The Structure & Cost of US Health Care: Crash Course Sociology #44

Crash Course: Sociology
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The healthcare situation in America is...complicated.

Doctors, hospitals, insurance and drug companies; it can be hard to navigate all the moving parts of healthcare and it's even harder if you're trying to do it when you're sick. Theory and statistics can give us a broad understanding of the social and cultural forces that affect health.

But for the average American making choices about healthcare, the questions that matter most are the practical ones. After all, when you're running a fever, the most important question is where can you find a doctor to make you better. And then after the fever has gone down and you get the bill, your question might become, "How do I pay for this?

And why does giving me an aspirin count as a separate thing that I get charged for?" It's easier to answer these questions once you understand how the US structures and finances its health care system. So, let's do it. [Theme Music] Let's start with the basic structure of the healthcare system in the United States. Health care is split into different sectors: the private, the public, and the voluntary sectors.

Private and public sectors supply insurance and care to most Americans. In the private sector, 56% of patients pay for their health care with insurance that they get primarily through their employer. There are also public health insurance plans for vulnerable groups--like Medicare, which covers elderly Americans, and Medicaid, which covers Americans below a certain poverty threshold. The government also provides healthcare through things like VA hospitals and the Bureau of Indian Affairs, and it has a legal mandate to provide healthcare for people in federal prison. But the voluntary sector is different, in that it includes charitable organizations that do health research and provide free or low-cost health services, like the American Cancer Association or the March of Dimes.

So, with all of these options available, what determines how easy or hard it might be to get access to health care? In this context, access refers to entry into, or use of, the health care system. In 1981, two professors of Public Health at the University of Michigan--Roy Penchansky and J.

William Thomas--came up with what they called the Five A's of health care access: availability, accessibility, accommodation, acceptability, and affordability. So, the first "a" asks: Does the person live where the health services they need are readily available? If you live in a major city, you might take it for granted that finding a doctor or a 24-hour clinic on short notice is just a Google search away.

Urban areas have more doctors, specialists, and hospitals--all of which means that a wider variety of services are available. By contrast, rural areas are more likely to experience shortages of healthcare workers. Urban areas have twice as many doctors per person as rural areas!

Rural areas also tend to have issues with the second "a": accessibility. Accessibility here refers to a person's literal ability to get to facilities and keep appointments. Transportation to appointments can be much more difficult in rural places, where providers tend to be farther away.

This is especially hard for people with chronic illnesses or disabilities that make it impossible for them to drive by themselves. Time can also be a limiting factor. Doctor's appointments are usually during business hours, so patients may have to miss work to get the care they need.

Low-income and blue-collar workers are more likely to have jobs that don't offer paid sick leave, and they may even be fired if they miss work due to illness. Sociocultural factors can also impact the accessibility. And so can the accommodations provided by health services. Accommodations are the ways that services are organized to accept clients, like the hours that they're open or the ways that they communicate with patients.

Language barriers can make it especially hard for non-English speaking patients in the US. So accommodations like translators or multilingual information packets, can help mitigate the disparities. And finding the 'right' accommodations for different populations can be difficult, too.

For example, Hmong Americans, who primarily immigrated as refugees from Southeast Asia in the wake of the Vietnam War, have higher mortality rates than native-born Americans. Providing medical information can be hard, because no written form of the Hmong language existed until the 1960s. Meaning that many Hmong people can't read or write in their own language, and dialects vary, making it hard to find the right translator.

Once you get past all those other obstacles, there's still the matter of whether the doctor and patient have similar ideas about how the whole doctor-patient relationship should work. Some people want a doctor who gives them the information they need to make decisions themselves. But others just want to leave all the decision-making to the doctor and just be told what pills to take.

How satisfied a patient is with their healthcare tends to depend on the match between their preferences and their doctor's style of care, or the doctor-patient congruence. A patient's satisfaction with a provider will determine if they return. So the next "a", acceptability, is based on whether a doctor meets the patient's preferences—both in terms of their professional abilities and in their personal traits, like gender, race, or age.

For example, many people feel more comfortable with a doctor of the same gender as themselves, so if none are available, they may not find that health care experience acceptable. The last "a" of the five A's is a pretty important one, particularly in the United

States: affordability. How people pay for health care int he US, and more importantly if people can pay for health care, is closely linked to how we financially structure the healthcare system. The US has what's known as a 'fee-for-service' healthcare system, where services are unbundled and paid for separately. So if you go in for a check-up and the doctor orders a blood test and an x-ray, the charges on the bill will be separated into three parts: the x-ray, the lab test for the blood, and the cost of the doctor's time. There are pros and cons to a system like this.

It incentivizes doctors to do a lot of tests, because they'll get a separate fee for every test. Which can be good—you want your doctor to be thorough when you're not feeling well. But a fee-for-service system also incentivizes over-treatment, and this drives up the cost of care. The US also relies on a third-party payer system, which means that medical costs are paid through a third party, like a commercial insurance company that's responsible for paying the doctor on behalf of the patient.

Third-party payer systems often rely on cost-sharing, where the insured patient pays a little each month, whether they need care of not. This helps limit the overall costs to the insurance provider. An insurance premium is the amount you pay to the insurance company each month so that you can keep your coverage. A deductible is a the portion of the health care costs that you're responsible for yourself before your insurance kicks in.

Most insurers offer lower monthly premiums if you accept a higher deductible—so it's kind of a trade off: do you want to pay more per month and not have to worry about meeting the deductible or would you rather pay less per month and worry later when faced with more expensive medical bills? Health insurance exists to protect us from health uncertainty. We don't know if we'll get sick or how expensive being sick will be, making it pretty much impossible to save enough money against the possibility of a very costly illness.

So, let's go to the Thought Bubble on last time, to discuss how health insurance helps us manage financial risk in the face of a health crisis.
Suppose there's a 1 in 50 chance that you'll break your leg and have to pay $7,500 to get an x-ray, a cast, and some physical therapy. You might not be able to dig up that much money. But what if you have 49 other people who also are worried about breaking their leg?

If you all agree to chip in $150 dollars to a pool that will go to whichever one of you breaks their leg, you all can rest easy knowing that you won't have to empty your bank account if you fall out of a tree. This is a simple example of a risk pool—a group of individuals who are covered under one insurance plan. An insurance company decides how to set their premiums and deductibles based on how likely the 'risk' is that they'll have to pay out an insurance benefit. Take our broken leg example. What if some of those fifty people were really into extreme sports actually had a 50% chance breaking their leg?

If the insurance company knows that, they might increase the price that you have to pay into the pool, because there's a greater likelihood that more people will need them to shell out $7500 for a broken leg. Some insurance plans set prices using community rating in which everyone in the risk pool is charged the same price to buy into the insurance plan.

But in the US insurance plans typically use experience rating, where different groups that have higher or lower risks pay different prices. For example, smokers are at a higher risk for heart disease and lung cancer, so an insurer might charge you higher premiums if you smoke. Thanks Thought Bubble. Hopefully that helps you better understand how insurance plans work. Access to affordable insurance can make a huge difference in the quality of health care that a person receives. People without insurance use preventative services less often, are more likely to postpone medical care, and are more likely to move between different doctors, resulting in worse continuity of care.

As a result, being uninsured is associated with a greater need for more expensive and more urgent medical procedures. The high costs of medical care in the US and the high number of uninsured people are big parts of what spurred the passage of the Afordable Care Act, and kicked off the national debate about the best way to deal with these twin problems in the US health system. Of course, what we've covered here today is only one understanding of how healthcare works in the US. There's so much more to consider and explore in this topic, and quite frankly, with everything else that we've discussed throughout this course.

But even though Crash Course Sociology has to come to an end, the number of questions that remain unanswered about how societies work is never ending. Hopefully this course has given you some helpful tools and perspectives to use as you analyze and participate in the social world. Thanks for joining me and don't forget to be awesome. Today, we talked about what the health care system in the US looks like, the five A's of health care accessibility, and a couple of contributing factors to the affordability of health care, fee for service care and the structure of our health insurance system which encourage higher spending.

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