Eckenfels
5344 S. Hyde Park Blvd.
Chicago, IL 60615; USA
eckenfe@rush.edu