

An Analysis of Current Healthcare Proposals: Obama and McCain

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ABSTRACT

The healthcare system of the U.S. is broken. The next opportunity for overwhelming healthcare system reform will be when the next president takes office. This paper analyzes the 2008 presidential election candidates McCain and Obama healthcare proposals through a look at key players in the current healthcare system (government, pharmaceuticals, doctors, hospitals, and health insurance companies) and the affects of implementing such a plan. The presidential plans are presented side by side. Projected outcomes of the changes offered by Obama will be an increased role of the government and decreased power of the health insurance companies while increasing coverage. The McCain plan would have more choice for individuals with a transparent system, and less governmental bureaucracy while embracing the free market competition of the health insurance industry. There will be obstacles and/or resistance to any reform passed by the presidential elect, no matter which man had won.

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INTRODUCTION

Health can sometimes be a matter of bad luck; everyone gets sick every once in a while. The healthcare system in the United States is a confusing patchwork system from the different historical generations, each generation adding a new piece. Currently, the different players in the healthcare system are so interwoven, and dependent on one another, whenever something happens to one, it affects the others. The last few attempts to reform the system have been met with high opposition, and the political motivation to make sweeping change has been absent. This paper identifies some current problems in the healthcare system and analyzes how the proposals by the two presidential candidates would affect the system, both as a whole and the distinct parts. Obama and McCain identify similar problems, but offer very different solutions.

A LOOK AT THE U.S.'S CURRENT HEALTHCARE SYSTEM

Key Players

Government

Currently, the government paid 47 percent of total healthcare spending in 2007, however this figure does not include the tax subsidies for health insurance, which would put it over 55percent (Getzen, 2007, pp. 331). Employers paid about 25 percent and households about 13 percent in 2006 (National Health Expenditure Data, 2008).

Medicare and Medicaid

Medicare is a federal government sponsored health insurance for those generally over the age of 65. Medicaid is federal and state government sponsored health insurance for those with limited income or resources. These are accepted at just about all doctors' offices and hospitals. It is estimated that more people are going to move onto these plans as the baby boomers turn 65 and begin to retire putting more stress on Medicare and as other healthcare costs continue to grow. Medicare has four parts; Parts A, B, C, and D. Part A covers hospital insurance or "inpatient care in a hospital or skilled nursing facility (following a hospital stay), and some home health care and hospice care."(Social Security Administration (SSA), 2008) Part B or medical insurance, "helps pay for doctors' services and many other medical services and supplies that are not covered by hospital insurance."(SSA, 2008) Part C or Medical

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Advantage plans, are optional plans through a managed care company that bundles many Medicare parts together and possible other coverage into one plan. Part D, covers prescriptions, “pay for medications doctors prescribe for treatment.”(SSA, 2008) Part A does not charge a premium if the person has paid into Medicare enough through his/her lifetime (a certain number of quarters) but does have deductibles. Part B has a monthly premium and annual deductible and co-insurance after the deductible has been met. Part C and part D premiums and deductibles differ depending in the companies running them, as there are no set standards, (Medicare A, 2008).

The government effectively negotiates with hospitals, drug manufacturers, and doctors’ offices about the re-imburement rates for various treatments generally at a lower price than what it costs the other party. The losses sustained by hospitals and other parties by Medicare and Medicaid are passed onto other patients and insurers through higher prices to cover those losses. About a decade ago Medicare Advantage plans were created, which are run by managed care companies and are basic Medicare plans plus other benefits that the company can decide to offer. Some health insurance companies also offer Medigap or Medicare supplement insurance, which covers what Medicare does not. In July 2008, Medicare was scheduled to lower re-imburement rates again (originally put in a bill to control healthcare costs) however, doctors resisted and lobbied through the AMA, some even temporarily not taking on any new Medicare patients before the bill was overturned (Pear, 2008). The doctors claimed that they could not afford to take on any more Medicare patients, and that they are pressed as it is. This was unique in that many doctors’ offices did this to show how the system relied on them to provide care, and yet was asking too much from them. Medicare and Medicaid offer healthcare access to those that would not normally be able to afford it, but do not re-imburse the fair amount for services, placing a burden on the rest of the participants.

Veterans Health Administration

The Veterans Affairs (VA) offers a type of network health insurance to all U.S. veterans known as the Veterans Health Administration (VHA). This network has grown, and due to the long-term commitment of the patients (once a veteran, you are always eligible for this system) has taken advantage of some cost saving techniques (Longman, 2005). Eligibility is determines on a step-basis, with service and reason for illness taken into account and veterans

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registered accordingly (Department of Veteran Affairs, 2008). Veterans may have to pay co-pays if they do not meet certain income thresholds or service requirements or net worth thresholds. In 2006, the VHA served 5.5 million people, with a total of about 8 million enrolled with about 1400 sites of care (Dept. of VA, 2008). The VHA will pay private insurance premiums, and is currently mostly funded by the federal government. Currently, the VHA is a leader in technological adaptation and preventative care. There are now more outpatient clinics for veterans than ever before, which has helped raise the quality of care. The VHA has an incentive to keep costs down, and therefore thoroughly provides preventative care, which lowers the overall costs of this healthcare system. This network of subsidized, tiered healthcare is one of the closest systems to socialized medicine that currently exists in the U.S. and has shown similar results as those countries in Europe with socialized medicine. This system is not without its problem though. Veterans and their families often have a hard time receiving care because it is somewhat “complicated and not well understood by the public” (Coonan, 2008). Coverage for specialists is often harder to coordinate and there are limited guidelines of actions if denied coverage treatment. Any changes to the way the VHA operates may be slow to take effect since it is a government bureaucracy.

Pharmaceutical Firms

The pharmaceutical industry is referred to as those companies that make drugs, whether it be prescription, over-the-counter or other medications. There are also a number of companies that make medical products and supplies which have a similar interest as the pharmaceutical industry. The National Institute for Health (NIH) performs a large amount of research funded by the government, of which affects products and supplies companies more than drug manufacturers. Many grants are offered by the NIH to different researchers and may also be co-sponsored by medical schools or pharmaceutical firms, but the budget for the NIH is a direct result of the federal government. The drug manufacturers, (pharmaceutical companies) have huge amounts invested in research and development, therefore creating a large barrier to entry for any new start-ups. There are a small number of very large drug companies, an oligopoly structure, with a lot of very small unprofitable start-ups that usually get bought out when they make a discovery. As discussed before, the incentives for pharmaceutical companies do not match those of patients. The pharmaceutical industry must make money in

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order to provide for more research and development, while also subsidizing those markets overseas where the companies cannot charge as much as they do in the U.S. The drug market is heavily regulated in the U.S. by the Federal Drug Administration (FDA) and for a company must prove a drug is safe and successful at what it does. The overall drug development, testing, and approval process can take anywhere from seven to thirteen years (Bolognese, 2008). This drug testing by the FDA is usually after the patent has begun; therefore the drug companies must charge even higher prices to pay for this patented-with-no-sales period. Many drug manufacturers charge different prices in different countries for the same drug; different regulations and laws make this price optimization possible. For example, patent protection differs among countries as do the laws prohibiting bringing prescription drugs over national borders. Many other developed nations have socialized medicine and therefore more bargaining power when negotiating prices with the drug companies, especially since the growth of generics. Tom Nagleⁱ claims that pharmaceuticals should show the economic benefit of using a drug as a value to the user when determining price instead of the claiming to support more research and development (The Price is Right, 2007).

Doctors

Doctors do not have the same incentives as the managed care companies. When it comes to implementing new technology into doctor's offices, there is no economic benefit for many small practices (Lohr, 2008). Physicians may have conflicts of interest if they were to hold a financial stake in a hospital or clinic, and are banned from such ownership of pharmacies. When a doctor refers a patient, he/she is making a decision for the patient on "who is best and to negotiate the lowest price" (Getzen, 2007, pp. 167). Doctors and hospitals are in a tough position to help the patient as much as they can and go by their instructions, while trying to persuade the insurance companies and governmental agencies to pay for the surgeries, prescriptions, and check-ups. Doctors compete for patients on quality, and not price; patients do not usually see the full price anyway. Patients have little knowledge of how to judge a doctor, and once they have settled on one, usually do not switch doctors often. The term "consumer" may not fit in the medical field due to the lack of knowledge of the patient, and inability to display rational consumer behavior, "patients do not know what they need what it should cost, and even once paid for, how much good the treatment actually did" (Getzen

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2007, pp. 146). The supply of physicians is regulated through the number of graduates from medical school, and the licenses granted to those graduates. The American Medical Association (AMA) and other affiliated professional organizations regulate the number of medical schools; no new medical schools can be built and current class sizes are fixed at 1981 levels. This limit on supply has created increased supply in other areas such as foreign doctors and other non-MD physicians, such as Osteopathic physicians (referred to as DOs, they do not need licensure and practice ‘healing the entire patient as a whole’).

Currently many people have a “primary” doctor that they see, a physician that knows them and the medication they are on, any medical conditions, or family medical history. These primary doctors are important, so patients are never prescribed drugs that may counter-act any conditions or other drugs. As important as these primary care doctors are, they earn less, and have more hectic hours, “an increasing number of medical-school graduates pursue specialties with a ‘controllable lifestyle’ and shun careers in primary care” (Iglehart, 2008b). Specialty doctors usually work office hours, make more per year, and include (but are not limited to) orthopedics, cardiologists, dermatologists, anesthesiologists, and some OBGYNs. Some of the pay difference can be attributable to geographic locations; primary doctors are fairly well spread out, however specialty doctors usually practice in cities, where they can serve more people, and all costs are higher. “In 1999, with the exception of general practitioners/family physicians, metropolitan counties had the highest physician-to-population ratios for all specialties” (AHRQ, 2006). These differences are causing more medical students to choose to become specialists rather than primary care physicians. “[The Bush Administration] believes that the market will equilibrate any distortions in the number and types of doctors” (Iglehart, 2008b) the market can correct itself, but the patient will pay more for primary care, and there is a significant time lag between when a medical student decides on a concentration and when they start practicing. Usually the more affluent a society is the more doctors are demanded.

Hospitals

There are over 4,000 hospitals in the U.S. and they provided 187 million patient days through 750 thousand staffed beds in the past year, (American Hospital Directory, 2008). Hospitals (and other larger medical care centers) are in a similar position as doctors since patients do not see the final bill, and are usually insensitive to prices. Since most of the revenues that

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hospitals receive come from third party insurance companies, and much of that from governmental agencies such as Medicare and Medicaid, they almost always compete on price and not quality. Hospitals have a limited control of their costs, and most changes to costs happen more long term when budgets are set, which would affect demand through their pricing. Any attempts to limit or control the supply of hospitals have been limited or short lived for two reasons: it is politically undesirable to do so, and the difficulty of explaining what the exact products that the hospital sells. The efficiency of a hospital really depends on the size and the specialty offered there (some specialty services operate more efficiently at small hospitals and some at larger ones). Most hospitals manage costs through cost shifting of the uninsured or of Medicare and Medicaid patients by charging higher prices to other patients. Also, a hospital is somewhat limited in their cost management since labor is a large part of costs. Hospitals went through a period of consolidation in the late 1990's and "consolidations among competing hospitals lead to higher prices" (Capps, 2004). The resulting higher prices could be attributed to a number of things, such as a lack of competition or proper regulation, and since economies of scale are present at different sizes for different services. There have been attempts to regulate hospitals, such as limiting new hospital construction, but that has since been appealed as a trade restraint that restricted competition. Medicare has tried certain types of price regulation, such as prospective payment system, but most of the regulations wind up shifting costs (in that case, from inpatient care/hospitals to outpatient care/clinics).

Health Insurance Companies

Most Americans have health insurance through their employer, which depending on the size of the company can outsource that health insurance to a managed care company, or can self-insure. Those large companies that self-insure usually outsource the paperwork of their health insurance programs to the managed care providers. There are also plans for small businesses which usually work similar to group insurance (the managed care company might pool together many small groups to stabilize the resulting pool). Managed Care companies are the large health insurance that come to mind (UnitedHealth, Aetna, WellPoint, Humana, etc.) which operate by insuring groups of people usually through their employers. These managed care companies usually operate a Health Maintenance Organization (HMOs) or Preferred

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Provider Organizations (PPOs) or now Point of Service (POS) network. When these companies were created in the 1970's and 1980's it was hoped that control over the facilities through these networks would help rein in rising healthcare costs. These companies have a financial incentive to keep costs down, which can be at odds with the intention of doctors and patients. The term "medical loss ratio" used by the insurance companies is the percent of revenue or premiums which must be paid out to providers.

These conflicting interests often lead to doctors trying to cheat the system into paying for some surgeries by reclassifying them, "upcoding" or having the patient go without surgery. Managed care companies are so large that they cannot see what the doctors see, and that leads to classifying surgeries that they will or will not pay for, and setting common standards (Brewer, 2008a). The current managed care system often provides only limited access, both to those that are members (limiting where they can go for care and what they will pay for) and non-members (limiting those who the company will accept). Managed care companies want to earn a profit, but also want to cover as many people as they can, which places them in an odd situation of not fully achieving either goal. These incentives have no checks-and-balances, and can go astray, as in a case where the medical reviewers of a health insurance company are paid bonuses based on how many claims they have denied. Most insurance companies use a fee-for-service method of reimbursing doctor's offices, meaning that the health insurance company will pay the amount that the provider of care charges (within reason) once an insurance claim is submitted. In a Prospective Payment System (PPS) the insurer reimburses the provider based on predetermined prices for services that fall under certain categories or diagnosis-related-groups (DRGs).

Another method of payment is using the capitation system in which the providers of care agree to cover or treat an individual enrolled in the system, regardless of cost (with a few exceptions in the contract) for a set monthly price (Hagland, 2008). This system works if there is a large pool of people that is covered, but the risk is on the hospital and doctors offices; if too many people need care, they will operate at a loss. Many of the capitation plans have been criticized for not covering enough to include preventative care. Employment-based health insurance is good from the managed care perspective, since it brings together a large group of diverse people for a reason other than to get health insurance (avoiding adverse

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selection) while keeping administrative costs down. Since these companies want to keep costs down, they may be more willing to deny services deemed “preventative care” since members often switch insurers, and covering the patient might help their competitors. Preventative care frequently costs much less than the outcome of letting the problem grow.

Issues

The U.S. faces a multitude of problems in the health care system. One of the first problems that should be worked on and considered to lower costs is the number of people that are uninsured or underinsured. Any changes to the current healthcare system must weigh the benefits of quality with the cost of the care. Although it would be nice to add more technology, preventative care measures, and research and development, people must understand that these investments have a long-term pay-off rather than look only at the up-front costs. Congress has made steps towards protecting privacy of health records, but precautions must be made if the country is to use technology to its full advantage in the health field. The fact that most people’s health insurance is tied to their jobs was a major issue, and Congress gave a “grace period” of sorts through COBRA and HPA, but whether more will be done is still to be seen. All signs point to higher and higher healthcare costs, but we must spend even more money to see significant cost savings.

Cost Trends

Healthcare costs have risen uncontrollably over the last two decades (Kaiser Family Foundation, 2008) with extended growth expected to continue as the American population ages and the Baby Boomers gear up for retirement. Past government efforts to lower costs have not been effective. Rising health care costs are not necessarily a bad situation, since research and development and technological improvements all improve life quality, but come at a cost (See Appendix A, International Cost of Care). Most people would argue that the improvements are worth paying for since it is hard to put a price on health and well-being. No one wants considerably lower quality even if they would pay a considerable lower price. Since scientists and researchers are not the end users of the research and development that they create, this can lead to overproduction of research (in a costs-benefits scenario). The marginal benefit of the research is less than the marginal cost (i.e., for an extra \$1 of research, there might only be 75 cents of benefit). This overproduction of research means that there is

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more research than the public would demand if they had to pay for the research themselves. The creation of the National Institute for Health (NIH) has partially alleviated this problem by acting as one large organization on behalf of the public since a true individual marketplace could not exist for such expensive and long term research. On the other hand, people may be willing to pay more for research than the marginal cost to marginal benefit analysis indicates since it is rather hard to put a price on life, one life that the research just might save. The amount spent on research and development will always depend on the supply of such services and not the demand. The increase in healthcare costs has been an international phenomenon, and in Britain, “a British government agency, the National Institute for Health and Clinical Excellence. The institute, known as NICE, has decided that Britain, except in rare cases, can afford only £15,000, or about \$22,750, to save six months of a citizen’s life” (Harris, 2008). The effect of putting a cap on the amount the national system is willing to pay for someone is seen as controversial (for moral reasons); but cost increases have left few other choices. Many other countries are now studying the British model or letting it set the standards.

Most people see healthcare costs through their health insurance coverage (and/or non-coverage); for this reason, politicians target health insurance as a way of lowering healthcare costs. There are other ways to lower the cost of health insurance such as reducing the number of preventable errors, and the number of uninsured people. Errors cost time, money and supplies to fix. Uninsured people add to the cost of healthcare because someone must pay for their healthcare. Since people with no insurance often forgo common procedures and treatments, their problems build and accumulate until emergency treatment is needed, usually costing much more than any preventative care. In the case of an emergency, care cannot be denied, but must be absorbed by the hospital or insurance companies, whether the person is covered under a policy or not. “[The uninsured] pray every day that they don’t get sick because 18,000 will die this year simply because they are uninsured,” (Moore, 2007). Reducing the number of uninsured people is regarded as the first step to lowering the overall cost of the healthcare system. Currently there are 45.7 million (DeNoon, 2008) Americans without health insurance, or 45 million non-elderly without insurance (Kaiser Family Foundation, 2008) which is about 15% of the population. “Schemes for the elderly and the poor, and tackling the large numbers of uninsured, will make up nearly one in every four

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dollars spent by private insurers in 2009, the study said” (BBC News, 2008). That figure does not include the large estimated number of those that are underinsured, or who have less health insurance than what is recommended, and “insurance” in that study includes only the most basic of health insurance in some cases. A study in 2005 found that half of personal bankruptcies are filed due to large medical bills. Other ways to lower the health costs are social trends, such as encouraging a healthy diet and exercise, and also infrastructure changes (cleaner water, sanitation, etc.). Even changes in laws can affect health outcomes in a country; “Firearm injuries represent a major public health problem that seems certain to be exacerbated with less handgun regulation” (Drazen, 2008). The largest problem with rising costs is the vicious cycle that it begins, “Rising health costs push total employment costs up and wages and benefits down. The result is lost profits and lost wages, in addition to pointless risk, insecurity and a flood of personal bankruptcies” (Cutler, et al. 2008). The more spent on healthcare, the larger piece of the economy it is.

Who Pays?

There are three different parties that can pay for healthcare services; the government, employers, or individuals, or a combination of those three. If the government pays the taxpayers will ultimately be paying (through higher taxes), so the question arises about fairness. Should a country charge higher taxes to provide for national health insurance, or should the individuals pay for their own health insurance? The government-paying option eliminates the factor of random chance of health issues and the unfortunate bill afterwards, but the individual system reduces moral hazard (people might not take the same precautions if the government pays when they get sick). The U.S. currently has an employer-based system with individuals paying a small portion through co-pays and paycheck premiums. The government in the U.S. also pays for certain groups if they meet certain criteria such as being a veteran or over the age of 65, or living under an income threshold of poverty.

Long Term Care

Long term care is “medical and non-medical care to people who have a chronic illness or disability” (Medicare, 2008b) and usually is provided at either the person’s home or some type of assisted living or nursing home. It is unclear how many people will need long term care (LTC) since about 70 percent (Medicare, 2008b) of those that need LTC today are cared

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for by family or friends. Most of the work done by providers of long term care are daily activities or support services. Long term care can be expensive, especially since “About 10 percent of the people who enter a nursing home will stay there five years or more” (Medicare B, 2008). The current cost for a one year stay in a nursing home is \$183 per day, or \$66,795 per year (Houser, 2008b) but only about 25% of that is paid out-of-pocket (Medicaid and Medicare along with some private insurance picks up most of the rest). People can buy long term care insurance when they are younger, but it gets much more expensive the older the person becomes; however most people do not consider it until they are ready for retirement (when the price shoots up dramatically). There are other options than nursing homes (which tend to be the most expensive) such as assisted living, or hiring a home health aide. Assisted living is when a group of people live together that need some help with day-to-day activities (activities of daily living, or ADLs, think daily functions). These groups are similar to nursing homes, but do not offer as much medical care and have less supervision with more independence and privacy. Costs for assisted living can vary by region, but averaged \$35,600 per year in 2006 (Houser, 2008a). Enrollment and costs of assisted living may depend on the ADLs that are needed.

The need for long term care is only expected to grow with more baby boomers retiring. The care that elderly receive in their last few years of life can be very expensive depending on the region (Hartocollis, 2008). There is a typical cost-benefits analysis here: how much should someone pay for a few extra months of living? If extensive medical attention (and/or surgeries) is needed in the last few months of life, the quality of life is decreased, and not what most might think of when considering living for a few extra months when they are young and healthy. Many people are deceived about an actual amount spent on the last year of life, “spending in the last year of life accounted for 27.4 percent of all Medicare outlays for the elderly” (Hogan et al., 2001). The system should get ready to receive the baby boomers and strive towards efficiency and value; otherwise the healthcare cost spiral will only continue. Estimates based off of the Census Bureau’s statistics predict anywhere between 14 to 54 million American aged over 85 years old by 2040, depending on different mortality and life expectancy rates, (Gavrilov, 2003) compared with about 5 million currently. Even if most stay with family or friends, that burden might not necessarily be counted towards LTC costs,

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and the opportunity costs to earn more money or spend on other items will affect the rest of the economy. The process of delivering care through assisted living might benefit if more basic help is used, instead of underutilizing very specialized help (such as a nurse).

Individuals in current system

People who pay for their health insurance individually, and not through an employer-based network or group commonly pay higher prices. Managed care companies must charge these individuals higher premiums for a higher administrative cost and also to compensate for the risk of adverse selection (only unhealthy people would buy health insurance on their own, right?). There are a few laws to protect the individuals, such as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and The Health Insurance Portability and Accountability Act (HIPAA). COBRA allows people terminated from their jobs (or other qualifications) to continue under the company's health insurance policy for temporary period depending on how they lost the insurance. The individual must pay the full amount of the deductible plus a 2% administrative charge. The intent of COBRA is that finding individual coverage can often be expensive and time-consuming, and this law covers most job transitions that people make. HIPAA was created to make buying individual health insurance fairer and is for those who change or lose their jobs and their dependents. The HPAA limits the use of pre-existing conditions exclusions (which will usually exclude people with pre-existing conditions such as cancer from qualifying for health insurance), prohibits discrimination based on health status, and guarantees availability and renewability of health coverage to certain employees and individuals (U.S. Department of Labor, 2008). The HPAA also has security measures to protect private information such as medical history and payment history, which is increasingly more important in this information age of the internet. These two laws combine to give people who were formerly employed and covered by a health insurance plan some time and options before they would become uninsured.

Typically, an individual without health insurance would buy a catastrophic health insurance or a high deductible health plan. These plans would cover the individual for large bills (emergency room visit), but not for smaller bills such as doctors visits and prescriptions (a high deductible, or out-of pocket amount) but costs the insurance less since there are fewer claims. Individuals cannot be seen as rational consumers when it comes to healthcare, even

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when they do see the final bill, “It is an awful feeling to try to put a value on your body” (Moore, 2007). An individual may also use a Health Saving Account (HSA) (Office of Public Affairs, 2005) in which a high deductible plan is mandatory. A HSA works similar to an IRA, the money goes into a savings account tax exempt with an annual maximum contribution amount, and the money accumulates tax free. The money in a Health Saving Account can be withdrawn tax free and used for any health expenses, or can be taken out after retirement with a tax levy raised. These accounts do allow for large purchases since the money can accumulate in them, however may be ill-suited for those with a pre-existing condition who may use the money rather fast. One reason that these accounts are not popular is that the patient/consumer must pay full price for any health expense, whereas insurers and other providers usually have a lower price negotiated before any procedures are performed. If someone has had an HSA for a few years and then develops an illness, such as would qualify as a pre-existing condition, then that person could use the HSA to pay the high deductible of their catastrophic health insurance. The risk is that the total annual out-of-pocket amounts for a high deductible health insurance plan usually run about twice the annual contribution of the HSA, therefore the longer the person has had the HSA, the better off they are but the worse the condition, the faster the money will run out in the HSA. Most people prefer to stay in a group plan where they know they are covered if they were to develop such a costly condition. These accounts are praised for their economic logic, the patient or end-user actually pays the costs, and can therefore make better decision when judging marginal benefits for marginal costs.

International Comparison

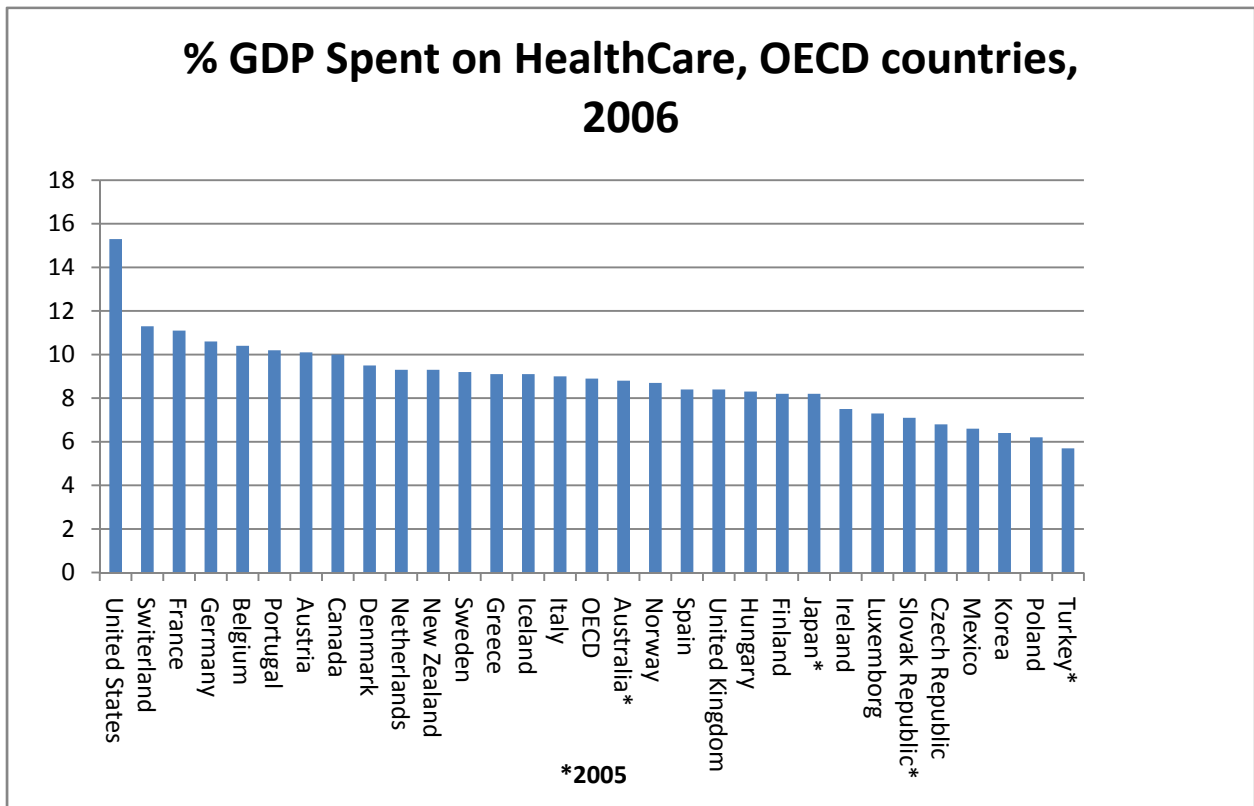


Figure 1 – Percent GDP Spent on Healthcare

The U.S. spends much more as a percent of GDP on healthcare than all other developed nations (see figure 1), yet has average returns for that money spent (similar life expectancy, infant mortality, etc. see figure 2 on next page) (Index Mundi, 2008). These two measures of a country's healthcare system can be misleading; there is a discrepancy in the way infant mortality is reported, and many other aspects affect life expectancy than just the healthcare system (Hogberg, 2006). This above-average spending does have some perks, such as shorter waiting periods (many other countries have universal healthcare coverage). The U.S. also is one of the leaders for healthcare research and development, from which many of the technological advances and drug formulas come from and which the whole world benefits. The price for a non-generic drug in the U.S. is often more expensive due to the lack of socialized medicine, and many drug manufacturers charge more in the U.S. because no party in the system will stop them. Pharmaceutical companies often find ways around to hide the real price of their drugs (some countries use the British system as a standard for which drugs

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to allow) “But because of the institute, Britain’s National Health Service has been among the first to balk at paying such prices, which has led many companies to offer the British discounts unavailable almost anywhere else,” (Harris, 2008). People started demanding the ability to see certain doctors and the control that the insurance companies had was lost; “Insurance companies no longer had the ability to negotiate with a doctor or hospital because they couldn’t throw them out of the system,” Anderson says. “Prices for insurance took off.”(Consumer Reports, 9/2007). This is a form of tiered pricing (WHO)ⁱⁱ which gives the pharmaceuticals enough incentive while more widely distributing the research.

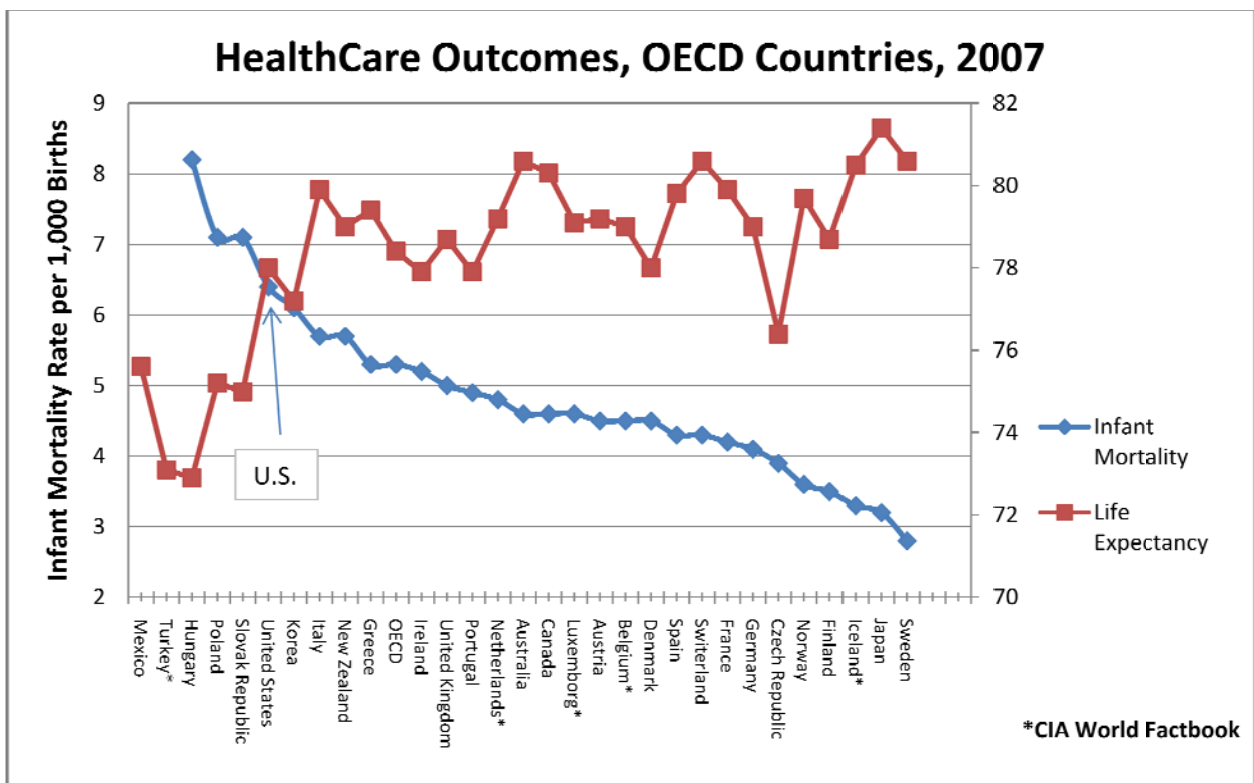


Figure 2 – Healthcare Outcomes

Also, the U.S. and South Africa are the only countries that do not have socialized medicine, unlike the OECD (Organization for Economic Co-operation and Development) nations. The private sector makes up a little more than half of the total spending on healthcare in the U.S. There are a few reasons why the U.S. should spend more than other developed nations on healthcare, but the fact is the U.S. is spending much more than those countries, and is still lacking on key health measures. The U.S. spends the most on healthcare, as a percent of

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GDP, however ranks 20th out of the 30 developed countries for life expectancy, and 25th on infant mortality. The population of the U.S. is much more diverse than other OECD countries, which tend to have one major ethnic group with small minorities, and so biological and cultural factors may also play a part into a lower outcome of key health measures. In a study of the healthcare systems of 22 European countries, “Our results suggest that although a reasonable level of social security and public services may be a necessary condition for smaller inequalities in health, it is not sufficient. Lifestyle-related risk factors have an important role in premature death in high-income countries, and also appear to contribute to the persistence of inequalities in mortality in the northern region” (Mackenbauch, 2008).

A LOOK AT THE PLANS

Both candidates agree that the healthcare system in the U.S.A. is broken and needs fixing. However, the candidates disagree on just how to fix the complex system. No matter who was to be elected, there will probably be political forces against any changes to the current healthcare system. Besides the obvious lobbyists, these forces might include the issue of persuading Congress, budgetary concerns, and the effectiveness (outcomes) of the plan.

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| | Differences | |
|-------------------------------|--|---|
| | McCain | Obama |
| Goals | <ul style="list-style-type: none"> • Improved Access & Choice • Improved Quality • Increased Affordability • Increased Portability & Security | <ul style="list-style-type: none"> • Increased Coverage • Increased Efficiency • Improved Health & Disease Prevention |
| Steps to Achieve Goals | <ul style="list-style-type: none"> • Refundable tax credit to individuals by taxing health care benefits paid by employees • Allow individuals to purchase insurance across state lines • Create state-run Guaranteed Access Plans for those unable to get health insurance • Expand role of Health Saving Accounts (HSAs) | <ul style="list-style-type: none"> • Insurance market reform – require pre-existing conditions coverage, create national exchange, create basic/minimal federal insurance plan, and encourage employer insurance • Mandate coverage for children • Information technology investment to improve efficiency |

McCain

The McCain-Palin ticket had four major components to it. First, the tax law would have needed to change to add a refundable tax credit to all individuals or families if they choose to purchase individual health insurance rather than group insurance through their employer. Second, the McCain plan would have created a Guaranteed Access Plan (GAP) in each state for those unable to get insurance in the individual market because of pre-existing conditions. Thirdly, the role of HSAs would have been greatly increased. The McCain plan also would have allowed patients to purchase insurance across state lines, the idea behind this is to empower the individual in the health insurance market and therefore make the market more competitive. The GAPⁱⁱⁱ would lower the administrative costs of the plan, and also provide assistance to those under certain income thresholds, as well as limits on premiums. These GAPs would also be able to converge with other states to further lower the overhead costs. McCain’s plan would have eliminated the tax incentive used by employees (but not employers) and give it back through these refundable tax credits. “Currently, workers do not pay taxes on health insurance premiums paid by their employers. The McCain plan would

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eliminate this tax exclusion and use the revenue generated — projected to be \$3.6 trillion over 10 years — to pay for refundable tax credits for Americans obtaining private insurance (\$2,500 for individuals, \$5,000 for families)” (Oberlander, 781).

McCain wanted to concentrate research on chronic diseases and autism. “[About chronic diseases]... By emphasizing prevention, early intervention, healthy habits, new treatment models, new public health infrastructure and the use of information technology, we can reduce health care costs” (McCain, 2008). When a patient buys insurance through the individual market and pays less than the refundable tax credit, the remaining amount will be transferred into a HSA. The McCain camp had an underlying focus of lowering overall healthcare costs, and offering more choices (through availability of plans) and portability of healthcare insurance to Americans.

The Republican candidate offered many smaller changes to reduce costs and improve the healthcare industry, such as cheaper drugs through safer re-importation and faster introduction of generics. He wanted tort reform to remove malpractice lawsuits if the physician was practicing “clinical guidelines and adhering to safety protocols” (McCain, 2008). One larger component was the increased transparency or public knowledge that such a plan resting more on the individual market needed to include. Other smaller proposals included smoking cessation programs, and promoting technology and coordinated care. McCain’s proposal also aimed to reform the payment system of Medicare and Medicaid to promote certain outcomes by doctors. McCain wanted to promote “proper incentives to reduce costs such as disease management, individual case management, and health and wellness programs” (McCain, 2008). One proposal by McCain would have allowed states to change different aspects of the healthcare system within that state, such as licensing of doctors, insurance policies or forms of access, or limited changes in Medicaid.

This plan relied on the American consumer to choose their healthcare options, and the effectiveness of working with state governors on GAPs. The other goals of the plan relied on how they would be implemented, and how the different parties in the healthcare industry would adjust to them. This plan would have created more choices for consumers as well as fixing some other problems, such as rising costs.

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Obama

The Obama-Biden ticket healthcare plan is based on expanding coverage, and other smaller goals such as more preventative care. The Obama plan expands coverage through four ways: first by requiring health insurance companies to cover pre-existing conditions, second, by creating a national exchange where people can pool together to buy insurance, third, by creating a new governmental health insurance plan in which the basis would be set for private plans, and lastly by requiring large companies to contribute to healthcare. Large companies that self-insure would need to at least offer the same benefits as the national plan or if the company does not offer health insurance to their employees, then it must pay into the national plan. Small companies would receive a health tax credit, which would partially subsidize health plans for small business. Obama also proposes that the federal government act as a second insurer, or re-insurer on catastrophic health costs of businesses over a certain amount, and asking that this saving be returned to employees through lower premiums. Health insurance for children would also be mandatory but with changes included in current systems making it more accessible and affordable.

The Obama healthcare plan focuses on holding companies responsible, providing affordable, accessible coverage, and promoting prevention and strengthening public health. These forces are ideals behind having businesses shoulder more of the payments, and insurance company reform.

Many other proposals include reforming the insurance market, expenditures on technology, as well as documentation of costs and data. The plan would also “strengthen antitrust laws to prevent insurers from overcharging physicians for their malpractice insurance” (Obama & Biden, 2008). Lower drug costs would be achieved through importation from safe countries, increased use of generics in public programs, and a tougher stance on drug companies that block generics from market. There will also be a tax credit based on need for health insurance, as well as a focus on chronic disease management.

The healthcare solutions proposed by Obama rely on the amount or degree of participation among businesses. Whether companies provide adequate coverage, or cancel their health insurance policy and just pay into the national program, may be up to competitive pressures. There is some ambiguity in the plan by stating a “meaningful” contribution to the national

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plan must be made. How this plan is received by health insurance companies and/or their political power could be interesting. This plan would reduce the number of uninsured but at the price of increased government regulation, and would fix other problems, such as the health insurance industry structure. “Sen. Obama's proposal will modernize our current system of employer- and government-provided health care, keeping what works well, and making the investments now that will lead to a more efficient medical system. He does this in five ways: ...Learning, Rewarding, Pooling, Preventing and Covering” (Cutler et al., 2008). The five ways previously stated focus on his goals of increased coverage and efficiency, a focus on preventative care, and more balanced incentive system.

CURRENT PROPOSALS IMPACT

It is necessary to examine the proposals through the angle of the different participants in the healthcare system in order to gain a comprehensive understanding of the plans. Many of the pieces to the plans affect more than one key player, and whose future might depend on budgetary support of future presidents for such systems.

Government

The largest differences in proposals between the two candidates are the roles of the government and of health insurance companies in the respective plans.

The McCain plan would have reformed the payment system of Medicare, allowed private insurance companies to offer/provide Medicaid, and created GAPs and other organizations for those denied coverage through the states. McCain also proposed increasing federal funding for R&D for cures of chronic diseases, and taxing health benefits paid by employers. The reasoning for reforming the Medicare payment system is to promote certain outcomes from doctors (efficiency based). One proponent of the McCain plan was to coordinate payments per episode for Medicaid, and to create alternatives with the help of the states. The Veteran Health Administration is not specifically mentioned in the McCain plan.

The effects of the changes proposed by McCain are large. Medicare Advantage plans are Medicare plans offered through private insurance companies, created with the intent to lower costs, but currently cost 12% more than Medicare administered through the federal

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government, therefore offering Medicaid through private insurance might not lower costs, as intended. An exact cost benefits analysis is difficult since it is unclear who will be covered by the GAPs and non-profits set up with cooperation with the states, and also because McCain did not said how he would finance these changes. These were to be state-run operations, but the McCain plan also allowed for them to converge forming even larger economies of scale. The taxing of employer benefits rests on the tenet that if the employer does not wish to continue to carry health insurance, they will give their employees a raise (the amount of benefit they would have gotten from the prior health insurance). The overall effect of these changes will force more people into the individual market for health insurance as more companies drop health insurance (due to the lack of tax benefit), or making people pay more of their health insurance as companies cut back. The tax benefit offered by McCain (\$2,500 for individuals, \$5,000 for families) might not have been enough to cover someone, or they would not be able to afford a plan with similar benefits, “The average family policy in the United States now costs about \$12,000, of which the average employer contributes about 75% (\$9,000)” (Blumenthal, 2008). Many people would find themselves in the individual market with less generous plans. McCain recognized some of the problems of the individual market; but his other proposals to fix them, such as increased transparency, were not so clearly defined and would have take a while to see the results.

“McCain argues that his tax credit will cut the ranks of the uninsured by 30 million, but there is no empirical basis for this contention. The Congressional Budget Office (CBO) estimated in 2007 that President’s Bush very similar proposal would reduce the uninsured by 6.8 million in 2010. However, the CBO used a very conservative estimate of the number of workers who would lose employer-sponsored insurance: about 6.3 million. The actual number could easily be double or triple that figure” (Blumenthal, 2008).

The move to tax employer based health benefits and to offer Medicaid through private insurance will increase costs, and will out-weight the cost savings of GAPs, Medicare payment reform, and increased R&D for chronic diseases.

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The Obama ticket will mandate health insurance for children, expand Medicare and Medicaid by creating a national exchange to buy health insurance, and create a federal health insurance plan as a basic coverage fall-back. Other proposals by Obama include letting Medicare negotiate drug prices, and creating a play-or-pay system with employers for offering health insurance. The Veteran Health Administration will not be changed by Obama.

These changes offered by Obama will leave the employer based system intact, but require large employers not offering insurance to pay into the federal insurance fund, and also give small businesses an additional tax benefit for offering health insurance. There will be increased coverage under the Obama plan, since people will be able to buy insurance easier and form groups in the national exchange, or buy the federal insurance if their employer does not offer insurance. Patients will still be blind to the prices, as is before, and these measures alone will not curb the spending trend (it is unclear how much cost savings will come from increased coverage). Obama plans to finance these changes through his cost savings and the Bush tax cuts, however the cost saving are long term, and may not cycle back to the federal government, making large short term costs. “According to the campaign, federal health care spending could increase by as much as \$65 billion a year – but only after the \$200 billion a year in cost savings” (Antos, 2008). The exact implementation plan of these changes will vary the outcomes also; how businesses react to the pay-or-pay system will be a large proponent of its success or failure. If it is cheaper for large businesses to pay into the federal system than to offer health insurance to their employees, that will create a large number of people in the federal system or national exchange. The new federal plan would face cost-benefits trade-off. Also, for those companies that did not offer insurance plans, this would drive up the costs of labor.

Pharmaceuticals

Drug re-importation has been proposed by both candidates, along with a stronger presence of generic drugs, both of which would have major consequences for the drug companies.

Currently, the pharmaceutical companies have one of the largest lobbyists firms in Washington, so any changes might be met with opposition. Drug re-importation is buying drugs in other countries such as Canada and bringing them to the U.S.

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The McCain ticket proposed faster introduction of generic drugs, and re-importation of drugs from abroad. McCain supported research and development for cures of chronic diseases. These parts of the McCain plan would have translated into cheaper drugs for U.S. citizens, and decreased profits for the drug companies. The drug companies will have shorter patents (since generics will be introduced quicker) and would probably raise global prices for the drugs to offset the shorter patents and drug re-importation in the U.S. The prices of many drugs would fall to the new import price, whereas drug prices in the rest of the world would increase slightly, but the U.S. would probably still be paying less than we did before.

Research and Development would decrease with profits, and the number of firms might fall as smaller players cannot maintain the amount of research and development. Overall, the pharmaceutical companies would be less profitable, spend less on R&D, and might change their goal from making profit to a focus on public benefits of their products. To introduce generic drugs quicker, the FDA might be considered for revision, which might be very good step towards increased efficiency.

Under the Obama plan, there would be increased use of generics in governmental plans, drug re-importation from countries deemed “safe”. Also, Obama proposes that Medicare be allowed to negotiate for lower drug prices, and drug companies would be challenged if they block cheaper generics. The effects on pharmaceutical firms would be more pronounced than McCain’s plan. Obama supports increasing the amount of money spent on federal R&D. When Medicare Part D (the part covering prescription drugs) was passed the reasoning behind not allowing Medicare to negotiate prescription drug prices was that Medicare is too large of a player in the system. Medicare would cause the pharmaceutical firms to undercut their profits, and before long, the insurance companies and other countries would want that lower price also. Although neither candidate spells out exactly what their plan will do to pharmaceutical firms, the emphasis of generics and other ideas to lower the cost of prescription drugs would have a large impact on drug manufacturers.

Doctors

Both presidential candidates recognize the need for some type of malpractice or tort reform, and neither offer any clear solution for the primary care predicament.

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The largest element of the plan offered by McCain that would solely affect doctors is tort reform. McCain wanted to eliminate torts from medical liability when doctors have followed clinical guidelines and safety protocols. Other proposals having a direct effect on doctors would have been promoting quick, simple care through greater access and convenience. One of the tenets of this whole plan was greater transparency and access to data, which would require doctors to measure, record, and publish more records. McCain wanted to empower the doctor, by having the doctor make more decisions (versus health insurance companies right now). This part of the plan taken alone would have been good for doctors. In the short term, the small-time doctors might complain about the costs of implementing new technology and record keeping, but it is a necessary evil to improve the system. After a while, the malpractice insurance would go down due to fewer torts, and the doctors would probably enjoy their increased empowerment, since the bureaucracy can be frustrating. However, only the tort reform piece is clearly defined, whereas the other pieces are more goals without a clear plan for implementation.

The Obama plan proposes malpractice reform by limiting what insurance companies would charge doctors. Other parts of the Obama plan that would impact doctors are reducing preventable medical errors through proven strategies, and insuring that patients have their choice of doctors and care without governmental interference. The malpractice reform, if done properly, would reduce costs to doctors, but the patient choice would probably slightly increase overall costs. The long term situation of primary care is recognized by the Obama administration however they have no clear plan to address it. In the long run, these parts of the plan would slightly improve quality and slightly lower overall costs.

Hospitals

The plan for increased information technology and records has support from both candidates. Neither man mentions hospital regulation, but many of the portions of the plans have indirect effects on hospitals.

Presidential candidate McCain wanted to promote quick, simple care through greater access and convenience, along with information transparency. Information transparency will cover many aspects of care: treatment options, medical outcomes, quality of care, costs and prices.

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This information requires an investment in healthcare infrastructure to document and compile this data, which might fall on the hands of hospitals. Another proponent of the McCain plan would have been to reform the payment system of Medicare in order to promote diagnosis error prevention, and care coordination. The short term effects would be a financial strain on smaller hospitals that cannot afford the technology upgrade as easily as larger hospitals, however the data generated could be used to have the hospitals run more efficiently in the long run, therefore lowering costs. The McCain plan was silent about hospital competition or regulation.

Presidential candidate Obama proposes reducing waste in the healthcare system through proven strategies (which will probably be left up to the physicians or hospitals). The Obama plan would require hospitals to collect and report healthcare costs and quality data. Other items of Obama's healthcare policy that would affect hospitals would include the goal of increasing preventative care measures, and aligning incentives for excellence. The short term effect would be to increase costs as more hospitals implement new data collection processes, and possible increase in demand for hospitals or clinics for preventative measures. In the long run, these proponents of the plan should lower costs due to increased efficiency, and maybe lower the demand for hospitals as more people receive preventative care. The information technology is seen as a measure of the system and feedback in the system where necessary reactions can be taken. The one unclear piece of this part of Obama's healthcare plan is the aligning of incentive for excellence; this might include reforming the payment systems, which would affect the hospitals, but since no clear path has been set, the effect is uncertain.

Health Insurance Companies

What will happen to health insurance companies if the next president is successful in passing healthcare reform is one major difference between the two plans.

Under the McCain plan, the competition of the health insurance companies would have been embraced, and more people would likely have entered the individual market. Much more health data would be made transparent and the use of HSAs and tax benefits would affect how people spent money on healthcare. McCain proposed allowing people to buy health insurance across state lines, and create GAPs and other organizations with the different states for those

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with pre-existing conditions and to lower administrative costs. The payment system of Medicare would have been reformed to reduce errors and health insurance companies would have been able to offer Medicaid.

The effects of some of these proposals have already been discussed earlier, but need mentioning again to better understand their interaction. Fewer companies would offer health insurance since the health benefits are being taxed, which would push more people into the individual market and increase administrative costs due to increased enrollment in the individual market and the packaging of Medicaid by private health insurance companies. Many health insurance companies would sell plans with less generous benefits for a reduced price, and might decide not to sell directly in a state, since people would be able to purchase health insurance across state lines, and therefore the health insurance companies would avoid state requirements to cover certain items. As for the high risk pools or GAPs that McCain proposed, “Thirty-five states currently maintain such pools, but they enroll only about 190,000 people. The reason is that states are unwilling or unable to subsidize adequately the extremely high premiums that pools charge the chronically ill” (Blumenthal, 2008). The funding for such high risk pools has been vague by the McCain camp. The amount of the tax credit might not have been enough for people to buy insurance in the individual market, as discussed before. The tax rules can be changed in a short period of time to move people into the individual market, however the information needed by the public to make rational decisions would not be available for at least a year or two after the implementation of better record keeping. The McCain people argued that individual people will be able to make rational decisions about their care and make the healthcare system more efficient like a free market. The ease of “voting with your feet” as consumers of healthcare is questionable, since in many locations the places of care are limited, and the difficulty of individuals trying to take legal action. Health insurance companies will become more efficient and innovative, claimed the McCain plan by embracing the competition between health insurance companies; however this claim might be uncertain due to the current oligopolistic structure. Innovation is seen to be offering different benefit amounts for different prices, giving everyone a tax benefit would effectively set a price floor for a basic health insurance plan. These proponents of the plan would reduce costs in the short term, but increase costs in the long term as health insurance

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companies adjust. The role of the government is decreased in the McCain plan, and the slack would be compensated by the health insurance companies.

The largest part of the Obama plan that would affect health insurance companies is offering federal health insurance. The Obama plan would mandate health insurance for children expand the State Children's Health Insurance Program (SCHIP), and require coverage for preventable services, and pre-existing conditions. Obama wants to strengthen the current employer based system by making a play-or-pay system, but would offer re-insurance for catastrophic illnesses and tax credits for small businesses that offered health insurance. Families would also receive a tax credit for health insurance, based on need. The major components of the Obama plan are the creation of a national exchange, where people without access can form groups to buy health insurance, and the creation of a federal health insurance program, similar to Federal Employees Health Benefit Program. Health insurance companies would be unable to overcharge doctors for malpractice insurance through anti-trust laws, and prevented from abuse and waste in the Medicare program. The overall goal for the Obama administration is to make the health insurance companies accountable.

The effects of the Obama plan would be large up-front costs since many of the cost savings are long term. Many smaller effects such as requiring coverage for pre-existing conditions, malpractice policies and other new requirements would hurt profits in the short term before the health insurance companies could adjust their policies. Medicare Advantage would become more efficient, if health insurance companies decide to still offer plans in the program. Depending on the reaction from employers, the effects could be larger or smaller. There would be an overall increase in coverage over the long run due to the national exchange and federal insurance programs, but both would also increase costs. The profits and overall industry structure of the health insurance companies would be hurt in the long term, "Community rating coupled with a potentially high minimum benefit would deter innovation by insurers, who could not offer coverage with a lower actuarial value at lower premium rates even if they found a more efficient way to provide benefits" (Antos, 2008). The way business is conducted by health insurance companies would have to change because the federal basic plan would set a floor for basic requirements of coverage, and medical underwriting would be very limited. The federal government would be subsidizing insurance for high cost

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individuals and there would be more regulation of insurance companies, maybe even eventually a limit on the profit margins. One cause for concern is the trade-off between benefits and costs of any federal plan, as politicians would want to increase benefits, but might not have the same political support to increase taxes.

Long Term Care

The presidential candidates do not specifically mention their plans to help solve the long term care problem however, if a reasonable amount of changes are made to the healthcare industry, the long term care situation may change. The amount of people anticipated to need long term care may not change, but the costs might, and the next president might even promote a solution once the changes to the healthcare system are in place and better understood.

Plans by Aggregate

The plans have some similar aspects, such as drug re-importation and larger role of generics that will likely hurt pharmaceuticals and help the other players in the system. Both candidates propose investments in IT and record keeping for better feedback on the healthcare system, which will help all players in the long run, but someone will have to make that investment in the short term. Doctors will be better off when it comes to malpractice insurance and suits, since both men plan to help fix that.

The overall effects of the McCain plan would have been more access and choice for individuals, and more powerful health insurance companies. The short term effects would have been people might be unable to afford items due to the nature of HSAs, and the lag of information to the market. The long term effects would likely to be more expensive healthcare, since a move to health insurance companies did not work in the past with the creation of managed care, and unsure financing for GAPs that will hurt governmental budgets. Most of the goals that McCain set out in his plan would have been met, (access & choice, quality, portability & security) although the goal of affordability was never given any specific numbers for federal pledges to the GAPs. Individuals would have been making more decisions regarding their health insurance.

The overall effect of Obama's plan will be increased coverage and a more efficient system in the long term due to long term cost savings. The doctors and hospitals will be better off as

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more people go for preventive care, however, health insurance companies will be much weaker. The short term costs of the Obama plan are large, and the ability to pass such sweeping reform during a budgetary crisis might be limited. The goals that Obama set (increased coverage, reduced waste and inefficiency, and improved infrastructure) would be met if everything he proposed passes. However, the overall reason that the healthcare system is in need of fixing is the cost trends and expenditures, of which the cost savings proposed by Obama are more difficult to account for when taken in aggregate.

CONCLUSION

The presidential elect Barack Obama has laid out his plan for the future of the U.S. healthcare system alongside presidential nominee John McCain. Both men set ambitious but similar goals, and proposed a very different way than the other of achieving those goals. The healthcare system in the U.S. is very complex with many parts, and inefficient when compared internationally. The largest impact of the Obama plan will be less power in the hands of the health insurance companies, and increased governmental power in the health insurance market.

Any changes proposed by the next president will also need the support of Congress and the participants to implement those changes. Other problems will need to be addressed before healthcare (such as the economy), and when Obama tries to implement his changes to the country's response will be interesting. The longer U.S. citizens wait to reform the healthcare system, the worse it gets, "The big threat to growth in the next decade is not oil or food prices, but the rising cost of health care. The doubling of health insurance premiums since 2000 makes employers choose between cutting benefits and hiring fewer workers," (Cutler et al., 2008). Now that the election is over, Obama will probably make slight changes to his plan, maybe even adopting some of the items proposed by McCain, to form an even better proposal. Another look at the plan by the Obama administration will be beneficial, to make the plan more comprehensive and sound, possibly even addressing the long term care issue. Presidential elect Obama has made his intentions clear, it is now up to him when to implement it, and also up to the public and current system to support it.

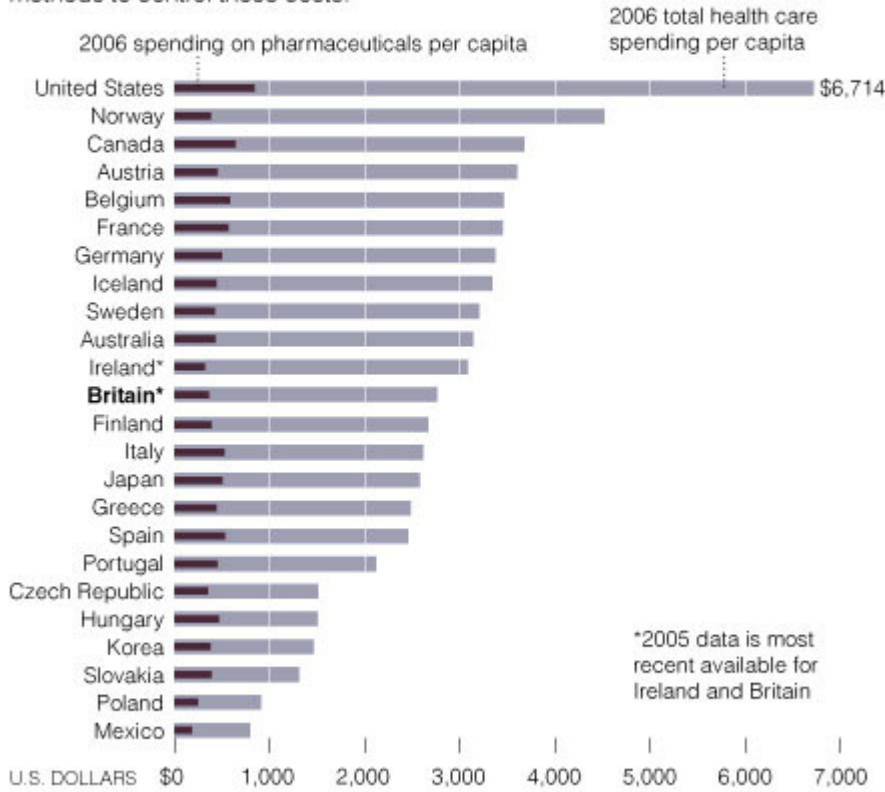
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APPENDICES

Appendix A – International Cost of Care

The Cost of Care

The United States spends more per capita than any other country on health care and on drugs in particular. However, drugs make up a greater share of overall health spending in many other countries, some of which are considering British methods to control those costs.



Source: Organization for Economic Cooperation and Development Health Data

THE NEW YORK TIMES

(Harris, 2008)

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ⁱTom Nagle founded Strategic Pricing Group, and published the first edition of *The Strategy and Tactics of Pricing*, and was quoted in the following source.

ⁱⁱ WHO, http://www.who.int/immunization_financing/options/en/briefcase_pricingtiers.pdf

ⁱⁱⁱ although not clearly defined as what this would be under McCain, an example is provided on his website, which is used here