America’s Healthcare System: A Looming Crises

Abstract

America's healthcare system faces a critical juncture marked by escalating costs, disparities in access, and systemic inefficiencies. This paper explores the imminent crisis, analyzing factors contributing to its complexity and urgency. Through examination of current trends and policy frameworks, it highlights the need for transformative reforms to ensure equitable, sustainable, and patient-centered care. By addressing affordability, quality, and accessibility, this study uncovers systemic deficiencies undermining the health of millions. It advocates for collaborative solutions that prioritize equity and innovation, emphasizing the fundamental right to healthcare for all citizens.

Keywords: Healthcare crisis, Healthcare system, Equity in healthcare, Healthcare in America

Introduction :

Each election cycle, citizens in the United States look to elect leaders who rank healthcare as the most important issue in their manifesto when elected to office both at the local, state, and federal levels. The quality of healthcare, lower prescription drug cost, outcome of care, and lower healthcare costs are some of the ideal metrics used to determine the best healthcare systems around the world. The United States spends more money on health care than any other country, yet life expectancy continues to decline, obesity is at an all-time high, and maternal and infant mortality is higher. While only about 90% of the population had healthcare coverage in 2016, the United States spent about 18% of its GDP on healthcare. Other countries spent much less of their GDP on health care, ranging from 9% in Australia to 12% in Switzerland, despite having more than 99 percent of their populations covered (Florimon, 2019). One would expect a free-market healthcare system style to encourage competition, therefore, driving the price down. On the other hand, however, the cost of pharmaceutical medication continues to be expensive, and the average physician'searnings in the United States are ridiculously high.

Furthermore, the divisive nature of Washington politics has made whoever is occupying the white house promote legislation that only appeals to their political party. Health is supposed to

be a right of every citizen, but the political elite continue to make it a tool for big pharmaceutical companies, and insurance companies. Expensive campaign advertisements paid by insurance and pharmaceutical lobbyists to swindle voters continue to be used as bait to meet their selfish interests when their choice candidates are elected. One party believes in a patient-centered healthcare system based on free markets, which promotes competition and supposedly drives down healthcare costs. But does it? They believe that a government-run healthcare system will reduce both efficiency and quality of care, as well as compromise the patient-physician relationship and increase waiting times within the healthcare system, as evidenced by government-run healthcare systems around the world (Republicanviews.org, 2016; Grassley, 2009). The other party supports big government involvement in healthcare and believes they are, "fighting to secure universal health care for the American people for generations, and we are proud to be the party that passed Medicare, Medicaid, and the Affordable Care Act" (Democratic Party Platform, 2022). With the different ideological and political shifts pushed by both the media and the political parties, it can be difficult to establish long-lasting solutions to America's healthcare system's problems.

Many chronic diseases have clinical preventive measures available, which include intervening before the disease develops (primary prevention), diagnosing and treating the disease at an early stage (secondary prevention), and managing the disease to reduce or stop its course (tertiary prevention) (Levine et al. 2019). These therapies, when paired with lifestyle changes, can significantly lower the incidence of chronic disease, as well as the disability and death that comes with it. Despite the human and economic costs of chronic diseases, the availability of evidence-based tools to prevent or mitigate them, and the success of prevention efforts, clinical preventive treatments remain underutilized in the United States. Chronic diseases place a significant strain on both patients and the healthcare system. The majority of adults in the United States had at least one chronic disease or condition in 2014, and about half the adult population had multiple diseases (Buttorff, Ruder, Bauman, 2013). "Chronic diseases, such as heart disease, cancer, chronic lung disease, stroke, Alzheimer's disease, diabetes, osteoarthritis, and chronic kidney disease, are the leading causes of illness, disability, and death in the United States" (Levine, Malone, Lekiachvili, Briss, 2019). Rather than preventive care, our system focuses on disease, specialty care, and technology. Preventive care lowers the risk of diseases, disabilities, and death; however, millions of Americans do not receive recommended preventive health care

services. Children require routine checkups and dental visits to track their development and detect health issues early when they are usually easier to treat. Screenings, dental check-ups, and vaccinations are critical to keeping people of all ages healthy. However, for a variety of reasons, many people do not receive the necessary preventive care. Cost, the lack of a primary care provider, living too far away from providers, and a lack of awareness about recommended preventive services are all barriers.

The United States is unique among developed countries in that it is the only one that does not safeguard its citizens against unfair prescription medicine pricing. American pharmaceutical and retail drug companies have gotten away with overcharging American citizens for far too long. Japan, Taiwan, the United Kingdom, Germany, and Switzerland have all negotiated cheaper rates for brand-name pharmaceuticals on behalf of their citizens with pharmaceutical companies. Citizens in these countries pay significantly less for prescription pharmaceuticals because of the negotiated prices, which greatly reduces the total medical expenditure in these countries. A patent prescription price review was done in Japan and Taiwan to enforce restrictions that regulate the maximum cost at which manufacturers can sell brand-name drugs and to also negotiate a cap at which companies can sell brand and generic drugs. This negotiation between the government and the drug companies has devised a pricing system for brand-name pharmaceuticals that is on average 35 percent to 40 percent cheaper than in the United States. President Joe Biden emphasized during his State of the Union address the problems with the high cost of prescription drugs in America. “We pay more for the same drug, produced by the same company in America than any other country in the world,” he said as he highlighted how expensive the cost of insulin is and how many Americans depend on insulin to live daily because of diabetes. President Biden shared a story of Joshua Davis and his dad who currently have diabetes. “Insulin costs $10 dollars of vials to make, pharmaceutical companies charge Joshua and his dad up to thirty times that amount.” Imagine being Joshua’s parent and you currently earn a minimum wage or slightly above that. This is what millions of Americansdeal with every day. These drugs are badly needed, but how do you afford them when you are raising a family of four with other needs like rent, clothing, feeding, and tuition at hand? Many Americans end up neglecting their health because they must prioritize other bills, which eventually causes them to be sent to the emergency room and some end up paying the ultimate price with their lives.

In 2018, pharmaceutical firms and their trade partners spent around $220 billion lobbying in the United States (Scutti, 2019). Even though countries understand the serious challenges created by high prescription drug prices, little has been accomplished in terms of regulatory or legislative reform due to the pharmaceutical and healthcare industries' lobbying prowess and high dollars. Prescription drug costs are out of control, putting pressure on healthcare budgets and limiting financing for other areas where government investment is required. The rising cost of prescription pharmaceuticals poses an additional problem in nations without universal healthcare: prohibitive out-of-pocket expenditures for individual patients. Due to high out-of-pocket prices, around 25 percent of Americans find it difficult to afford prescription medications (McDermott, 2019). High drug prices, according to drug corporations, are critical for supporting innovation. However, the power to demand exorbitant costs for each new drug may stifle innovation. Developing medications that are small modifications of current drugs with incremental improvements in efficacy or safety is less hazardous than investing in truly new drugs with a higher risk of failure.

Health insurance in the United Statescontinues to be a major drawback in the healthcare system. There are currently about fifty million people and households, which also include seven million undocumented immigrants who do not have health insurance (KFF analysis, 2021). When a major tragic disaster happens to one’s family requiring quick and urgent care in a hospital, they cannot get the care they deserve because of how expensive and inaccessible healthcare insurance has become. Health insurance is inequitable, poor, undocumented, and immigrant families are not properly insured. As a result, they suffer from greater health issues than those who do not have insurance. Costs of health care and insurance premiums are rising much faster than the cost of living. For a long period, monthly public wages and expenses have been increasing, with very little increment in the minimum wage. People and governments, on the other hand, are struggling to keep up. The system continues to be unfair to poor families, minorities, immigrants, and undocumented people. If you lose your Job, it is becoming increasingly hard to access quality care without having to be thousands of dollars in debt. Countries like Japan and Taiwan have all their citizens covered comprehensively and exclusively by either national medical insurance for the self-employed or social insurance for employees. Copayments are capped depending on one’s income and if a Japanners loses their job, they don’t lose their health insurance, because they are automatically switched to community insurance (Nakayama, Nomura, 2005; Wu,

Majeed, Kuo, 2010). The Taiwanese government before 1995 mirrored their insurance system like the United States. There was a range of different healthcare coverages covering slightly above half of the population. They had labor insurance, governmental employee insurance, fishermen's insurance, and farmers' health insurance. They soon realized the loopholes that were created with many general practitioners (GPs) practicing independently with expensive out-of-pocket payments from patients. They then introduced the National Health Insurance (NHI) system in 1995 to integrate all the different healthcare coverages into a single national insurance system. Their primary objectives were to improve the effectiveness and efficiency of the Taiwanese healthcare coverage system and to make healthcare more equitable for all citizens, not just rich or more privileged citizens (Wu, Majeed, Kuo, 2010). Every Taiwanese has a National Health Insurance card which is used to identify a person's medical history and bill the national insurer. The system is funded by tax revenue from employees, employers, and the local and national government. As of 2020, Taiwan spends about 6.2 percent of its gross domestic product on healthcare, while the United States spends about 19.7 percent (Wu, Majeed, Kuo, 2010).

The Association of American Medical Colleges (AAMC) estimates that the United States could face a shortage of between 54, 100, and 139,000 physicians by 2033. David Skorton the AAMC president said, "This annual analysis continues to show that our country will face a significant shortage of physicians in the coming years"[13] while highlighting the dangerous gap and challenges shortage of physicians across the country will create in delivering quality care to vulnerable patients. Because there aren't enough trained doctors and services to use, it's difficult for those who require health care to find good doctors. Instead, they rely on inaccurate online reviews to determine the quality of things like the friendliness of the employees and the length of time they must wait. These platforms, on the other hand, do not consider how well a doctor can assist patients with their health problems. Adequate availability of healthcare providers is needed to deliver improved quality care, increase access to care, and control healthcare costs. With an aging and increasing population, physicians' availability to patients has been recognized as one of the predominant barriers to meeting the healthcare needs of patients in the United States (Kullgren, McLaughlin, Mitra, Armstrong, 2012). Prior to COVID-19, the United States already had a health-care worker shortage, but the situation has gotten much worse (Romero, Bhatt, 2021). The pandemic was so eye-opening to the loopholes with healthcare workers shortage across the country. Healthcare workers including doctors, pharmacists, and nurses were granted

permits to practice across state lines, retired healthcare workers were called back into practice, and student healthcare workers were given temporary permits to practice as real professionals in some states. When the epidemic struck, the country maintained its healthcare system by employing doctors and nurses from all over the world, particularly from India, Pakistan, and the Philippines. This led to gross misconduct in the practice, and inexperienced workers putting the lives of vulnerable patients at risk. The current pandemic has also placed an unprecedented amount of physical and mental stress on healthcare workers. The fear of risking infection for themselves and their families, the pain of losing loved ones, patients, and colleagues, the multiple waves of the pandemic, and the current high death rate have all compounded the issues causing healthcare workers to quit in masses across the country (Prasad, Mcloughlin, Stillman, Poplau, Goelz, Taylor, et al, 2021).

What the country did not do, however, was use the crisis to reform its student loan system, which has buried healthcare employees with crippling debt and continues to be a barrier for those who wish to pursue a career in medicine. Student loan debt continues to be a big barrier for all professions across the country. This is especially true for medical personnel. Many nurses, doctors, and others in the field have been unable to repay their obligations for years, making the stress of rising debt a disincentive to entering the field in the first place. The average nursing student loan debt is between $40,000 and $54,999, according to the American Association of Colleges of Nursing. The average medical student loan debt load was $161,290 in 2013. Many of the hidden charges that entrapped young doctors over time, such as compound interest, license and maintenance fees, and board exam fees, contributed to this debt. By 2020, that number had climbed to $207,003 in average debt. None of this comes as a big surprise. In 2021, the average cost of four years of medical school at a public school was $259,347, and $346,955 at a private university. Many students are forced to take out loans to cover the costs of residency and migration, which average around $12,000 per person (Hsu, Caverzegie, 2013). In comparison to other developed countries such as the United Kingdom, Germany, Taiwan, Japan, and Switzerland, medical education is significantly cheaper and medical students are not thousands of dollars in debt before they start their practice. Imagine the emotional stress of spending eleven to fifteen years in school and residency, only to start off your career already $300,000 in debt with constant monthly interest piling up. A much bigger systemic concern is the impact that high healthcare educational debt has on minorities and underserved populations. These underserved

communities already have compounded issues to deal with, they mostly are trying to survive by having basic amenities and access to healthcare. Imagine being born into a low-income household as a minority, but you have big dreams of becoming a physician someday and doing great things. Your parents barely survive to feed you, clothe you, and barely have enough to take care of your daily needs. With such odds already staked up against you, one wonders how being a physician can ever be a reality with tuition fees that high. Access to loans for such families in those neighborhoods is very limited, which then creates a downward spiral of having to give up on such incredible dreams because of how high medical education has become in the United States. There is also a problem with cultural representation in healthcare in America. Only about five percent of physicians identify as black or African American, despite being thirteen percent of the United States population. Fewer than six percent of physicians identify as Hispanic, despite Hispanics making up nineteen percent of the population[22]. This staggering statistic speaks to issues of systemic oppression and the lack of cultural diversity which all stemfrom the lack of financial capital to fund medical education in underserved communities.

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