Health Care in the United States: What Does that Really Mean?

According to the U.S. Census Bureau, nearly 50 million people did not have health insurance in 2010. Some of the groups that experienced the greatest loss of coverage were working adults between ages 35-64; people with annual incomes below $49,999, Workers with no disability more likely to be uninsured (22.3% of workers without disabilities versus 17.3% of workers with a disability are uninsured). Hispanics continue to experience a disproportionate effect, as many are not eligible to obtain insurance (30.7% of Latinos go uncovered). Also, 20.8% of the Black population remains uncovered, 18.1% of Asians, and 11.7% of non-Hispanic whites. Furthermore, there are 7.3 million children (under the age of 18) who are uninsured. In the World Health Organization's 2000 World Health Report, the US health system ranked 37th in the world for performance and 55th for fairness in financial contribution.

Privatized Health Insurance is a contract bought through a market, where people pay a maintenance cost that over a longer period of time will benefit them by keeping the costs of preventative care, medical procedures, and prescriptions down. However, not all the money people pay to insurance companies goes to health care costs. Private insurers spend 30 cents of every dollar on administrative and shareholder costs. Health Maintenance Organizations (HMOs) make their money by denying services to people — the less money they pay, the more profit they make. This is only one form of accessing the health care system, but is the method that is seen as the best way by politicians whose efforts of health care reform attempt to mandate private health insurance.

People with private health insurance may actually be **Underinsured**. This occurs when people have a contract with an insurance company, paying the monthly fee, and yet are not be able to fully or constantly access the health system. Depending on the individual's plan, some health issues and emergencies may be covered or assisted with, and yet others may not be. Dr. Steffie Woolhandler, a professor at the City University of New York School of Public Health and visiting professor of medicine at Harvard Medical School, noted that "not having health insurance, or having poor quality insurance … is a source of mounting stress, personal bankruptcy and poor medical outcomes" and that the Census Bureau has continued to be silent on this problem. In fact, a 1997 study by Dr. Steffie Woolhandler and Dr. David

Himmelstein found that nearly 100,000 people died each year from a lack of access to health care. Now, 15 years later, would it even be possible to think those numbers have decreased?

Employer-based health insurance is a group insurance plan that is paid by businesses, usually as part of an employee benefit package. In fact, most private health care in the United States is employment-based. America is currently the only industrial nation that links health care to jobs and yet only 59% of Americans are covered by their jobs. Over the last five years, there has been a 15% drop in the number of private employers offering plans. Today, 85% of uninsured people are either not offered or are ineligible for insurance through their employer. The share of working adults and their children, who had insurance through an employer, fell 10% during the last recession, according to a study by the Center for Studying Health System Change, a nonpartisan research group. The major contributor to the decline was the loss of employment during the downturn, with almost a third of the people younger than 65 living in a family where no one was working.

Medicare and Medicaid (Medi-Cal in California) are health insurance programs funded by a federal to state match program that assist in covering medical and prescription expenses for elderly, disabled, and low-income Americans. In 2010, Medicare allowed almost 48 million people to have access to healthcare and life-saving treatments, and Medicaid did the same for about 60 million people. This type of care is mediated through insurance and privatized, profit-based pharmaceutical and health technology producing companies. In other words, the money allocated for people in vulnerable populations does not go to them directly, but rather, gets mediated through these companies first. As a result, not all the money allocated to care for someone's health is actually used for that purpose. Furthermore, the cost of administering these programs has increased over the years partially because of the rapid escalation in insurance and health care costs. This rise in costs has forced the states, and consequently the federal government, to cut funds to the public healthcare system. As a result, people have been forced to ration their visits to the doctor and forgo getting necessary prescriptions.

Referring to the Affordable Care Act, Dr. Steffie Woolhandler noted that "the new law's subsidies for health insurance will not be sufficient to provide quality and affordable coverage to the vast majority of Americans. Tens of millions will remain uninsured, underinsured and without access to care. We need more fundamental reform. We need a single-payer national health insurance program." In actuality, there will still be about 23 million people who remain uninsured by 2019.

A nationalized single-payer health care system is one that is facilitated by the government, comprised by the people for the people, where all health care providers are not-for-profit and provide health services (including vision and dental care) to all peoples and populations regardless of wealth and the ability to pay. The "United States National Health Insurance Act," or H.R. 676 is a pending piece of federal legislation that would establish a single-payer healthcare system in the United States. This system would be an expanded Medicare program that would focus on federal and state funding of health care services, so that monthly premiums that would have been going to private insurance would go directly into a collective healthcare pool that all people can use.

With this system, stories like the one shared by John in Portsmouth, New Hampshire would no longer be an everyday experience. One day, while John's son, an X-ray technician, was working, a woman came into the emergency room (ER) with a splitting headache. After doing scans, they discovered she had a brain tumor, but she also had no job and no insurance. The doctors in the ER told her there was nothing they could do to help her. Later, John's son found her sitting in her car in the parking lot, crying. "I'm dead," she told him. Unfortunately, this story is not uncommon. A 2009 study in the American Journal of Public Health showed that 45,000 deaths occur annually based on a lack of having health insurance. This means that there is about one preventable death every 10 minutes. What would it mean to have a system that prioritized a person's life over whether or not they are able to pay for health care?

The government already pays half of the funds for health care. As a result, the elimination of a profit-based system could save California $343.6 billion dollars in the next decade. Currently, California has over 1500 health coverage plans to choose from and 60% of the care delivered is sub-standard. Hospitals are closing and emergency rooms are the care of the last resort. A single-payer health care system would streamline bureaucracy, saving $400 billion a year on administrative overhead; this is enough to pay for all the uninsured and to upgrade everyone else's coverage. This is the system we need to strive to achieve.