

The History of the U.S. Health Care System

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“The United States of America is one of the wealthiest nations in the world but it is far from the healthiest” (Aron & Woolf, 2013). The statement is quoted by Aron, Lauden, and Steven (2013) in the article titled “U.S. Health in International Perspective: Shorter Lives, Poorer Health” by the “Institute of Medicine” in January 2013, reflecting the complexities and challenges in the U.S. healthcare. The health disadvantages in the United States prevail due to the significant differences in spending patterns, health outcomes between the U.S. and other industrialized countries, and healthcare expenditures even though the U.S. spends “far more per person” on healthcare than any other country. Building on the history of the U.S. healthcare, this paper discusses the “evolution” of the care system over the years due to demographic, legal, or political factors and the comparison of spending patterns of the U.S. to other industrialized countries. It also discusses reimbursement trends and the key reform initiatives that impacted the care providers and the care delivery of the United States.

Evolution of the U.S. Healthcare System over the Years

- **Political, Legal, Regulatory, or Demographic Factors**

In the United States, the current state of the healthcare system is shaped by a complicated interplay of demographic, legal, regulatory, and political factors. These factors significantly and collectively contribute to the challenges and complexities of the care system. Unlike other industrialized countries, the U.S. spends more on healthcare per capita, driven by high prices for administrative, pharmaceuticals, and medical services which significantly contributes to the economic costs of the nation. The “Health Insurance Portability and Accountability Act” (HIPAA), passed in 1996, serves as the legal or regulatory factor that provides security

provisions to protect the medical information of patients across the country. Agencies like the “Food and Drug Administration” (FDA) and “Centers for Medicare and Medicaid” play crucial roles in ensuring the safety of medical information, setting care standards for organizations, and regulating healthcare practices throughout the healthcare system.

Furthermore, a “significant” portion receives health insurance through employers because of employment-based insurance, which ties health coverage to employment status. The ever-changing demographic factors such as the aging population and population diversity with diverse healthcare needs required the U.S. to develop a flexible and inclusive care system for which the ACA (Affordable Care Act) was enacted in 2010. The act aimed to expand health insurance coverage and improve care delivery across the United States healthcare delivery systems (Thomasson, 2013). In addition, in 1965, the Medicaid and Medicare programs were established to provide health coverage to low-income, elderly, and disabled individuals and to influence the “financing” of the U.S. healthcare system to date.

- **Three Important Factors Shaping the Current State of the U.S. Healthcare**

One of the important factors that was introduced to increase health insurance coverage measures in the U.S. was the Affordable Care Act. It was largely introduced for Medicaid expansion and subsidies for people with low income as well as to prohibit insurance companies from denying care coverage based on pre-existing health conditions to patients across the United States. This legal factor in healthcare not only allowed “young adults to stay on their parent’s insurance plans until age 26” but also significantly “increased the number of insured Americans” in order to improve individual access to healthcare services (Doonan & Katz, 2015).

Secondly, the innovations in medical devices, diagnostic tools, and treatment methods or other advancements in medical technology have dramatically and significantly changed the U.S. healthcare system. However, this has also increased overall expenditure on healthcare while trying to improve the care system. Third and the significant factor that shapes the current U.S. healthcare state is demographic shifts due to the aging population which has increased the demand for healthcare services, especially for elderly people and for chronic and long-term diseases (Haughton & Stang, 2012). This factor has led to higher healthcare spending and a greater focus on chronic disease management in the care delivery system of the country.

- **Changes in the U.S. Healthcare System**

The factors that have significantly changed the U.S. healthcare system include the “Affordable Care Act” which has minimized the number of uninsured individuals significantly. In an attempt to improve access to healthcare services, the aging population has significantly shifted the focus of care organizations towards providing long-term care and managing illnesses that have chronic histories. In addition, technological advancements have contributed to rising expenditures for healthcare but they have proved to be beneficial for healthcare and the U.S. population who need quality care.

Comparison of Healthcare Spending Patterns of the U.S. to Other Industrialized Country

- **Spending Patterns**

In the United States, people tend to spend more on healthcare, housing, and education compared to their industrialized counterparts. For instance, in the United Kingdom, people allocate a larger portion of their income or spending to transportation and leisure activities like camping, attending concerts, or travelling across the U.K. Generally, the residents of the United

Kingdom are more likely to save a higher percentage of their income, weekly or monthly, compared to their American counterparts. Americans tend to be more confident and optimistic in their spending but British are generally more cautious with their spending, influenced by a more pessimistic outlook on the future. British spend more on housing, food, and transportation compared to Americans who spend more on dining out and out-of-pocket healthcare accounting for about 9-10% of their total spending.

- **Healthcare Spending**

In comparison to U.S. spending on healthcare, industrialized countries like the U.K. spend less on health per capita. The U.S. has higher administrative costs due to its complex insurance system whereas the National Health Service of the U.K. has lower administrative overhead which provides healthcare funded through taxation. This is mainly due to the single-payer system in the United Kingdom which leads to lower spending than the U.S. where the care spending was \$4.5 trillion in the year 2022 but the U.K. spent about half of that. This is about 17% of the U.S. GDP whereas the healthcare spending in the U.K. was about 10% of its GDP, spending approximately \$5000 per person annually on healthcare (Thomasson, 2013).

- **Healthcare Outcomes**

The U.S. has a “higher infant mortality” rate compared to the U.K. and other industrialized countries. The U.S. healthcare system reports about 5.4 deaths per “1,000 live births” so the “average life expectancy” in the country is around 78 years (Singh & Stella, 2019). Compared to the U.S., the U.K. has a lower infant mortality rate of about 3.8 deaths due to which the average expectancy of life is approximately 80-85 years. Though the U.S. spends more on

healthcare, the country does not necessarily achieve better and more effective healthcare outcomes, as evidenced by higher infant mortality rates and lower life expectancy.

Reimbursement Trends in the U.S. Healthcare System

- **Evolution of Reimbursement Trends from the Historical Perspective**

In the early 20th century, the healthcare reimbursement model was primarily focused on a fee-for-service model. According to this model, the patients had to directly pay for the services provided to them by any healthcare provider in an organization. The model was straightforward but the fee for each service often led to high out-of-pocket costs for patients, especially for those who suffered from long-term illnesses.

Later, in the mid-twentieth century, the rise of “employer-sponsored health insurance” changed the trend as insurance companies began the trend to cover a substantial portion of care costs. This somehow reduced the financial burden of patients which was further reduced with the introduction of Medicaid and Medicare programs with the U.S. government becoming the major payer in the healthcare system (Marjoua & Bozic, 2012). The late twentieth century saw the growth of MCOs (Managed Care organizations) which aimed to control costs regardless of the number of services provided to the patients.

The 1990s also saw the introduction of “capitation payments” where healthcare providers received a set care cost for the service provided to the patient. The value-based reimbursement trends in the twenty-first century through the enactment of ACA in 2010 and programs like the Hospital Value-Based Purchasing tied payments to the quality of care provided and “incentivize” healthcare organizations to improve patient outcomes.

- **Primary Payers**

The primary payers are patients who are responsible for out-of-pocket costs depending on the type of service received and the type of insurance coverage. Other payers include private health insurance companies that negotiate rates with providers and cover substantial costs for their policyholders. The government also acts as a major payer of healthcare costs through federal programs like Medicaid and Medicare to provide care coverage to low-income families and individuals aged 65 or older.

- **Payers Responsible for Payment of Care Services**

In the early 20th century, patients were supposed to cover their medical expenses out-of-pocket for the services provided to them due to a lack of federal government initiative and insurance companies. However, with the employer-insured insurance companies' rise, private companies began to take on a larger share of care expenditures which shifted the trend with Medicaid and Medicare as the government was supposed to pay a significant portion of care costs. With the technological advancements, the introduction of federal programs, and the private insurance companies in the late twentieth century to the present, the reimbursement trends have significantly changed with Medicaid and Medicare as the primary payers for the healthcare services provided to individual American citizens. While government programs and insurance companies cover a significant portion of care costs, patients with long-term or life-threatening illnesses still bear medical expenses out of their pockets from their small portions of income. These trends reflect the evolving landscape of reimbursement in the healthcare arena, with a growing emphasis on delivering value and quality care to the unhealthy population of the United States.

Healthcare Reform Initiatives

- **Impacts of Healthcare Reform Initiatives on “Operational Planning and Decision-Making” of an Organization**

Within healthcare organizations, care reform initiatives significantly impact the decision-making processes and operational planning as these initiatives often introduce care delivery models, new regulations related to the healthcare delivery system, and funding mechanisms. Healthcare organizations must adapt to these reform initiatives in order to remain compliant and financially viable in the care industry.

- **Key Reform Initiative**

The key reform initiative in the history of the U.S. healthcare system is the enactment of the “Affordable Care Act” which aimed at reducing healthcare costs and increasing as well as improving healthcare outcomes for the unhealthy population of the country. The act introduced several key provisions including the implementation of value-based care models for healthcare organizations across the United States healthcare system. It also introduced health insurance marketplaces which reduced the medical expenditures for the patients. The act was a major factor in the expansion of Medicaid for the elderly and disabled youth who cannot afford medical expenses.

- **Healthcare Provider Impacted by the Reform**

In terms of the healthcare providers that are significantly impacted by the reform initiatives, hospitals are the ones that are majorly impacted by the ACA due to the shift from a “fee-for-service” approach to a “value-based” care approach. This major change brought to the

healthcare system due to ACA emphasizes the “quality of care” provided to the patients rather than the “quantity” of “services rendered” on each visit of the patients to any healthcare facility. Thus, hospitals are the facilities that are “incentivized” to reduce readmissions of patients which was the case in the early 20th century to make more profits out of each visit. This initiative of incentivizing the hospitals has led to several operational changes in the healthcare delivery models. For instance, hospitals have to adjust their financial planning to account for changes in reimbursement trends, shifting to cost-efficiency to receive full reimbursement under “value-based” care models.

- **Impact of Healthcare Reform Initiative on “Operational Planning and Decision-Making” of a Healthcare Provider**

The ACA has driven hospitals to become more efficient, focused, patient-centered, and impactful while delivering high-quality care. These changes in decision-making processes and operational planning have been essential for hospitals which ACA ensured through its value-based care model so that hospitals can adapt to the evolving healthcare landscape. The ACA encouraged better care coordination among different healthcare providers by encouraging hospitals to introduce and implement more effective strategies such as effective communication with primary care physicians and other healthcare providers to ensure continuity of quality care. For quality improvement initiatives, hospitals under ACA implemented various initiatives such as investing in health IT systems for better patient data management and in order to avoid penalties due to mismanagement of patient information. To receive further incentives, hospitals increased efforts to engage patients in their own care which included providing better education about preventive measures, treatment options, and health conditions. Many care organizations

like hospitals invested heavily in infrastructure improvements such as adopting new medical-related technologies and upgrading facilities to meet the requirements of the ACA.

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