Reform is necessary: An analysis of the United States Healthcare System after the Patient Protection and Affordable Care Act with Comparison to South Africa's Pluralistic Healthcare System

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Abstract

The structural and functional complexity of the United States healthcare system affects its citizens. As such, the healthcare system has caused both economic and social issues to arise, which have demanded the need for healthcare reform. The two major issues in the healthcare system which are disadvantageous to citizens are limited accessibility to healthcare and its cost; both of which are disadvantageous to citizens. The Patient Protection and Affordable Care Act (PPACA), was passed in order to combat these issues within the healthcare system, however, its impacts did not produce a comprehensive solution. Since the enactment of PPACA there have been positive changes, but healthcare costs continue to rise and the United States still ranks lower than other developed nations in healthcare quality. The country of South Africa has a pluralistic healthcare system like the United States, and it is currently undergoing a healthcare system reform. Due to this similarity, the United States can study the impacts of South Africa's healthcare reform in order to determine that healthcare reform is necessary, and to discover which reforms are essential to construct a thriving healthcare system. The current United States healthcare system is unsustainable and further healthcare reform is necessary to ensure accessibility to quality healthcare for all citizens at an affordable cost.

Chapter 1. Analysis of Issues in the United States Healthcare System

The healthcare system within the United States is one of the most varied in the world and affects all individuals who receive, provide, or are responsible for financing healthcare. There are issues in United States healthcare such as cost and accessibility that are detrimental to individuals who are affected by it and, as a result, the United States has worked to provide healthcare reform (Goudreau, 2014).

The purpose of this paper is to support the idea that the United States healthcare system needs reform. In order to conclude that reform is necessary, the United States healthcare system will be analyzed with regard to current issues such as cost of and accessibility to healthcare, address the role and impact of the Patient Protection Affordable Care Act, and discuss the possible effects that may result from recent reform of the United States healthcare system based on the South African healthcare system.

Throughout the last few decades, due to population demands and rising costs, healthcare has become a topic of concern for people and reform of the healthcare system has become a controversial part of political platforms. The Patient Protection and Affordable Care Act (PPACA), known as Obamacare, a form of universal healthcare plan reform, was signed into law by President Barack Obama on March 23, 2010, to help provide insurance for those who could not afford it or the cost of healthcare (Goudreau, 2014). Universal healthcare or public healthcare refers to a health care system that provides care and financial assistance to all of its citizens. The PPACA caused a reform in the healthcare system by changing the way that health insurance was obtained and financed. The PPACA caused the United States to lean towards a more public healthcare system, which is healthcare coverage for citizens provided by the government (Goudreau, 2014). A multitude of countries around

the world have a public healthcare system in place already, and, as such, it is important for the United States to analyze and discuss how the health care systems are structured in other countries, like South Africa for example, and use that knowledge to determine that further healthcare reform may be necessary in the United States.

The United States Health Care System

The United States government has attempted to create some form of universal health insurance to address both the needs of its citizens and determine the reforms that should occur within the healthcare system, but future reform is still needed (Goudreau, 2014). In the past, healthcare has been predominately private and paid for through insurance companies or out-of-pocket payments. This became problematic in the 1900's as the cost of healthcare rose at double the rate of inflation and a greater number of citizens were becoming unable to afford health insurance (Holly, 2013). As a result, a group of reformers believed that a form of universal healthcare needed to be established to help citizens who were unable to afford health insurance. Between the years of 1910 and 1970 various attempts were made by the government to establish a form of universal healthcare insurance for United States citizens to help fund healthcare (Holly, 2013). A large impact on establishing such a system was made through reformers who worked to improve social conditions for the working class and made proposals for health insurance and healthcare coverage for the poor (Holly, 2013). Some progress was made in the 1960s when Medicare and Medicaid were signed into law by President Lyndon B. Johnson (Holly, 2013). Medicare provides healthcare insurance to those above of the age of 65 and those with disabilities, and Medicaid provides healthcare insurance plans for families and individuals with low incomes (Ridic et al, 2012). However, universal healthcare as a whole did not have enough support behind it, and commercialized

insurance agencies opposed it, so privatized healthcare remained central (Holly, 2013). In the 2000s health care costs and insurance became popular topics of interest for several reasons: the costs of healthcare services and insurance continued to rise, Medicare began to be viewed as unstable by the United States government and citizens due to the growth in the population of those over the age of 65, employer-based systems of insurance were not as common because employers could not afford it due to rising costs of insurance and healthcare services, and the recession in 2008 caused financial problems for patients and hospitals (Holly, 2013). These financial issues caused the United States to discuss healthcare reform policy more seriously (Holly, 2013).

Currently, most healthcare insurance is provided by insurance companies operated by the private sector. Close to 60% of hospitals are non-profit, 29% are state owned, and around 18% are for-profit (US Hospitals, 2014). Between 60 and 65% of the spending on healthcare comes from programs like Medicare, Medicaid, and other insurance programs (Health Care Policy, 2015). Individuals are able to afford health insurance on their own or are insured through their employer or a family member, the remainder of the population is uninsured or are state government employees who are paid for by government. The disadvantage of insurance being covered by an employer is that during economic crises the employer is unable to afford the cost of employee insurance. This leads to employers firing employees, dropping healthcare coverage, or cutting work hours (Holly, 2013).

Similar to present time, in the past there was not a nationwide system of government medical facilities that was available for the general public. There were people who did not qualify for Medicaid, were not given health insurance by their employer, or could not afford it, and as a result they lived without necessary and preventative health care (Holly, 2013).

The costs that arose from treating the uninsured citizens was then forced to be absorbed by charity care or was passed on to the insured through cost shift or high health insurance premiums, or taxpayers through higher taxes (Health Care Policy, 2015).

As the number of families and individuals without healthcare coverage continued to rise the government began to discuss options for healthcare reform. As a result on March 23, 2010 the Patient Protection and Affordable Care Act (PPACA) was passed by President Obama which called for major changes in health insurance in the United States (Health Care Policy, 2015). The PPACA included new regulations, with the most prominent being health care coverage and health insurance mandates that force all citizens to purchase health insurance (Health Care Policy, 2015). Though this appeared positive for uninsured citizens, the PPACA prompted a lot of controversy for people that would be forced to pay higher taxes to fund this new act as well as their personal health insurance plans (Health Care Policy, 2015). This overview of the United State healthcare system shows that while the PPACA was enacted to combat the issues within the system, future healthcare reform is necessary.

Summary of Healthcare and Statistics in the United States

Understanding the healthcare statistics of the United States will help provide information on the current state of the healthcare system and provide evidence to support the idea that future health reform is necessary. In 2011, The World Health Organization reported that the United States spent more on health care per capita ($8,745) and also more on health care as a percentage of its total GDP (17%) than any other nation (Health Care Policy, 2015). Health care spending break down in 2010 showed: 30.74% paid for healthcare facility resources, 20.04% paid physicians for their medical services, prescription drugs accounted

for 10.01%, other health care providers like nurses accounted for 5.44%, and private health insurance administrations costs was 3.75% (Health Care Costs, 2015). Each of the remaining costs was less than 2% each. According to the Commonwealth Fund, the United States was ranked lowest in quality of care but had the highest costs for healthcare (Squires, 2012). This statement can be further supported through other statistics which show that the average life expectancy is 78.4 yrs, which is 50th out of 221 countries in the world, infant mortality rate is number 57th in the world, with a rate of 6 deaths per 1000 births, and heart disease is the leading cause of death with 610,000 deaths annually (Deaths and Mortality, 2015). This is problematic given that the US Census Bureau recorded that 49.9 million citizens or 16.3% of the population were uninsured in 2010 (Ridic et al, 2012). The poor healthcare statistics could also be a result of the 49.9 million citizens who do not have health insurance.

These statistics help to support the idea that future healthcare reform is necessary. It is important to be aware of these statistics when considering reform in the United States. The country already spends more than any other nation on healthcare, but it still ranks poorly on overall health because of the millions of citizens who were unable to afford insurance before 2014 (Health Care Policy, 2015). The data show that the central issue regarding healthcare is about a topic other than insurance such as healthcare accessibility or costs.

Reasons for reform

Healthcare is a major economic and social issue in the United States today. There is active debate among politicians and citizens about health care reform concerning questions that span many issues. The two main healthcare issues facing the United States today are: accessibility and affordability (Ridic et al. 2012). Accessibility refers to whether citizens are able to receive or obtain healthcare services necessary for improving quality of life.

Affordability, the other major issue, refers to the ability to afford being evaluated and treated by a healthcare provider. Future reform beyond what the scope of the PPACA covered is necessary to address the issues of accessibility and affordability.

Accessibility is one of the major issues in healthcare because millions of citizens in the United States struggle to or are unable to obtain health services (Sweeney, 2015). Public concern about accessibility is an important topic of discussion because they include issues of an individual's ineligibility due to health insurance plans and pre existing conditions due to age, location of residence and distance to healthcare facilities, and poor quality or efficiency of care.

Another part of accessibility is the right to receiving healthcare services, such as who can be treated and also who should and should not be treated based on factors like age, location, or health conditions. Depending on the health insurance plans that a company provides, there will be different stipulations as to what specifically the insurance agency is willing to cover based on the previous factors (Access to Health Services, 2014). Some plans may cover birth control or a particular surgery, and other may not. It is at the discretion of the insurance company or the government insurance policy to decide what will be covered. Age is also a factor with regards to who is able to receive treatment (Access to Health Services, 2014). Some health insurance plans or healthcare facilities are unwilling to fund and treat certain conditions due to age if the condition is not life threatening. Some insurance companies are not for profit, however if they consider an applicant too high risk, then the company can deny them coverage. Some women have health insurance premiums that are higher because they have a possibility of becoming pregnant and also visit the obstetrics and gynecology healthcare provides, which will cause an additional cost to the insurance

company (Access to Health Services, 2014). Also, some insurance companies will refuse to provide health insurance if they are aware that an individual has preexisting health conditions such as cancer, HIV, or back pain, or being a woman who can become pregnant, diabetes, and issues with obesity (Access to Health Services, 2014). To combat these issues, the PPACA was enacted in order prohibit the denial of insurance coverage based on pre existing conditions. However, further reform is necessary to make coverage more accessible and affordable.

Accessibility can be limited for people residing in rural communities. Healthcare facilities and providers are commonly located in cities or areas of higher population, and individuals living in rural or under populated areas have a more difficult time obtaining healthcare (Access to Health Services, 2014). This causes problems because it leaves people unable to obtain preventative healthcare, and leaves individuals susceptible to life-threatening circumstances and untreated illnesses (Healthcare Issues, 2015). Patients without access to preventative health measure have a higher likelihood more serious illness, like heart disease or cancer, than being diagnosed early (Access to Health Services, 2014). Being unable to receive preventative care has the potential to lead to a more serious disease. This causes problems because it will then be the responsibility of the government, insurance agencies, or the person alone to fund the health care treatment (Access to Health Services, 2014). Procedures for treatment of diseases such as cancer, heart disease, and other illnesses that are not diagnosed early are more expensive than preventative treatments. If the patient had the ability to seek preventative care through public health insurance care and the government was willing to fund it, then less money would be spent later when on preventable diseases. Accessibility is also an issue for patients of lower socioeconomic classes (SES)

status residing in both rural and urban communities (Sweeney, 2015). Regardless of the community, people in low SES may be unable to pay or find the time for transportation to a healthcare facility. The population of low SES is increasing which means that healthcare facilities must find a way to accommodate the growing population (Access to Health Services, 2014). This will make it even harder for all United States citizens to have access to healthcare because current facilities will become oversaturated and not be able to serve everyone in urban communities (Healthcare Issues, 2015). Due to this over saturation healthcare facilities will be unable to expand into rural communities because of healthcare provider shortages, resource shortages, and funding shortages (Access to Health Services, 2014).

Access to healthcare can also involve issues regarding quality and efficiency of health care. Driven by higher patient loads, healthcare providers may vary from being attentive and caring to going through the motions to get patients in and out of the healthcare facility as quickly as possible (Sweeney, 2015). Higher patient loads in lower SES causes an increasing demand for publicly provided healthcare facilities (Healthcare Issues, 2015). As a result quality of care has the potential to decrease for two main reasons. The first is that the federal government will not have the resources to fund all of the healthcare providers necessary to treat the growing population, thus providers will be forced to spend less time evaluating each patient and patient time spent is waiting rooms will increase (Access to Health Services, 2014). Quality also includes how long patients have to wait for necessary procedures. In an oversaturated system, the waiting period at the emergency room and for simple examinations could be hours (Healthcare Issues, 2015). The second reason for a decrease in healthcare quality is that the federal government will be unable to afford all procedures necessary for

the growing population, so quality of treatment may decline. (Access to Health Services, 2014).

While accessibility is an issue in itself, it can also be a part of and lead into the next major issue within the healthcare system, which is affordability. There is no relationship between what healthcare providers charge for services and the cost to them as providers in both time and resources (Silverman, 2015). This does not occur in other commercial businesses or operations. Typically companies will charge a price that is reflective of manufacturing and service expenses, which will result in a fair profit for the company (Silverman, 2015). However, with medical care, individuals typically do not have other competitive options for services and must pay what is charged for treatment. This is problematic because hospital prices rose 4.6% and provider prices increased 18% in 2011 and are still increasing presently (The Facts About Rising Health Care Costs, 2015). In addition, healthcare costs are already expensive, but when an individual does not have health insurance, the cost of healthcare can be astronomical (Silverman, 2015). A trip to a healthcare provider for something as simple as a 15 minute physical exam might cost $400, which can translate to $27 per minute and $1600 per hour (Silverman, 2015). There are many speculations for why healthcare costs are so high, such as that doctors need to pay their medical school bills, which usually exceed $155,000, and they need to protect themselves by paying high malpractice insurance premiums (Silverman, 2015). None of these speculations are able to justify that the rise in healthcare and health insurance costs is increasing faster than wages and inflation. The Kaiser Family Foundation, conducted recorded that from 2000-2006 the inflation rate increased 3.5%, wages increased 3.8%, and health care premiums

increased 87% (Health Care Issues, 2015). This leads to increased health insurance rates causing even more citizens to be unable to afford the cost of health insurance.

One result of rising healthcare costs is that in 2007 the USA spent around $2.2 trillion on healthcare, which is about $7,421 per person (Sweeney, 2015). This is twice the cost that it is in any other developed nation. More money is spent on healthcare than on housing, food, or other living expenses. It is speculated that if the cost of healthcare continues to rise, then by 2025 one out of every four dollars within the national economy will be involved in healthcare (Sweeney, 2015). Even with the PPACA, currently, 45.6 million United States citizens about 38 million adults and 9 million children are still uninsured (Sweeney, 2015). High costs of healthcare services and insurance will cause millions of citizens and small employers to purchase individual coverage or remain uninsured. As of 2015, the United States spends more money per individual than any other country, but is still ranked near the bottom from health care quality when compared to other countries. This helps to support that future reform beyond the PPACA is necessary to combat the issues still plaguing the United States healthcare system.

When discussing healthcare reform the federal government should realize that simply adjusting insurance plans will not help the health care system. Every year more than 40 million people do not obtain necessary medical care even if they are insured, and as a result thousands of preventable deaths occur every year that are attributable to the cost of healthcare services or accessibility to it. With the rising costs of health care and health insurance, and population growth, the government must intervene to reform healthcare beyond the PPACA. It is evident that some form of intervention needs to occur within the

United States healthcare system and reformers must consider all of the factors that affect health care.

Understanding the United States healthcare system makes one aware of the healthcare issues, and leaders have attempted to reform and establish a successful and comprehensive healthcare system for all citizens. This reform is known as the PPACA and was formed with the intention of enforcing and ensuring that all United States citizens would have some form of health insurance coverage. Due to it being a controversial topic it is important to analyze the purpose and effects of the law on citizens to decide whether the benefits outweigh the costs or not. Currently, the PPACA is enacted and there has been wide spread debate among politicians and citizens regarding the pros and cons of the Act because has not provided strong enough reform to mend all the issues within the healthcare system. Looking at the state of the United States healthcare system and seeing the negative healthcare statistics after the passage of the PPACA, it can be concluded that future healthcare reform is necessary.

Chapter 2. The Patient Protection and Affordable Care Act

The PPACA known colloquially as Obamacare, was signed into Law by President Obama on March 23, 2010 (Patient Protection and Affordable Care Act, 2015). It is the greatest reform of the United States healthcare system since 1965 when Medicare and Medicaid were passed. It was passed in response to the healthcare issues in the United States in order to alleviate some of its growing problems. The PPACA caused facilities and providers to adjust their healthcare practices financially and clinically with the intention of forming a more comprehensive form of care consisting of lower costs, accessibility, and better health outcomes. The PPACA was intended to increase the affordability of health insurance, to decrease the costs of healthcare of citizens and the government, and to lower the number of uninsured individuals by increasing private and public insurance coverage (Rosenbaum, 2011). The United States Supreme Court ruled the PPACA as constitutional on June 28, 2012 in the case of National Federation of Independent Business *vs.* Sebelius (Reynolds et al, 2012). Since the court case it has been implemented and began to affect citizens and the government. Despite the law, people who will remain uninsured include illegal immigrants, citizens not enrolled in Medicaid even if eligible, citizens willing to pay the annual penalty instead of purchasing insurance, citizens residing in states that opted out of Medicaid expansion, and citizens with insurance coverage that would cost more than 8% of household income (Patient Protection and Affordable Care Act, 2015). It is important to analyze the impact that the PPACA had on the United States Healthcare system to see which parts of the Act were successful, and which parts call for further reform.

The PPACA incorporated many provisions to take effect between 2010 and 2020. Most of the significant reforms that caused the greatest amount of financial and clinical

adjustment began on January 1, 2014 (Patient Protection and Affordable Care Act, 2015). The PPACA consisted of ten titles, but most of what individuals know as Obamacare is contained in *Title I* of the act known as *Quality, Affordable Health Care* for All Americans. It consists of the new benefits, rights protections, employer rules, insurance company rules, insurance purchasing mandates, tax credits, and information and cost insurance on State insurance exchanges and other state healthcare programs (Patient Protection and Affordable Care Act, 2015). The PPACA aimed to produce a transformation of health insurance through shared responsibility among tax payers and the government. In spite of the drastic changes enacted by the PPACA, future healthcare reform will be required.

Impact on the Public

It is important to analyze the impact that PPACA had on the healthcare system to support the idea that further reform is necessary. The passage of the PPACA was a turning point in U.S. public healthcare system. The PPACA established an almost universal guarantee that citizens will be able to access affordable health insurance coverage through a progression of expansions, revisions to, and creating multiple laws that make up the government framework of the United States healthcare system. The PPACA consists of ten legislative *Titles* to address five major goals (Rosenbaum, 2011).

The first and main goal of the PPACA is to reach a near-universal healthcare insurance coverage for all citizens through a shared responsibility among the government, employers, and citizens. The PPACA made health insurance coverage a legal requirement for all United States citizens through provisions that formed premium and cost-sharing subsidies,

creating new rules for health insurance industry, and building a new market for purchasing health insurance coverage (Rosenbaum, 2011). The Act strengthens already present versions of health insurance plans, while constructing a new health insurance system for citizens who do not have coverage from an employer or another type of minimum essential coverage, like Medicare or Medicaid. The Act helps to reconstruct Medicaid to provide coverage for all citizens with family incomes that are less than 133% of the federal poverty level (Rosenbaum, 2011). Near-universal healthcare guaranteed coverage is funded by and is the duty of all U.S. taxpayers. This tax requirement makes insurance coverage possible, and, without the mandate, private health insurance companies could not afford to eliminate discriminatory pricing and coverage. It is the responsibility of the state insurance departments to implement and enforce the laws presented under the PPACA. As well as forming a shared responsibility to establish universal insurance coverage, the PPACA created standards for health insurers by offering coverage for individuals, small businesses, and employer sponsored health insurance plans. Some examples of standards required for insurance companies include extending coverage of individuals to 26 years of age under their parents' plans, enforcing a ban on denying coverage to individuals 19 years old and younger with preexisting conditions, providing health coverage of preventative care, and creating restrictions on annual coverage limits (Patient Protection and Affordable Care Act, 2015). The main reason for these standards is to prevent discrimination against women, the elderly, children, and adults with preexisting conditions, and to require insurers to cover routine medical examinations. The PPACA also formed state health insurance Exchanges for individuals and businesses that are meant to simplify the process of purchasing health insurance by setting up a single shopping market for insurance products that meet federal

standards for qualified health benefit plans. The largest reform, which became effective in 2014, included eliminating pricing and coverage discrimination against individuals. The PPACA aims to restructure the financial relationship among citizens and how health insurance impacts the healthcare system and services (Rosenbaum, 2011).

The second major objective is to improve the quality, efficiency, and accountability of equal access of health insurance coverage for all citizens (Rosenbaum, 2011). The PPACA included reforms beyond insurance. It also includes restructuring the healthcare system for long term adjustments in quality, the organization of healthcare practice, and making the presentation of health information more transparent. This is accomplished by Medicare and Medicaid changes that give power to the Secretary of the U.S. Department of Health and Human Services and various state Medicaid programs to trial new types of payment and services. The intentions of these changes was to allow the public to analyze and report on the quality of the care they are receiving, to force health providers to work in a more clinically incorporated way, and to look for reasons why patients are frequently admitted and readmitted to hospitals. Both the Health and Human Services Department along with the state are expected to test these payment and delivery system reforms to attract private payers in order to allow for potential cross-payer reforms (Rosenbaum, 2011). In addition, the Act promotes the growth of a multi-payer National Quality Strategy, which is a system that encourages increased safety and more health information that is provided for public and private insurers. From 2010 to 2019 it is projected that the government will invest close to one trillion dollars in healthcare in order to make coverage more affordable (Rosenbaum, 2011). This will be accomplished through changes in Medicare and Medicaid spending, new taxes on more expensive plans, and higher taxes on affluent families. Through greater

funding the PPACA acts to assess and improve patient healthcare reporting and efficiency of care (Rosenbaum, 2011).

A third aim is to decrease unnecessary spending and make the health care system more accessible to a diverse patient population. There are around 60 million United States citizens who are deemed medically underserved due to health risks and inaccessibility to health care providers. The PPACA called for investments in expansion of community health centers to try and fix this healthcare provider shortage. It is expected that expansion will lead to a doubling of patients who are evaluated by increasing the number of healthcare center patients from 20 million in 2010 to about 40 million in 2015 (Rosenbaum, 2011).

The fourth goal of the PPACA is to strengthen primary healthcare access, increase the availability of primary and preventative healthcare, and improve training of health professionals through investments in public health. New regulatory requirements were put in place to cover preventative healthcare services without cost sharing. A Prevention and Public Health Trust Fund was established to provide prevention plans and improve public health through funding of preventative care services. The Act also funds new training programs for primary healthcare professionals (Rosenbaum, 2011).

The fifth aim is to make investments and strengthen public health through expansion of preventative care and community investments in long term care. The Act forms another Medicaid option for the public to encourage community based care systems like nursing homes to prevent the elderly from not getting necessary medical treatment and becoming impoverished (Rosenbaum, 2011).

The PPACA is transformative and includes many adjustments and challenges for the people that it will impact. The Act aims to adjust coverage of insurance, healthcare quality, and also encourages public and preventative health services be provided. Its transformative nature has helped to pave the way for future healthcare reform by establishing that healthcare reform is both possible and necessary.

The Patient Protection and Affordable Care Act Titles I to X

The PPACA contains 10 *Titles* that outline the reforms that will occur (Patient Protection and Affordable Care Act, 2015. It is essential to know what requirements and stipulations are contained in each *Title* so that politicians will be able to accurately assess which reforms produced positive outcomes for positive health, and which *Titles* may need to be reformed in the future to better serve the public.

Title I of the PPACA caused immediate changes in healthcare coverage for all citizens in the United States. By 2014, an American Health Benefit Exchange was established to assist individuals and employers in obtaining health insurance coverage (Patient Protection and Affordable Care Act, 2010). Plans that are a part of the Exchange will advertise their benefit option in an organized manner. It is meant to provide necessary health benefits and includes cost sharing limits. Out-of-pocket payment cannot exceed the amount in Health Savings Accounts, and deductibles from small group market cannot be greater than $2000 for individuals or $4000 for a family. Coverage through this plan will be provided at four levels and define how much the insurer must pay. For example, with Platinum 90% is covered, Gold covers 80%, Silver 70%, and Bronze 60% of healthcare costs. Coverage will

be made more affordable through refundable tax credits for citizens whose incomes fall between 100% and 400% of the federal poverty line. A new credit providing 50% of total premium cost was enacted to assist businesses with less than 25 employees (Patient Protection and Affordable Care Act, 2010).

Starting in 2014, individuals became responsible for possessing health insurance or pay a penalty beginning at $95 in 2014, $495 in 2015, $750 in 2016, and as much as 2% of income by 2016. If an individual or family with coverage desires to retain it, they are permitted to under the grandfather provision. Employers that had coverage are also allowed to continue providing the coverage under the grandfather policy. The grandfather provision satisfies the individual responsibility of purchasing health insurance (Patient Protection and Affordable Care Act, 2010)

Another significant part of the *Title I* reform is that it makes coverage more affordable and more available. This allows people with a preexisting condition to gain access to health insurance. Insurance companies are unable to deny coverage or set certain rates based on health conditions, gender, or genetic information. It enacts an insurance program that provides financial assistance to those who have been uninsured and also have preexisting health conditions. It limits premium rates for people who are newly insured. One of its most notable reforms involved the coverage of preventative health service. This requires insurance plans to provide coverage for preventative services, such as immunizations and physical evaluations. It also requires that insurance plans allow for individuals to remain on parents' health insurance until the age of 26 (Patient Protection and Affordable Care Act, 2010).

Title II is about the role of public programs and the PPACA expanded Medicaid eligibility for lower income individuals through the government accepting responsibility to

fund the expansion. Beginning in 2010 states were able to expand Medicaid eligibility, and in 2014 families not entitled to Medicare but who earned incomes up to 133% of the federal poverty line became eligible for Medicaid. The government is required to fund the cost of insuring new Medicaid individuals. People became able to apply for Medicaid through a simplified enrollment process online (Patient Protection and Affordable Care Act, 2010).

Title III was written to improve the quality and efficiency of healthcare. The PPACA will help improve the quality and efficiency of healthcare services for all citizens, and especially for people enrolled in Medicare and Medicaid. The Medicare Part D prescription drug benefit will be improved and the coverage gap will be reduced. The PPACA made investments to improve the delivery of care giving and support research in order to inform patients about their health outcomes. New methods of patient care will be formed and evaluated so that patients and providers living in rural communities will undergo significant improvements through greater funding (Patient Protection and Affordable Care Act, 2010).

Title IV is about the prevention of chronic disease and improving public health. Its purpose was to provide a set of goals to orient the United States healthcare system towards health promotion, preventative care, and disease prevention. The Prevention and Public Health Investment Fund is meant to support education on public health and help remove barriers preventing individuals from obtaining preventative healthcare. The top priority is creating a healthy community (Patient Protection and Affordable Care Act, 2010).

Title V involves the health care workforce and is meant to provide an energized, diverse, and knowledgeable work force. A new workforce commission is to be established through innovations in healthcare workforce, training, recruitment, and retention. Other provisions were established in order to increase the number of competent health care

providers like physicians and nurses. A fresh infrastructure was created to encourage training and education of a new workforce (Patient Protection and Affordable Care Act, 2010).

Title VI involves transparency, program integrity and it is meant to ensure integrity within government funded and sponsored healthcare programs. This Title outlines new requirements of the government to provide information to the public about the healthcare system. It also created a set of requirements to battle fraud and abuse regarding healthcare coverage in both public and private programs (Patient Protection and Affordable Care Act, 2010).

Titles VII through IX do not have as a significant effect on the public with regards to controversial changes it will make as the others Titles do. *Title VII* was formed to improve access to innovative medical therapies. *Title VIII* discusses community living assistance services and support to establish a national voluntary insurance program for purchasing community living assistance for elderly. *Title IX* involves revenue provisions for insurance companies and business employers such as a tax on high cost employer-sponsored health coverage and increasing transparency in W-2 tax reporting of health benefit values (Patient Protection and Affordable Care Act, 2010).

Title X created improvements to the previous nine *Titles* through strengthening quality and affordable care. Significant changes that *Title X* caused in *Titles I through IX* have already been incorporated into and were discussed previously during the description of Titles. Changes that did not amend previous Titles included more improvements in the role of public programs, Medicare improvements, workforce improvements, and transparency and program integrity improvements (Patient Protection and Affordable Care Act, 2010).

The 10 Titles aimed to organize the parts of the PPACA into groups that citizens could follow to be informed as to which parts of the law caused what effects on the healthcare system. Citizens should know the effects that PPACA has on the public to be aware of specifically what steps are necessary in order to create more successful healthcare reforms.

Opposition to the Patient Protection and Affordable Care Act

The PPACA legislation became law in 2010, however, it continues to be a controversial topic among political parties. Since the beginning when healthcare reform was first discussed until the present time when citizens are beginning to see the potential effects the law can have, there has been significant opposition to the reform. There are many reasons that certain groups of people oppose this new legislation, such as legal issues, personal opinions and experiences, speculations from those who are educated on the potential outcomes of the law, and empirical data that is now being obtained (Reynolds et al, 2012). Politicians should address opposition to the PPACA in order to see that future reform in the United States healthcare system is necessary.

One of the most prominent arguments against the implementation of the PPACA is that it is unconstitutional due to its mandate that requires all United States citizens to purchase health insurance or pay an annual fee (Rosenbaum, 2011). In 2012, opponents looked to federal courts in order to challenge the legislation's constitutionality. On June 28, 2012 the National Federation of Independent Business *vs.* Sebelius ruled that the healthcare

mandate was constitutional under Congress's power and authority to tax (Reynolds et al, 2012).

However, the court also ruled that the PPACA will no longer be considered a mandate but instead a tax (Rosenbaum, 2011). This means that individuals who decide not to purchase health insurance will be forced to pay a tax, and individuals who decide to purchase health insurance will be eligible for a tax break. Several years later on June 25, 2015, the Supreme Court ruled that for the 34 states that did not have insurance exchanges set up, that they would be eligible for federal subsidies for health insurance premiums. States that opted for exchanges had to establish a new system to check household finances in order to decide who was eligible to receive federal subsidies (Liptak, 2015). Though the Supreme Court ruled the PPACA constitutional there are still individuals who continue to believe it is a breach of federal powers.

There are many other common agreements among the individuals who oppose the PPACA, which are considered opinion based rather than legal issues. One example of this opposition is that in order for the government to raise the money necessary to insure all these new people, there are new taxes that citizens are required to pay, and some citizens do not want to be forced to pay these taxes (ObamaCare, 2015). The Act assesses at least 20 new taxes which add to about $500 billion a year to the national budget that will all impact health insurance prices, medical providers, and the cost of healthcare. Another reason some are against this new tax is that a population of people barely misses the Federal Poverty Level limit of 400%, and they are impacted the most because they do not qualify for assistance, but are still required to purchase insurance, as well as pay the necessary taxes (ObamaCare, 2015). Also, now that insurance companies are required to cover those with preexisting

conditions, the cost of health insurance must be increased. Some businesses have also cut employee hours, which mean that lower wage employees will be cut from the full time benefit of having a health insurance plan and will also be unable to afford coverage. Medicare is also responsible for paying a large number of doctors. With the increase in the number of people eligible for Medicare and Medicaid this causes a greater demand for doctors, which in return causes an increase in taxes in order to fund all the doctors in an already oversaturated patient system. People who oppose the PPACA believe that healthcare funding should be the responsibility of the individual and not a responsibility of the government (Obamacare, 2015).

Another notable concern from individuals who oppose the PPACA is that the government will have control over medical decisions rather than doctors (Obamacare, 2015). The PPACA sets up value-based payments, quality reporting systems to encourage transparency, and federal comparative effectiveness boards that have the potential to control how doctors practice medicine, provide quality of care, and have authority to decide doctor salaries. There is already a doctor shortage in the United States and it is believed that the PPACA will further increase the shortage due to lowering of wages and enforcing stricter federal regulations (Rosenbaum, 2015).

Those who oppose the PPACA have consistently been unsuccessful in their effort to repeal the Act and are still hopeful that the next presidential election will produce a president who seeks to repeal the Act (Obamacare, 2015). Even though the Supreme Court ruling did not repeal or change how the PPACA will impact people, it did alter the way that courts will handle the law and think about reform in the future due to its controversial outcomes (ObamaCare, 2015). This opposition regarding the PPACA provides support for the notion

that future healthcare reform is essential to combat both the issues within the PPACA and create new legislation that better serves all citizens.

Progress made through the Patient Protection and Affordable Care Act

The PPACA has effectively been in place since 2013 and it is necessary to analyze what progress has been made in healthcare insurance and services as a result of the Act. The Act has been successful in expanding healthcare coverage by limiting out-of-pocket expenses and requiring that preventative care be covered through insurance plan. Around 16.4 million United States citizens have gained health insurance as a result of the PPACA. This is mostly a result of Medicaid expansion, and millions more are expected to register in the coming year. The PPACA allows for states to expand Medicaid to individuals who were not eligible previously, however, the United States Supreme Court ruled in 2012 that this expansion was optional for states. As such, only 27 states and Washington, D.C. have expanded, and states without expansion form a coverage gap that is harmful to people who earn too much to receive traditional Medicaid or receive federal subsidies but earn too little to be able to afford insurance premiums. There were 7.3 million people who signed up for private insurance through the online exchanges and nearly 85% qualified for federal subsidies that decreased their premiums cost. On average these subsidies lowered the cost of premiums by 76% ("Is the Affordable Care Act Working?"). Healthcare analyst experts believe it is too early to project data on whether the PPACA has improved health outcomes. However, the most reliable data has been obtained from young people, and it suggests that they are benefiting

from being able to stay on parents' insurance plans until 26 years of age. The number of 19-25 year olds who do not have health insurance has declined from 34% in 2010 to 21% presently ("Is the Affordable Care Act Working?"). Young people also have a better health report due to being able to receive more primary and preventative care than before. Economists also suggest that the passing of the Act has the potential to help the healthcare system financially through providing insurers with new customers and adding more paying patients into the healthcare system ("Is the Affordable Care Act Working?"). It is still too early to conclude whether the PPACA will cause more beneficial or detrimental effects to the healthcare system and United States citizens, but either way future reform will be needed to cover the negative outcomes or issues that have not been addressed.

It will be several years before enough empirical data is produced for individuals to support or oppose the PPACA fully, however early speculation already supports that future healthcare reform will be inevitable in the future despite the outcome. Since empirical data from the PPACA will take a few years to obtain and analysts must look elsewhere when trying to make speculations of the outcome of the PPACA on the United States healthcare system. The PPACA is a form of universal healthcare because it established a system that provided healthcare protection and financial assistance for its citizens. Though the concept of universal healthcare was new in the United States, it had previously been exposed to the notion of publicly funded healthcare services through establishments such as Medicare and Medicaid. The PPACA increased the public healthcare system overall, but the United States is not under complete universal healthcare regulation. This makes the United States unique because it is a pluralistic system consisting of both a private sector and a public sector of healthcare that aim to provide healthcare insurance coverage and services for all of its

citizens. Unlike the United States, there are many countries around the world that have been under the rule of public healthcare for decades. It would be useful to examine the benefits and flaws in the healthcare systems in these other countries, especially ones with both a private and a public healthcare sector, so that possible future reforms to the United States system will have evidence-based studies to support or reject proposed healthcare reforms.

Chapter 3. The Pluralistic Healthcare System of South Africa and its Reform

In order to better understand the direction that the American Healthcare system is heading it is important to analyze the way it works in another country in which the government and taxpayers are highly involved. This comparison between the United States and other countries healthcare system is important in order to have evidence of the direction the United States healthcare system could head socially and economically depending on which reforms are created. In analyzing the healthcare system of another country, it can be determined that future reforms are necessary, and also help discern which reforms are most needed.

Increased government intervention as well as lack of government intervention can cause severe problems in costs, accessibility, and quality of healthcare for all. Several countries around the world, specifically South Africa as an example, have a healthcare system in place that have both a lack of government intervention, known as the private healthcare sector, and a profound presence of government intervention, which is the public healthcare sector.

Overall, the United States is a wealthier nation than the South Africa; however, a comparison can still be made because the United States is facing strikingly similar health issues concerning access, costs, and quality of health care. Currently, there is a prevalence of private and public sectors within South Africa, which is similar to the direction that the United States is headed. The private and public sectors of South Africa will be analyzed in order to better understand the shortcomings that are present in both areas of healthcare. This evaluation of the differing sectors will help to better understand the healthcare crisis and reform that the United States is currently facing and address whether future reforms should

be more directed at creating privatized or public healthcare. It will help to support the idea that healthcare reform is necessary in the United States and looking at other countries healthcare system will help to determine the more promising reform for the United States.

Overview of South African Healthcare System

It is important to understand how the South African healthcare system constructed to see how it affects the citizens, and how similar reforms to the United States could impact its citizens. South Africa currently has two different sectors of healthcare: private healthcare and public healthcare. They have complex and different histories, and the South African healthcare system at present is very dysfunctional due to the nation's complex political history, including colonial suppression, apartheid conflicts, and post-apartheid problems that still resonate throughout the country. The private sector has faced a lot of opposition due to its inability to meet the needs of the population as a whole; the high prices mean that it only benefits upper class citizens and thus the rest of the population is unable to receive the same standard of quality care. Over the years the public healthcare sector has become a national service, but a failure in proper leadership and stewardship of tax money has led to inadequate care of the general population. Even combined, the private and public health care sectors are inadequate to address the health care needs of the population, and, as a result, health care reform is essential if health of the South African people is to reach optimal standards (Coovadia, 2009).

Just like the United States, healthcare reform has been a major topic of interest in South Africa's political, social, and economic environments since the early 1990's. The

process of Healthcare reform continues to be considered a crisis and a scandal due to the media portrayal (Wadee, 2003). This image is seen within the country as well as on the international scale. As such, South Africa is in the process of attempting to reform the entire healthcare system (Coovadia 2009).

In order to understand where healthcare in the country is heading, it is ultimately important that one understands the history from which both the private and public sectors come from, as well as the benefits and detractors from the ways both areas have historically operated. Coupled with financial and numerical statistics, the goal to be reached is an optimal solution for the South African Healthcare system, regardless of whether the plan chosen is the NHI (National Health Insurance) plan, the 10 point plan, or another objective solution (Ritchie, 2013). Since South Africa is currently establishing a solution for future healthcare reform it would be wise for the United States to study its outcome to see that future healthcare reform is needed in the United States and discover the pros and cons of the reform.

A History of Private and Public Healthcare in South Africa

Privatized healthcare in South Africa can be traced by to the late 19th century. Its history must be studied by the United States to determine which aspects of the private healthcare system require future reform. The first medical scheme to ever exist was the De Beers Consolidated Mines Ltd Benefit Fund, which was established in 1889 for workers, mainly miners (Heever, 2012). It should be noted that the private healthcare was primary, as

a centralized public system had not yet been put into place. The government for the most part tried to avoid dealing with the health care system.

In 1911 the Union Legislature passed the Native Labour Regulation Act. The purpose of this act was to require employers to take care of their employees. The requirements for the act were to provide a good diet, clean housing, and hospital service to employees. However, this act only went so far because a tax was not put into place, therefore not giving a standardized bar for care given. As a result, mission hospitals began to appear across the rural communities throughout the country. This was also a direct result to the fact that local governments, such as in cities or provinces, were unable to provide the necessary care for the people inside of their respective communities (Heever, 2012).

Private hospitals began to emerge in the early 1920s. By this point in time public healthcare had been slightly established with the national authority that was present, but health still largely remained the responsibility of the individual and therefore most citizens were reserved to only private healthcare. More commonly however, there was no healthcare plan whatsoever for the impoverished or rural communities. As private hospitals made their debut, they were split into two categories. These two categories designated whether they were a for-profit institution or a nonprofit establishment. The government instituted a charge that would tax the people for profit hospitals. The money inside of this fund went on to create hospitals that were designed specifically to provide medical care as well as fund jobs (Heever, 2012).

In 1946 legislation was passed in order to outline the functions of the healthcare system that were assigned to the federal government and the provinces that were under its influence. This was dubbed the Public Health Act. For instance, this act outlined that general

hospital services were to be the responsibility of the individual provinces, instead of the national government as a whole (Heever, 2012).

Despite the legislation under the Public Health Act, parts of the financial responsibility of ambulatory care were still considered the responsibility of the federal government. This also marked the first time that a refund approach was implemented. If a province needed to receive money, they first had to spend the capital available at the time, and then acquire a refund from the federal government (Heever, 2012).

In 1977, legislation was passed further identifying the role that the federal government took within the healthcare domain (Coovadia, 2009). The National Health Act was established in 1977 in order to define what control the national government had over the provincial and local levels of government. These roles would largely remain unchanged until 2003, where its role would be further defined (Heever, 2012). The South African government has historically put most of the responsibility of the healthcare system primarily in the hands of the private domain. The only areas that the national government intervened in were those of communicable diseases, mine workers, and the poor.

Early on, the government defined its role in the history of healthcare as not wanting to interfere with the system, and keep it privatized. It wanted to leave the responsibility of health care to the individual citizens. This still remains as the main reason that South Africa does not have an established and positively working general public healthcare system. It is speculated that had the government intervened from the beginning in the healthcare domain, a more efficient system may be intact today.

The private sector of South African healthcare began as medical schemes. Over time it evolved due to the tendency of the national government to focus the main funding of the public sector by a taxation of the upper and working class. This taxation went on to fund and provide health care for non-paying patients. This meant that in some cases wealthy citizens were paying for both the public and private healthcare sectors (Heever, 2012). The problem with this system was that it also meant that these taxpayers could not receive free services, even though they funded both private schemes and the public area. Therefore the private healthcare arena evolved from the need of insurance (Ataguba, 2012).

In 1956, legislation was created to further define the establishment of the Advisory Council for Medical Fund Societies. This legislation was titled the Friendly Societies Act and served the singular purpose of regulating the medical schemes in South Africa (Inquiry into the various Social Security Aspects of the South Africa Health Care System, 2005). The Friendly Societies act was the first act that helped to positively regulate current medical schemes and lay the groundwork for the evolution of more successful acts in the future.

The year 1967 saw the establishment of clearer legislation that helped to allow the federal government to exact some sort of control over the privatized medical schemes present within the country. Legislators wrote and implemented what was known as Medical Schemes Act No. 72. This Act went on to take all of the responsibilities aforementioned in the Friendly Societies Act of 1967, and was created with the purpose of defining an expansive infrastructure that would help better regulate the medical schemes of the private sector. The Act had the intentions of creating a scheme that would take the costs of medical expenses and spread them over the course of years (Inquiry into the various Social Security Aspects of the South Africa Health Care System, 2005).

This was primarily done to keep costs of medical expenses lower. It also had the responsibility of controlling different funds in order to create the stated schemes. The Act also had the important role of establishing the Central Council for Medical Schemes (Heever, 2012). This was an executive council whose responsibilities consisted primarily of controlling the present and future medical schemes. This went from simple areas such as registration to more complex nooks, such as the way that a certain scheme may function. The council also had the authority to settle disputes that related to or directly involved medical schemes that had existed through the registration. Being an executive entity, the appointment of a Registrar of Medical Schemes was also implemented in order to help run the council and make decisions (Inquiry into the various Social Security Aspects of the South Africa Health Care System, 2005).

For the next two decades, South Africa's private healthcare sector saw the refund idea being used to pay back medical schemes for private professionals. These fees were primarily charged to citizens by public hospitals. These individuals usually fell outside of a means test. These fees paid primarily for specialists and general practitioners directly, meaning that what they were paid was directly linked to their livelihood. These fees were negotiated on an annual basis, and these negotiations, as well as the schedule by which they were paid, were known as a scale of benefits. The option to opt out of a scale of benefits was always present, so if an annual change was not particularly in the interest of a professional they had the option to not partake in the respective schedule (Heever, 2012).Professionals opting out resulted in making it more difficult for doctors to be paid due to the use of paper invoices. Doctors could only be reimbursed if there were records that were consistent within those established by the scale of benefits (Heever, 2012).

The year 1969 saw the emergence of Amendment Act, No. 95 (Inquiry into the various Social Security Aspects of the South Africa Health Care System, 2005). This amendment created the Remuneration Committee, which held the responsibility of looking at the tariff around doctor's fees at least on a biennial basis. The sole purpose of this committee being created was to prevent more doctors from opting out of the scale of benefits (Inquiry into the various Social Security Aspects of the South Africa Health Care System, 2005). Opting out had the tendency to create tension in doctor/patient relationships and as such made the system appear unstable and unsuitable for a scheme.

Despite the intentions, the Remuneration Committee was unpopular in the medical professional world. This was due to the fact that the Act was a federal action and as a result many believed that the Act was created with the purpose of furthering government control in the medical industry. Therefore, doctors, dentists, and other medical professionals were wary of the way the Remuneration Committee was lead and often believed that the committee was against medical professionals. This ended with the Medical Association and the Dental Society refusing to cooperate with the Remuneration Committee in 1978.This was less than one decade after the inception of the committee (Heever, 2012). As a result, government organizations considered the possibility of taking away the option for doctors to opt out of scale of benefits. In the end the drafting of such legislation ended with over one thousand more medical professionals contracting out immediately (Inquiry into the various Social Security Aspects of the South Africa Health Care System, 2005).

Due to the high amount of tension between the medical professionals of South Africa and the federal government, in 1978 Amendment Act No. 51 was passed strictly for the purpose of eliminating the Remuneration Committee (Inquiry into the various Social Security

Aspects of the South Africa Health Care System, 2005). The amendment also eliminated the Commission, which made recommendations regarding how much fees should be charged. The responsibility for setting fees was now given to the Medical and Dental Councils to set. The condition for this was that doctors and dentist would no longer contract out of a scale of benefits. If they were unable to comply with these terms then the federal government would decide to let the Minister create a new regulation and process by which doctors would contract out of the scale of benefits (Heever, 2012).

Tensions arose once again in 1980 when Amendment Act No. 42 was passed. In order to create a wider gap of definition between doctors who had contracted in or out, the amendment made contacted in doctors to put their accounts in with schemes. This created conflict due to the fact that doctors had previously been able to submit their accounts through members. Submitting to schemes created a backup with the schemes. Delays in payment were common and even some pay was not guaranteed for doctors that were still contracted in (Heever 2012). Correcting this problem was the Amendment Act No. 59 of 1984. This act did the opposite of its predecessor, functioning solely to get rid of any difference between contracting in or out for doctors. This allowed for any of the schemes to set their own fees. This heralded a nearly completely free market in the medical field(Inquiry into the various Social Security Aspects of the South Africa Health Care System, 2005).

Up until this point in time, medical schemes were not-for-profit (McIntyre, 2010). However, as the schemes grew larger, outsourced administration created room for mass commercialization. Large schemes began to provide for more than one employer, and that meant that they only way they could get a sponsor would be through commercial administration. This meant that these administrators began to set up schemes that were meant

for multiple employers, but they could not own these schemes due to legal reasons. Since they could not legally own these schemes that were being created, they instead charged fees for administrating such schemes (Heever, 2012).This movement resulted in an emerging commercial market revolving around multi-employer schemes. Though commercialization was technically not allowed by federal constraints, administrated duties were to go through the loopholes allowing the practice to be somewhat commercial (McIntyre, 2010).

In the beginning of the 1990s, the public sector of healthcare eliminated the need for membership to receive service. People were able to choose which medical scheme suited them best. Alternatively, they could also choose not to be covered by a scheme whatsoever. This was in anticipation of the change in government in 1994. On top of this the government decided to take away any mandatory benefits for any medical schemes. By this time full unregulated and commercialized healthcare was in effect (Lawn, 2009).

By the point of complete deregulation, risk rating was allowed on any criteria and mandatory benefits were removed from all schemes. Schemes would compete to have members by undercutting one another. This was done by lowering contribution costs, which was done through the practice of risk rating. This created an entire new market for insurance companies. Hired brokers began to advise their employers that they should move their schemes from occupational ones to commercial ones. By this point most of the medical scheme market was for profit, and illegal activities took place consistently, including the payment of administrators and brokers in the form of kickbacks (McIntyre, 2010). Businesses began to team up on the horizontal level in order to gain more power in the market. This team included groups of hospitals, medical schemes, and administrators. Trusts began to

form and the public sector began to decrease in value and in services given as a result to the economy feeding the private sector (Heever, 2012).

By the year 2000, re-regulation was in effect. This was important because many changes had taken place within six years, most noticeably the shift from closed occupational schemes to open commercialized ones. However, the damage had been done in some areas, as the private sector was now unaffordable to a large amount of the population and the public sector was understaffed and underfunded. Deregulation as a whole damaged the healthcare system to a point of crisis, with money going into the wrong hands and prices being elevated above reasonable levels (Ataguba, 2012). The privatized healthcare system in South Africa causes an increase in cost of healthcare, which is similar to the United States. The history of privatized healthcare of South Africa helps to specify the flaws in privatized healthcare system which the United States can reference for determining future healthcare reform.

Controversy in the Current and Future South African Healthcare System

In 2007 South Africa fell into public eyes and national criticism due to the deterioration of its healthcare system in both the public and private sectors. This deterioration is similar to what is happening in the United States healthcare system presently, and as such should be supported that future reform is necessary. The increased publicity helped make it so that the government was more honest in acknowledging the shortcomings of the health systems and forced the federal government to focus on a recovery plan. Reform became a necessity as the disparity separating the public healthcare system from the private had grown large (Ataguba, 2012). The overall conflict was the private sector had become too

expensive for the majority of the population but the public sector could not provide quality care due to a lack of funding. As a result, the South African government stepped in and began to draw up plans for a national healthcare system that would ideally serve all of the people in the country adequately, while maintaining lower costs and equal treatment of individuals regardless of income or contribution to the impending system.

In August of 2011, the government of South Africa put forth a Green Paper on NHI, or National Health Insurance (Reforming Healthcare in South Africa, 2011). The goal set at the time was for all South Africans to be able to have universal access to good healthcare within fourteen years. On top of this, it is also believed that this healthcare should be free for the person using the service. This is a key idea for the NHI plan, regardless of how much money members will contribute to the system or how much a procedure may or may not cost. This also includes how much money it may take to run the healthcare system in general (Reforming Healthcare in South Africa, 2011).

Critics of this ideology cite that it is an impossible goal to attempt to achieve universal access to good healthcare due to the fact that South Africa is notoriously unequal in terms of economic contribution, as well as having a significantly lower percentage of registered tax payers in comparison to other developing or developed countries (National Treasury, 2013). The healthcare plan being proposed has the goal of providing above adequate service and care to over fifty million individuals, meaning that the amount of money going into and being used by the system would have to be massive.

With deregulation occurring in the healthcare field through legislation in the early 1990's, South Africa has been under intense scrutiny in international and public view due to what is being deemed a healthcare crisis. In the year 2007, media sources across the globe

focused on South Africa, portraying the public sector in particular as failing its people. Due to this, the situation regarding primarily the public domain of healthcare is dubbed as being not only a crisis, but also as a financial and political scandal. This exposure to the public eye has forced the government to be more honest about the problems with the public healthcare system and is one of the roots that started the idea of the National Health Insurance plan (Coodavia, 2009).

One of the main reasons that NHI was being pushed so hard was due to the difference that was being shown between the failings of the public sector and the successes of the private area. Further straining this sore point is the strong correlation provided between income and care provided. Unlike other nations of its like, South Africa has no true middle line between care. The gap between private and public healthcare sectors is vast in both mean earnings per customer and in quality of care provided (Bridging the gap in South Africa, 2010). Critics of the private healthcare system blame the increasingly high prices, citing that they keep most of the population from being able to afford healthcare. However, critics of the public healthcare system focus primarily on the flawed design of the system and blame design and funding on poor medical outcomes. The overarching tendency in today's South African political environment is to primarily blame privatized healthcare for many of the issues regarding the weaknesses of the public sector.

Rather than calling for a reform of the private healthcare sector, many people are supporting the idea to completely eliminate the private sector in favor of the universal NHI program. Some politicians suggest that high tax rates on the upper class citizens will help to fund the national overhaul plan (McIntyre, 2012). The situation in the United States is similar in that one option for future healthcare reform is to provide universal health coverage for all

citizens, and there is a group of people that support this idea and the elimination of the private healthcare sector.

Private healthcare also has a set of problems regarding the amount of reform that is needed. For instance, one of the most commonly criticized aspects of the private healthcare sector is the high prices, those of which are still rising excessively (Pallot, 2010). Fewer citizens are able to afford adequate coverage each year, and the disparity separating the quality of care between the public and private domains is also widening. However, suggested plans for reversing this trend with regard to Universal Healthcare include adding incentives to lower prices, creating competition within the sector, and focusing the breadth of the system on preventative care and primary health care rather than investing mostly in the realm of specialization (McIntyre, 2012)(Harris, 2011).

The Green papers suggest that South Africa spends over 8% of GDP on the public and private healthcare sectors. About 4.2% goes to public sector and 4.1 goes to the private sector. For a country that is developing a middle class and consistent income, this is considered to be exceptionally high (Reforming Healthcare in South Africa, 2011). Most countries in the place of South Africa spend between 5 and 6% GDP on healthcare expenditures. However, South African life expectancy, mortality rates, and health outcomes are moderately poor in comparison to similar countries (Ritchie 2013). Infant mortality rate is around 43.8 for every 1,000 live births which is high in comparison to other developing countries. The life expectancy of a person is about 49.2 years which is very low in comparison to other countries like South Africa (Infant Mortality and Life Expectancy, 2014).

The current life expectancy and mortality rate in South Africa is difficult to record correctly. The data is difficult to categorize and dub relevant due to a massive skew presented in the numbers. This disparity is largely due to the vast difference separating the rural and urban areas of the country as well as those who have privatized healthcare and those who are only able to opt for care in the public sector. On top of this lies the fact that public healthcare in the more rural communities is considerably less dependable with regard to a positive outcome in comparison to its public counterpart in the more urban areas. As a result it is nearly impossible to adequately record health statistics within the country's current population (Reforming Healthcare in South Africa, 2011).

For the future, preventative healthcare will be necessary considering the nature of South Africa's culture. Poverty is common across urban and rural areas alike and the culture does not advocate for a healthy lifestyle. Tobacco and alcohol use are both rampant in excessive use, and the crime rate of the country does not afford individuals a good chance of lifetime safety (Lawn, 2009). For this reason, primary care is also important to focus on in a newer healthcare structure (Reforming Healthcare in South Africa, 2011).

When apartheid ended in 1994 the country faced many challenges that still resonate throughout the country. It is important to note that health equality is more difficult to strive for than initially expected. In other areas of the globe that have employed plans similar to that of what South Africa is striving for, patterns have emerged still detailing the stark differences regarding the poor and the rich and their respective life expectancy rate(Coovadia, 2009)(Harris, 2011).

This verifies the previous statements that lifestyle awareness and preventative care are integral in creating a healthier country. Generally speaking, more impoverished

communities tend to have a considerably lower life expectancy rate. This is regardless of whether or not healthcare is universal and easily accessible. As such, the system being built must also be accompanied by a change in cultural values as well as public awareness and education of healthcare (Coovadia, 2009).

The public sector of healthcare has problems primarily regarding incredibly poor management and financial emaciation. Of the previously stated 8% total GDP South Africa puts into healthcare, half of that is put into the public sector. This amount is projected to increase in the coming years. The main source for the funding that goes into the public sector primarily derives from income tax. The majority of the income tax collected comes from upper class citizens who are contrarily enrolled in the private healthcare sector. This causes problems because the people who are funding the public healthcare sector cannot obtain public healthcare for themselves, and in addition have to pay for private healthcare (Reforming Healthcare in South Africa, 2011).

This has two effects on the population. First, this means that the upper class pay large amounts into a resource they will never employ the use of. This generally breeds contempt in most societies and can possess the tendency to increase financial and cultural disparity between the classes. However, it can also be considered a major victory that the country found a way to concentrate funding in the public sector on the poorer classes, rather than the typical results of serving the higher classes (Wadee, 2003).

Over 250,000 citizens of South Africa have a job or a career in the public healthcare system. This number equates to approximately 0.5% of South Africa's entire population. One in five citizens works in the public domain of South Africa. This means that 20% of the citizens that work in the public sector of the country are employed by the public healthcare

sector. This gives rise to the knowledge that not many South Africans actively contribute to the economy and taxes. In fact, only around six million of the country's total population is registered as a valid taxpayer (Reforming Healthcare in South Africa, 2011). This clarifies the fact that those who do work in the public healthcare sector, including those who take their jobs very seriously, receive little to no support from any area and can be expected to work overly long hours weekly and possess incredibly high stress levels. If effective reform of the health care system is to take place within the country, all of these factors must be considered and countered by effective policies.

One of the most commonly addressed issues regarding the South African healthcare system is the stark differences that separate the upper class private sector and the lower class public sector. Expectedly, the largest area of contention resides in the difference in quality of care given in each of the respective domains (Pallot, 2010). However, this contention generally comes to blame the private sector for the majority of the ills plaguing the public sector and also tends to discount the successes present within the private sector itself.

These issues have also found their way into the NHI green paper, which outlines many of the objectives for the next fourteen years in the country. As such, the positive outcomes of the private sector are largely discounted and run the inherent risk of being completely overlooked in the future of South African healthcare. However, it must be mentioned that the privatized sector serves 30-35% of the population (Reforming Healthcare in South Africa, 2011). This includes payments out of pocket as well as those covered by differing medical schemes. It also reduces the amount of stress that is consistently put onto the public sector and also struggles with the amount of human resources that it is presented with.

Reforming the public healthcare sector in South Africa will take work considering the failings that it has been saddled with in the past. However, recent years have seen the public domain getting attention from the media as well as honest feedback from the federal government. Naturally, improvements politically, socially, and economically are all beyond necessary in order for healthcare reform to even be a possibility. The challenges presented with reforming the public sector range from financial funding to worker care and human resource management (Wadee, 2003).

Turning around human resource shortages will prove to be a challenge as both the public and private sectors are understaffed. This shortage is particularly devastating in the public sector as it is thought to be short on professionals by more than 60,000 workers. There are between 10,700-11,300 general practitioners and 4,000-4,400 specialists working in the public sector. The corresponding private sector contains 6,500-7,000 practitioners and 5,000-5,500 specialists (Reforming Healthcare in South Africa, 2011). With less than 40% of the total population being a part of the private health care sector the number of doctors represented in the private domain versus the public domain do not add up evenly. The majority of doctors want to be a part of the private sector due to better benefits such as higher wages, better equipment, and superior working conditions. The discrepancies between quality working condition of private sector and public sector will cause issues in the future if doctors are forced to change sectors due to lack of funding or policy changes (Pallot, 2010).

Doctors currently coming into the medical field also do not meet the numbers needed in order to establish a full healthcare overhaul. Between 2000 and 2008 the number of graduating doctors each year has only gone from 1,100 to 1,309 graduates. Another factor furthering the strain in this area is that more doctors have been immigrating to other countries

for their careers. They have been leaving due to the political instability associated with healthcare in the country as well as the high crime rate that is possesses. One of the leading ideas present for remedying this malady is to look to hire foreign health professionals in lieu of losing many native workers (Reforming Healthcare in South Africa, 2011). In fact, the Department of Health published a document in 2011 citing that the only way to fix such a shortcoming would be to create legislation that changed management in the healthcare domain that focused primarily on the recruitment of foreign professionals.

The NHI plan, which was introduced in 2007, focuses on the idea that within fourteen years healthcare will be universal and for all to come and be served. This is to be regardless of how much an individual contributes to the system, how much funding is going into the system, or how much a procedure may cost (Reforming Healthcare in South Africa, 2011). However, this idea also gives way for the misconception that the NHI plan is the only way by which South Africa will succeed in healthcare reform, and as such discounts the benefits of having coexisting private and public healthcare systems.

The Green Paper outlined what the NHI would do in 2011. The paper creates an image for what future South African healthcare will look like. However, critics of the idea cite a few places of concern regarding either lack of clarity or detail in certain areas. For instance, the funding that will be needed to create a successful system is not outlined as clearly as expected, with no clarification on increases in taxation or the well known fact that over half of South Africa does not even pay taxes (Ritchie 2013). Critics also worry that if NHI is the sole provider of healthcare for South Africa's population that it may not be good at managing such a tremendous burden. The idea presented is that power that the federal government possesses will contribute to the lessening of healthcare prices. However, this

depends on how much money is truly being spent on the private sector, as that is what most of the plan is based on. Basically, the NHI seeks to do the work that the private sector has been doing and aims to diminish costs by not employing commercialization. If however the private sector expenditure is not high due primarily to middlemen, then a problem regarding healthcare costs will still be a major problem under a unified system.

The Green Paper outlining the NHI does not fully address the role that the private sector will have at the inception of the national plan (Bridging the gap in South Africa, 2010). However, the past tends to show that many do in fact blame the private sector for the failings in the public, which would mean that it would be unrecognized that the private sector expanding would not necessarily be detrimental to the development of the field. In fact, expansion would more than likely lighten the load place onto the universal system and allow for a smoother integration and inception process (Reforming Healthcare in South Africa, 2011).

The most important factor to note is the fact that both the private and public healthcare sectors possess strengths and weakness that have accrued throughout their evolution. In order to develop a more sustainable, affordable, and efficient healthcare system for the majority of the population, it is imperative that legislators and medical professionals examine the benefits of both system and utilize their strengths in order to create a better system. Only through these actions can a better future of healthcare for South Africa be secured. It is also imperative that the United States healthcare analysts study and compare to the South African healthcare system and understand similar shortcomings in order to see that reform is necessary.

Connection between South Africa and United States Healthcare System

As examined above, there are flaws in both the private sector and public sector of the South African Healthcare. From this information, the United States could discern similar issues that it faces in its healthcare system such as cost and accessibility, and realize that future reform is required. With the idea of a public sector growing within the United States, it is important for politicians to look at how and why certain parts of the public system in other countries failed to meet the needs of the entire population and incorporate that knowledge into future reforms. The comparison can be made because like South Africa, the United States healthcare system began as mostly privatized. Only in recent decades has a form of a public sector been provided and a campaign for health care reform launched.

Like South Africa, healthcare reform in the United States will cause both creation and growth of a public sector system with a private sector still remaining that will provide the majority of the funding for the public sector. While the United State as a whole is wealthier and more stable than South Africa, it is still fair to analyze the health care system of South Africa to find evidence that healthcare reform regarding accessibility and affordability is necessary and determine what type of reforms the United States should enact.

Chapter 4. The Future of Healthcare Reform in the United States

In the past decade, the United States healthcare system has become one of the most complex and controversial issues both economically and socially due to the effects of recent healthcare reforms. Healthcare reform involves the right to healthcare, healthcare accessibility, quality of care, and tolerable costs for insurance and treatment. From looking into the issues within the healthcare system, such as cost and accessibility, and then analyzing reforms enacted by the PPACA, it can be determined that further reform within the United States is necessary to combat the remaining issues. To better understand what future reforms are necessary, the pluralistic healthcare system of South Africa was analyzed to determine its strengths and weaknesses in both private and public sector involvement of healthcare. The instability and controversy of the United States healthcare system shows that future reform is both necessary and inevitable.

Results of the Patient Protection and Affordable Care Act

Healthcare reform through the PPACA was a positive step forwarding in altering the United States healthcare system to serve its citizens better by increasing the quality and affordability of health insurance. This was done in order to lower the number of uninsured citizens by expanding both the public and private sectors of insurance coverage. Before the reform was passed it could be seen that the number of people uninsured was growing, the cost of healthcare was increasing, and both personal and government debt was growing due to medical costs (“Health Care Facts”). The PPACA acted to address the issues within the United States healthcare system, however, based on predictions and current data collections it

can be determined that the PPACA reform was not strong enough to be successful in combating the larger issue of cost within the system (“Health Care Facts”).

The PPACA positively reformed the United States healthcare system with regards to accessibility. Since the PPACA was enacted, about 16.4 million people have gained health insurance and over 12.3 million individuals are enrolled in Medicaid ("Is the Affordable Care Act Working?"). People are also no longer denied coverage due to preexisting health conditions. The PPACA has made positive contributions by making medical care more accessible. However, the rising cost of healthcare is still an issue, and this expansion in the public healthcare sector cannot be maintained if the government is unable to control cost or finance its citizens.

In spite of the provisions in the PPACA the United States continues to spend more of its GDP on healthcare than any other member of the United Nations, and The World Health Organization still ranks the United States 37th in the world in quality of healthcare provided based on costs required (“Health Care Policy”). The National Health Expenditure predicts that by the end of 2015 the United States will have spent 3.2 trillion dollars on healthcare, and will increase to 4.5 trillion dollars in 2019 (“National Health Expenditure Projections”). The PPACA was intended to slow the rate of healthcare spending through higher taxes, but due to increasing demand in the public healthcare sector, additional spending has taken place. The CDC calculated that 50% of United States citizens have some form of a pre-existing condition and that 75% of healthcare expenditures are used to treat chronic diseases that are preventable (“Health Care Policy”). As a result of being prohibited from denying healthcare insurance coverage, insurance agencies and the government have had to increase premium rates to combat the rise of healthcare costs and patient demand. In addition, the PPACA was

able to regulate insurance, but was not able to control the rise of healthcare costs, and as such resulted in insurance companies raising premiums. This further supports that the cost of healthcare is the larger issue at hand and reform is necessary because if healthcare costs were decreased, then insurance rates would decrease as well.

The healthcare system within South Africa was analyzed to determine its strengths and weaknesses in both the private and public healthcare sector. This analysis was conducted as a reference for discussion about the future of United States healthcare reform and what its goals should be for the most successful outcome both economically and socially. The South African healthcare system is similar to the United States in that it is pluralistic, meaning that it has both a privatized system and a public system in place for citizens to obtain healthcare. It was determined that privatized healthcare had negative impacts because only the wealthy class were able to afford this insurance, which grants greater quality of care and effective treatment options. The public sector also had negative impacts because both the quality of care and treatment options were far less effective than the private sector due to financial limitations within the healthcare system (Coovadia, 2009). This pluralistic approach of having a private and public healthcare sector causes stress economically and socially because the people within the private sector are responsible for financing their own private insurance as well as paying taxes to fund the public sector (Coovadia, 2009). An analysis of the South African healthcare system underscores the need for further reform to create an economically stable and functional healthcare system.

The healthcare crisis in the United States was not solved by the PPACA, and the new rules and regulations affected healthcare spending by reducing the number of uninsured people and increasing those obtaining care (Rosenbaum, 2015). According to the

Congressional Budget Office the healthcare debt is increasing at an unsustainable rate ("Health Care Policy"). It is important to fix the rising costs because as time passes the repercussions of delayed reform become worse. It is inevitable that the United States healthcare system is in need of future reform and the PPACA helped pave the way for future healthcare reforms.

The United States needs further healthcare reform

It is speculated that future reform within the United States healthcare system is expected ("Healthcare"). As such, it is important to determine which reforms would be the most successful at combating the important issues at hand like accessibility and affordability. Political parties have generally adhered to one side of healthcare reform or the other. The two major sides are expanding the public healthcare sector making it a more universal coverage, or expanding the private sector to make healthcare funding more of a consumer's responsibility. The United States is unique in that even after reform it continues to function pluralistically as a public and private healthcare system.

If future healthcare reform results in universal healthcare coverage, then all citizens would be covered through public insurance without exceptions. Patients would receive preventative healthcare services and long term care. The healthcare system costs for all healthcare services would be managed and regulated by the government. Healthcare funds would be provided solely through taxation, which would result in higher taxes to support the system. Those who oppose universal healthcare believe that it is an individual's responsibility to fund their healthcare services and do not want increased taxation. Also,

since medical care is funded by the government, there is potential for over saturation within the system. This means both doctors and patients will consume more healthcare than in the past, doctors will see more patients, and in turn will order more treatments which are expensive. Under public healthcare the doctors and patients do not face a direct charge for causing an oversaturation in the system, which will result in over spending, and ultimately an increase in taxes to fund healthcare **(“**Health Care”).

If future healthcare reform results in a more privatized approach to healthcare funding, then a more pro-market based healthcare system will grow. This allows for a greater freedom of choices for healthcare treatment and insurance plans. It is speculated that a market-based healthcare system would allow for more competition between providers and would help to reduce costs of services to attract more consumers **(“**Health Care”). While privatized healthcare is better economically for the government, it presents a multitude of ethical issues about the distribution and right to healthcare. There are millions of people that would be unable to afford insurance or cost of care under a strictly privatized healthcare system.

Whether future reform involves universal healthcare coverage or reverts back to a more privatized version of coverage, both cause economic hardships for the government and for individuals. A strictly public healthcare system will result in higher taxes on citizens, which could cause economic stress. A strictly privatized healthcare system could result in millions of uninsured people due to individuals being unable to afford healthcare coverage. This supports the idea that health costs are the real issue and future healthcare reform is necessary because healthcare costs affect all citizens in some way.

The excessive growth in healthcare costs is one of the major reasons that future healthcare reforms are desirable (Lorenzoni and Sassi, 2014). An increase in healthcare costs affects families, businesses, and the government. The costs have increased for families due to the cost of private health insurance premiums increasing, having to pay taxes under the PPACA, and general medical cost inflation to reflect supply and demand of providers and resources ("The American Health System's Big Problem"). The government does not always pay the total cost of health expenses and this causes an increase in the amount of out-of-pocket expenses that families must pay; which they generally cannot afford. An increase in healthcare costs is detrimental to businesses because on average healthcare insurance coverage is the most expensive benefit offered to employees ("The American Health System's Big Problem"). An increase in healthcare costs decreases the amount of money available to pay for employees and provide health insurance for them. The government is also impacted by the growth of healthcare costs. The expansion of Medicare and Medicaid caused strain on the federal budget due to being forced to coverage millions of new patients. The Congressional Budget Office stated that the growth in healthcare costs is the greatest threat to the national budget ("The American Health System's Big Problem"). The federal deficit will continue to grow unless significant intervention and reform occurs ("Health Policy"). As the cost of healthcare grows, so will the population of those who cannot afford it. This will lead to more people being under government provided health insurance plans which will potentially cause an increase in taxes on citizens for healthcare funding. Increased healthcare costs are a result of deficiencies in the healthcare system and will require reform in the future or it will remain unsustainable and eventually fail.

In order to provide better quality of care it is important that the government develop a plan for healthcare reform that serves to improve the healthcare system both socially as it has through the PPACA and also economically to reduce the cost of healthcare and tax expenditures. The most likely way for this to occur is for future reforms to allow for the continuation of the pluralistic approach of both a private and public healthcare coverage option, but with some changes to the conditions for each option. Socially, it is important to consider healthcare a human right so some method needs to exist to help grant people coverage who cannot afford it. Economically, the government cannot afford universal coverage for all without a very large tax increase, so it is important for financially able citizens to obtain their own privatized insurance while paying an acceptable tax to support healthcare programs for the uninsured. The solution seems to be making basic healthcare accessible to everyone. It should be considered the same human right as food and shelter in that all deserve basic healthcare just for being citizens, but wealthier individuals will be able to afford better products, for example a more expensive treatment like surgery. From present day, the next reforms should involve a way to lower the costs of healthcare. This can be done by several means: the government establishing set prices for healthcare visits and treatments, healthcare providers reducing costs to attract more patients, lower the cost of medical school and malpractice insurance, and not allowing Medicare or Medicaid to expand beyond their financial means.

The citizens of the United States need to analyze the negative aspects of its healthcare system and compare itself to other countries to find what actions must be taken to improve the healthcare system status. The United States healthcare system is on an unsustainable course and the PPACA was not broad enough to reverse the larger problem of

healthcare costs. Future reform is necessary in order to decrease the cost of healthcare overall, while still providing accessibility to basic quality healthcare for all citizens through both private insurance companies and through the government sponsored insurance programs.

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