How can we address financial and geographical barriers to improve access to healthcare in the United States?

Christopher Atchison

Senior Project Advisor: Susan Raleigh

Abstract:

Health care is one of the most essential parts of our society; it defines the health and well-being of the people. People in our country must have access to affordable healthcare that will not send them into crippling financial debt. Through my research, I have found multiple strategies for reducing healthcare costs and improving efficiency. Reducing expenditures would help solve the dilemma of overpriced healthcare and work towards affordable healthcare for all. Through scholarly articles and clinical studies, I found numerous bits of information about how we can start implementing daily changes to improve healthcare waste and create price reduction, along with some larger plans that would take more time, such as moving specialists around to areas where they are needed more. These changes will refine and break down our current healthcare system, leading to a more financially viable healthcare plan for all.

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The most prominent cause of bankruptcy in the country is medical debt. Hundreds of thousands of people live uninsured, and yet we deem these to be acceptable conditions. David U. Himmelstein, a doctor of medicine at Harvard Medical School, states, “medical problems contributed to at least 46.2% of all bankruptcies. Since then, health costs and the numbers of un- and underinsured have increased, and bankruptcy laws have tightened” (1). We live in a society in which 16.9% of the population cannot afford health care(Weinick 1) . This financial atrocity is unacceptable. Healthcare is a right everyone deserves no matter their age, race, economic background, or citizenship status. Within the constraints of our current healthcare system, such as low access to healthcare aid and excessive spending in hospitals. In the United States, the most effective way to increase healthcare access is to create more efficient delivery means to streamline access and reduce general costs.

An accident outside of one’s control shouldn’t force people into financial debt or bankruptcy. The United States has unique circumstances that make it challenging to deliver affordable healthcare: insurance prices based on the GDP (since 1998) in a time of ever-increasing wage disparity; distribution of costly, labor-intensive healthcare across a large country; and the difficulty of providing healthcare to rural and lower-income communities because of cost and accessibility boundaries, such as the inability to access transportation to a doctor’s office. Creating an understanding of these challenges is the first step in moving towards affordable healthcare reform. Cost reduction strategies for difficult situations like these could help people who need healthcare access to the care they require.

Three significant historical periods influenced the increased cost of healthcare in America. During the mid-1980s, the price of insurance inflated by almost 70% per year in 1985 and 1986 (Cummins and Danzon 2). This general liability crisis, a separation between the GDP

and healthcare prices, caused a general liability insurance crash. This resulted in a rise in health care costs and limitations of medical insurance coverage that started the exponentially increasing trend and decreased range that resulted in the high medical prices we have today (Cummins and Danzon 3).

The second landmark event relevant to our health care crisis occurred in the mid-1980s as general liabilities insurance spikes resulted in a healthcare reform around 1998, influenced by the Organisation for Economic Co-operation and Development (OECD). The OECD tried to tie insurance prices to the Gross Domestic Product, hoping the prices of insurance would mirror the total prices of goods and services provided in one region. It would create a sustainable market where they could pay a proportional amount to what the community earned each year, believing this would stabilize the price of managed health care. But with the increase in pharmaceutical company pricing, and hospitals' scope of practice expanding, healthcare costs increased much more than anticipated, significantly increasing insurance prices.

Third, after the great separation between GDP and insurance prices. The Affordable Care Act passed on March 23, 2010, opened a window for people who needed health care, helping a large portion of the population. However, the ACA excluded about 26.1 million people who remain uninsured, for reasons such as having undocumented status or earning slightly too much income to qualify for the ACA, or those with no stable income source. These three events led to today's increased costs and decreased ability to access 21st-century medical care. As we look at issues contributing to increased cost, we can break it down into three simple factors: geographical boundaries, economic boundaries, and pharmaceutical and hospital pricing. These three areas have potential solutions to reduce price and increase overall efficiency within today's medical management paradigm.

The United States is such a large country that it is difficult to provide high-quality medical care everywhere, which citizens of an affluent first-world country might expect. Healthcare should be a fundamental human right and something to which we are entitled , regardless of whether we live in a rural or urban location. People who live in areas that cause specific medical problems face geographical challenges and financial barriers. Such is the case in Flint, Michigan, with compromised water, air, and resultant compromised immune systems.

Economic barriers prevent people from affording healthcare insurance, which is necessary for navigating today's healthcare system. We can help assist lower-income citizens by providing information about government aid. These programs make it uncomplicated for people to apply and take advantage of their healthcare benefits, making them more accessible. By making these programs easily accessible, we can reduce the cost of healthcare at hospitals and clinics.

Last of all, pharmaceutical regulation is an impactful aspect of regulating healthcare costs. In 2003, the Bush administration implemented the Medicare Prescription Drug Act (MPDA). "Spending on prescription drugs in the United States grew twice as fast as total national health expenditures between 1990 and 2000. In 2002, total outpatient drug costs for adults over 65 were estimated at $87 billion, and they will rise to over $120 billion by 2005." (Brinckerhoff and Coleman 1). This regulation was explicitly tied to Medicare and focused on the spending of individuals aged 65 and older. Better regulated pharmaceuticals for people below the age 65, focusing on essential drugs like epinephrine and insulin, would allow people to buy necessary drugs for their daily lives more reasonably, and hospital price reduction to reduce the economic strain.

Geographical boundary challenges can be presented in many different ways, from

physical distance to the nearest health care facility, to the ability to staff a sufficient number of healthcare providers, to environmental causes that could decline a person's health such as air and water quality in a given area. One such example showing how environmental problems influence health, is shown in the film, *The Human Element,* directed by Matthew Testa. Testa interviews Yadira Sanchez, a local mother of three children who had much to say concerning the state of their neighborhood. The mother explains,"'We have the refinery and all of the pollutants from the semis that pass through[…]Asthma is a normal thing in this part of town. You're most definitely afraid of the air you're breathing in because although you need it to survive, that same air is also killing you and your family". In Denver's Elyria Swansea neighborhood, since 2006, the asthma rate has spiked 41%. Rising from 10 out of every 100,000 to 1,113.12 per 100,000 people (Sangosti 1). The 41% rise directly correlates to the increase in industrial production and traffic congestion in the area.

There are many more examples. In 2014, the story of Flint Michigan's water crisis reached headlines when the state started pulling unfiltered water from the local Flint River, declaring it "safe to drink." But the shocking color of the water and the testing based upon the LCR (Lead and Copper Rule), a standard way for testing the toxicity of the water, showed otherwise. In 2016 the water was 20 ppb (parts per billion) of LCR, five higher than the maximum government standard of 15 ppb. Since then, the State of Michigan has put more than $350 million into helping clean up their river, dispersing filter systems to all residents that requested it, and in 2019 bringing down the LCR to 6 ppb. While this is a positive step forward, it is still focusing on treating the symptoms rather than focusing on preventive care and fixing the root cause of the problem. Michigan has also taken no accountability for their citizens' long-term health effects from drinking the toxic water, putting them at a disadvantage for medical coverage

and more. Alas, geographical environmental health disadvantages are not the only variables that limit people from access to health care.

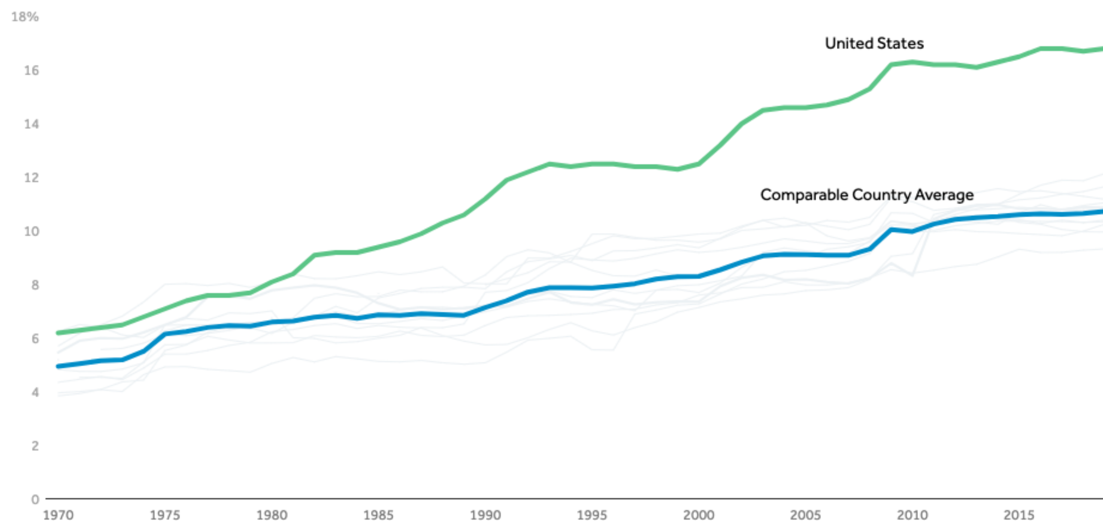
Another example is located in the state of Colorado, not in the urbanized city of Denver, but the small mountain towns scattered around the state. The isolation of these small towns is impactful. Rural Colorado communities with a population of less than a thousand people can be hours away from accessible health care. This great distance from medical facilities is not only impactful during medical emergencies, but if you had to take a day off of work or school to drive two towns over and deal with the hundred-dollar-plus medical bill for your yearly physical, most people would be inclined to forgo the appointment. The choice to refrain from medical care because of time and distance is not only irresponsible, but also dangerous. An annual physical's purpose is to check one's overall health and assess for signs and symptoms of acute diseases like cancer, liver failure, and other long-term, slow-onset health problems. Not having a local medical professional who is easily accessible often leaves a medical problem until it is too late and becomes a medical emergency, typically much more costly than that annual physical.

Telemedicine can be a positive solution for situations like these. In the words of John Craig and Victor Patterson in their piece, "Introduction to the practice of Telemedicine,": "Telemedicine is the delivery of healthcare and the exchange of healthcare information across distances". Telemedicine can take the form of a video call, a phone call, or even a letter. With the improvement of video conferencing, it is becoming an increasingly viable way to get in touch with a medical professional quickly, saving people the time and money of traveling to a hospital if they do not need immediate medical treatment. We live in a day and age where most people, regardless of income, will have a smartphone or a computer, which creates the ability to have a face-to-face conversation through video calls with a medical professional if we equip hospitals

with adequate equipment. Telemedicine will save money and time for everyone involved and hopefully streamline the process of medical care.

Despite healthcare advancements, some people still cannot pay for the medical treatment they need. Mahatma Gandhi once stated,"the true measure of any society can be found in how it treats its most vulnerable members." Even with programs such as the Affordable Care Act and Medicaid that make healthcare more accessible, a large majority of our most vulnerable population is left out because of the immense financial barriers in the United States. Financial barriers to health care can be caused by many factors: the sheer cost of insurance, the inability of people who earn too much to qualify for Medicaid, but not enough to pay for medical insurance plus living expenses, and lack of accessible information.

"In 2020, the average national cost for health insurance is $456 for an individual and $1,152 for a family per month." (*How Much Does Individual Health Insurance Cost*, pg. 1) Qualifications for insurance are strict. If a person has no stable income source, has pre-existing conditions, or is too old, they may not be eligible for insurance. Even if they qualify, a person living paycheck to paycheck (a more significant majority of our country than we would like to think) would not be able to pay the deductible. "In 2020, the average annual deductible for single, individual coverage is $4,364 and $8,439 for family coverage." (eHealth, para 1) It is impossible for some people to keep this much on hand, forcing them into medical debt or bankruptcy.



"Health spending per person in the U.S. was $10,966 in 2019, which was 42% higher than Switzerland, the country with the next highest per capita health spending."(*How Much Does Individual Health Insurance Cost*, pg. 3) The cost of U.S. health care is much above other developed nations. Our government-allocated programs lack funding and cover the bare minimum of the struggling population.

One example is Medicare. To apply for Medicaid, you must make less than $17,131 (benefits.gov 1) before taxes for one person, which is barely a living wage. If you earn more, that is scarcely enough to cover the costs of healthcare and other expenses such as utilities, food, rent, and other necessities. People making twice as much as this still struggle to find accessible healthcare for an affordable price. Even though government programs help the population of people they serve, it can be very tricky if not impossible to apply if people don't have access to information about financial aid opportunities. Despite this issue, access to information about government aid programs can be fixed relatively quickly and easily. However, some problems

are not so easily fixed, such as the sheer monetary gap between what people are able to pay and what healthcare costs.

Fortunately, there are ways to cut costs so America can start reforming our current healthcare system. The U.S. can cut costs in several ways: cutting back on excess administrative paperwork, streamlining daily operations, and monitoring the use of specialists and equipment and labor to fulfill the basic need of healthcare for the majority of the population, for a lower price.

Paperwork is one of the most significant factors that pull healthcare providers away from time with patients. It is inefficient and time-consuming. The complexities of our healthcare system require an immense amount of administrative paperwork. In an interview the author doncuted with a local nurse practitioner who has been a health care provider for over 30 years, she explained that the recent transition of their hospitals' data from one system to another required nurses at least 20 minutes of extra work entering the patients' information. This was time taken away from treating the patient and time they still have to pay for, despite it only being for filling out paperwork.

This is a problem that should be easily solved. With the rise of Telemedicine being implemented more and more into everyday work, the issue of slowly transferring data from one system to another will soon be over. We will now be able to access patient records easily and quickly. Post-appointment paperwork is being streamlined so healthcare providers can spend more time with their patients. Eliminating the needless and excessive complication of paperwork is just one step to the more significant healthcare price problem.

The next issue is the overpriced daily expenditures of running a hospital, covering the excessive spending in healthcare and some solutions to these high costs.

“Over 50% of our hospital beds are empty, we have 21 hospitals doing open-heart surgery, and 3 doing transplants (3 times what is needed). We have (for 3.5 million people) more MRI machines than Canada and far too many specialists. This, in a state in which 450 000 citizens are uninsured and another 400 000 underinsured. We have a large excess capacity in neonatology, yet 21% of our women give birth without adequate prenatal care. Excess capacity sits cheek by jowl with great need.” (Putsch and Pololi 1)

This quote highlights the excessive spending and over-development of hospitals beyond what is needed. One of the most important things we can do to improve medical care costs is to cut down on daily operations expenses. As mentioned in the previous paragraph, there are three main areas of healthcare costs: administrative paperwork, day-to-day operations, and specialist equipment and labor. As you can see in this last quote, *Putsch and Pololi* talk explicitly about spending on specialist equipment and labor. One of the most significant problems in hospitals today is over-treatment. Giving people immediate medications or surgery, opposed to assessing a medical issue over time could be the better option to reveal the problem’s origin. Doctors would be able to solve the issue better, with less overall harm to the patient. Controlling over-treatment is just one part of a plan we need to implement into our healthcare system. As Donald M. Berwick and Andrew D. Hackbarth discuss in their paper, Eliminating Waste in US Health Care:

“Effectively filling the health care cost stabilization triangle with enough wedges of waste reduction will require more than a list, however. It will demand a highly self-conscious and intentional leadership agenda, with bold and explicit goals, honest monitoring, and strong cooperation between public and private payers. Furthermore, its success will depend on committed leadership from health care professions, who can most accurately tell the difference between waste and what helps. Instantaneously reducing health care waste at the theoretically

accessible scale—that is, 20% or more of total health care costs—is neither practical nor, from the viewpoint of economic stability, desirable." (Berwick 3)

By implementing cost-reducing wedges, many small steps would lead to an overall significant price drop. This quote highlights that we can not just name these steps but we need to implement the ideas and hold the management and daily workers accountable for the initiation and implementation of these changes. Solutions could include holding off on treatment when waiting and watching might be better, streamlining paperwork streams and recordkeeping, and moving specialists such as respiratory and cardiac doctors to areas where they are more needed. One example could be moving respiratory doctors to areas like Denver's Elyria Swansea, where asthma is much more common. Another example would be moving cardiac specialists to cities like McAllen-Edinburg-Mission, Texas, which has an obesity rate 40-50% higher than the national average. These cost-reducing steps would enable people to pay for the medical care they need from local doctors who specialize in health concerns associated with their geographic locations.

One counter-argument to the health care reduction strategy is that we are pulling people who spent years on their degree away from the geographical area in which they prefer to live. Also, with the fixed and ever-expanding prices of pharmaceutical companies, it would be very difficult to substantially decrease medical care costs. Concerning the first statement, the government could introduce incentive programs for healthcare professionals to reallocate to areas with more need of their specialty, programs such as Americorps or TeachAmerica but within the medical field. Concerning the second, pharmaceutical issues are significant right now with the uncapped pricing, especially with life-saving drugs such as Insulin and Epinephrine. EpiPens are expensive because, in 2012, Mylan bought out the only competing company, Merck,

created a monopoly on the EpiPens market and unethically inflated prices 400% over a 5-year period (Marsh 1). Hopefully, our government will eventually step in and impose stricter regulations on big pharma, such as the EpiPen company Mylan. If the U.S. implemented these regulations, companies like Mylan would no longer be able to hold monopolies and we would be able to dispense needed medication for cheaper, much more affordable prices.

Throughout this essay, I explain how simple health care reduction strategies such as increasing Telemedicine, spreading out specialists to areas where they are needed, and increasing regulation of pharmaceutical companies so people can get the drugs they need to survive at an affordable price. These solutions are only possible if we convey our intentions and work every day to implement the changes. If we follow these steps, it will lead to a light at the end of the tunnel, which is every American getting adequate healthcare without fear of crippling medical debt.

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