Healthcare Spending and Barriers to Healthcare Access in the United States Leads to Financial Burdens and Poor Health Outcomes

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Abstract

Comparative analysis of healthcare spending in the United States is compared with other high-income nations, and the importance of diving deeper into this problem affecting all residents is revealed. Thus, further analysis is developed, beginning with high costs attributable to outpatient services. The pharmaceutical industry also plays a major role in overspending as drugs are unaffordable to many consumers. Furthermore, insurance coverage difficulties are brought to light as complicated plans and policies make access unaffordable and adequate coverage oftentimes inaccessible. This leads to a discussion on refugee, immigrant, and migrant populations, and barriers to healthcare that make access extremely difficult, leading to the discussion on improving naturalization rates to compensate for this discrepancy. Finally, the need for healthcare reform becomes imperative, and suggestions are incorporated into the final discussion to ensure ethical and affordable access to healthcare can be achieved for all in the United States.

Keywords: outpatient services, OOP expenditures, RIM communities, insurance, vaccinations, COVID-19, pharmaceuticals, generic drugs, name-brand drugs

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Healthcare spending in the United States has skyrocketed in recent years, rising at rates that may not be affordable to most Americans. It is estimated that $11,212 is spent per person each year on medical care and coverage (Ciarametaro et al., 2021, p. 388). The United States spends far more on healthcare than any other high-income country (Papanicolas, et al., 2018, p. 1204). Americans with insurance coverage experience hardships in affording healthcare services, particularly with OOP expenses. Moreover, this is particularly harmful for our more vulnerable population; that is, those who lack health insurance and those who are undocumented. This is compounded by an ethical quandary about how to provide appropriate healthcare and education to vulnerable groups (i.e., refugees, immigrants, and migrants) (Thomas et al., 2021, p. 433). The difficulties presented in obtaining quality healthcare and lack of affordable measures contributes to the increasing levels of poor health outcomes in the United States.

In 2016, it was estimated that 10.7 million unauthorized immigrants were living in the U.S. (Rubio & Castelló, 2019, p. 878) and that refugee, immigrant, and migrant (RIM) communities constitute more than 40 million people living in the U.S. (Thomas et al., 2021, p. 433). Unfortunately, despite being founded on principles of inclusion and immigration, the U.S. lacks supportive education and funding for these individuals (Thomas et al., 2021, p.434). And even for those who are American-born citizens, overspending on healthcare and the rising unaffordable costs of health insurance has become an alarming issue for all. Healthcare spending has a significant impact on those with lower income, oftentimes due to a lack of sufficient [private] health insurance coverage, causing massive financial difficulties for each respective individual and family (Aaron & Ginsburg, 2009, p. 1264). Out-of-pocket expenditures thus

increase tremendously. While it is important to note that health insurance coverage efforts have expanded and fewer Americans are without health insurance today (Jones et al., 2021, p.480), it is oftentimes not adequate to account for out-of-pocket expenditures (Jones et al., 2021, p. 480).

Along with the discussion on overspending and lack of adequate health insurance, the most detrimental effect is how high healthcare costs cause patients to delay treatment because of the financial trouble it places on the individual. When looking at this through a long-term lens, delayed care can lead to even higher healthcare costs as early intervention is not taken, placing patients in even greater financial distress and resulting in significantly poorer health outcomes. (Coughlin et al., 2021). Furthermore, social determinants lead to higher morbidity and mortality rates. Quality of care is immensely negatively affected; treatment of those in healthcare often differs based on socioeconomic status as well as documentation status. Most notably, undocumented immigrants, fearing deportation, will avoid healthcare facilities; they are amongst many whose healthcare needs are not being met (Doshi, Lopez, Mesa, Bryce, Rabinowitz, Rion, & Fleming, 2020).

Now, after experiencing a two-year-long pandemic, healthcare outcomes, access, and affordability are at the forefront of everyone’s minds. Ignoring the financial and medical consequences is unacceptable. In this world, where healthcare is ever-necessary, ignorance would not be bliss. This study will illustrate how high healthcare costs, socioeconomic determinants of health, poor care quality, and inadequate insurance/government support all lead to poor health outcomes in the United States.

Literature Review

U.S. Healthcare Overspending

Healthcare overspending in the United States has reached exuberant heights. In fact, "administration of U.S. healthcare cost $812 billion in 2017" (Kaplan & Abongwa, 2021, p. 36). This has had a detrimental effect on the population in terms of financial impacts as well as poor health outcomes. Administrative costs of care, pharmaceutical spending, and high costs of health insurance place Americans in a situation that makes affordable health care arduous, leading to increased financial burdens on patients and families. This is alarming, as studies suggest that healthcare spending will hit $27 trillion by the year 2027 (Ciarametaro et al., 2021, p. 389).

When considering the United States as a whole, it is frequently described as a prosperous country with significant breakthroughs in health care, science, and opportunities. While to a degree this is in fact true, when compared with other high-income countries, the opposite seems to be apparent. The fact: "Healthcare spending in the United States is the highest in the developed world" (Ciarametaro et al., 2021, p. 389). The ugly truth about American healthcare is that, through a comparative analysis of 10 other high-income countries, (namely: the United Kingdom, Canada, Germany, Australia, Japan, Sweden, France, the Netherlands, Switzerland, and Denmark), the United States healthcare spending is immensely outnumbered as indicated below:

> "...the United States spent 17.8% of its GDP on health care (range of the other countries, 9.6%-12.4%; mean of all 11 countries 11.5%) and had almost double the health spending per capita (mean, $9403) compared with the other countries (range, $3377-$6808; mean of all 11 countries $5419)" (Papanicolas et al., 2018, p. 1027).

Of particular concern is the excessive administrative costs. “Administrative costs of care (activities related to planning, regulating, and managing health systems and services) accounted for 8% in the US vs a range of 1% to 3% in other countries” (Papanicolas, et al., 2018, p. 1024). This data immediately stimulates concern as to why there is such a notable difference in healthcare costs and to question where all these costs are going.

A myriad of other factors also contribute to the skyrocketing healthcare prices. One study states, “that increasing rates of outpatient spending and remuneration of clinicians is a major contributor to the cost difference between the United States and other countries” (Papanicolas et al., 2018, p. 1025). This suggests that the United States healthcare system takes on a Capitalist approach as a “pay for service” (Aaron & Ginsburg, 2009, p. 1269). This creates massive overspending in which Americans have been found to pay “over four times more than Canadians for administrative costs” (Kaplan and Abongwa, 2021, p. 36). Increasing unit prices and the implementation of new technological advancements have also been attributed to this rise (Ciarametaro et al., 2021, p. 389,). Without effective regulation to keep costs down, these numbers will not improve.

Impact of the Pharmaceutical Industry & Brand Name Drug Promotion

The pharmaceutical industry also plays a major role in the high healthcare spending costs in the United States. While it would be great for health “care” to be focused on the promotion of health, it is becoming quite apparent that healthcare in the United States is in the for-profit industry. As a result, “For pharmaceutical costs, spending per capita was $1443 in the US vs a range of $466 to $939 in other countries” (Papanicolas et al., 2018, p. 1024). Drug companies, through confusing tactile strategies, have convinced consumers purchasing “name brand” drugs over “generic”, is better, forcing the consumer to spend more than they can afford and

diminishing the goal of affordable and fair healthcare (Bainer, 2016). One study showed just how massively detrimental that is, being that "the cost difference between allowing a company to product hop before a generic enters the market and restricting the product hop until a generic is available could be over $24 billion" (Bainer, 2016).

To better understand this process, it comes down to market control. Generic drugs must wait longer for approval to be on the market. However, generic drug manufacturers end up saving money because they do not have to go through as many of the costly steps as do brand-name companies. This thus allows generic brand companies to offer more affordable prices to consumers; this can range from $8 to $10 billion per year in savings (Bainer, 2016).

Health Insurance Costs, Access, and Out-of-Pocket Expenditures

Health insurance coverage is vital in this discussion. Adequate coverage is unaffordable for many Americans. Couple this with out-of-pocket expenditures and now Americans are looking at a massive financial headache. An enormous concern is that "costs are continuing to rise at a rate faster than wage growth, with most recent estimates suggesting a 4.4% increase in 2018 (up from 3.9% in 2017), a total spend of $3.65 trillion (representing $11,212 per person) and a year-over-year prescription drug spend increase of 3.3%" (Ciarametaro et al., 2021, p. 389). Whether one has private or public health insurance, Americans are nonetheless looking at unaffordable costs. Oftentimes, this leads to a delay in seeking medical treatment, which will, in turn, lead to higher medical costs in the long run.

The United States complicates insurance policies while the rest of the high-income countries have kept their policies relatively horizontal. In other well-developed countries, "the basic context of insurance has remained the same–private has stayed private, while public has stayed public" (Gruber, 2017, p. 4). Examples of such include, "direct public health provision in

the United Kingdom, publicly provided insurance in Canada, and mandatory nonprofit insurance in Germany and Switzerland" (Gruber, 2017, p. 4). One way in which the U.S. Government complicated insurance policies are from the original "single-payer system" towards transitioning into subsidizing those who take on private health insurance (Gruber, 2017, p. 3). The difficulty arises in how Americans can choose the best insurance option with so many different plans.

Out-of-pocket (OOP) expenditures play a critical role in this discussion. Because of the myriad of healthcare insurance options, finding the best plan seems to be an impossible feat. Even if one can discover a rather affordable and comprehensive option, OOP health care costs are outrageous. This places a particularly difficult burden on families. After accumulating data from U.S. parent reports, "nearly two-thirds (65.7%) of children incurred some amount of past-year OOP expenditures, with 13.3% of children incurring expenditures of > $1000" (Jones et al., 2021, p. 480). Furthermore, "children with both parents born within the United States were the most likely to have OOP expenditures (both parents born in the United States, 72.1%; both parents born outside the United States, 55.1%; 1 parent born outside the United States, 58.3%; $P < .001$) (Jones et al., 2021, p. 482). Interestingly, having parents born as U.S. citizens correlates with a greater chance for OOP expenses. Moreover, private health insurance is associated with OOP expenses significantly greater than those who have public health insurance (Jones et al., 2021, p. 482).

Furthermore, it is also important to understand the complexity of our healthcare system in approval for coverage. The best way to understand this is through first-hand accounts, which is why data from frontline healthcare workers adds such an important approach to this discussion. Studies have indicated that "one-third of all healthcare costs in the U.S. were due to insurance company overhead and time providers spend on billing processes" (Kaplan & Abongwa, 2021, p.

23). As healthcare providers spend time trying to advocate for their patients, they lose precious time caring for other patients. And even so, oftentimes their efforts are futile as insurance companies will oftentimes deny approval for medical treatments. For example, many insurance companies will deny approval for a treatment for those with out-of-network benefits with an out-of-network plan, making more documentation from health care providers necessary and thus delaying the time to obtain medical treatment (Kaplan & Abongwa, 2021, p. 37).

It is important to note that while progress has been made in terms of decreasing the percentage of children in the United States who are uninsured as reflected by the 9.3% decrease from 1997 to 2018 (Jones et al., 2021, p. 480), progress and change are still necessary. High expenses of low-income families are less common, noting that healthcare access is already incredibly difficult for this population. To support this claim, "among low-income populations, a threshold of 5% or more is common and reflects an awareness that this population may experience burdens at a lower level of OOP expenditures" (Jones et al., 2021, p. 481). In contrast, "when examining expenditures of family income, thresholds for excessive OOP expenditures are often set at 10% or more of family income spent on total family OOP health care expenditures" (Jones et al., 2021, p. 480-481). This discrepancy calls into question what is equitable and ethical when it comes to differences in financial/socioeconomic status. For example, Medicare and Medicaid are not available for those who are undocumented, increasing the number of persons with poor health in the country. Private payer involvement in Medicare and Medicaid programs can help explain the outrageous costs, contributing to the reason the United States has been spending an exuberant amount on medical expenses. (Kaplan & Abongwa, 2021, p. 36). Furthermore, the undocumented face barriers in obtaining health insurance as they are not eligible to obtain insurance via health insurance exchanges. (Haley,

2021, p. 1187). Those that are undocumented must be treated at federally approved centers with the exception being emergencies (Haley, 2021, p. 1187).

Undocumented Healthcare Access & Spending: An Ethical and Practical Analysis

To continue the discussion on ethicality, it is crucial to be mindful of the refugee, immigrant, and migrant populations that make up more than 40 million people living in the United States (Thomas, Osterholm, and Stauffer, 2021, p. 433). The Biden-Harris administration seeks to reform inclusion practices in America with a positive discussion on immigration and refugee protection (Kerwin, et al., 2021, p. 228). Furthermore, referring to refugees and immigrants as "new Americans", is a "a term that may be more inclusive than even 'intending' citizens or 'Americans in waiting' as it implies that new immigrants are already Americans" (Kerwin, et al., 2021, p. 228).

Regarding healthcare and immigration policies, many disputes have ensued. The issue stems from, "the public policy debate surrounding immigration often involves strident rhetoric, and arguments against undocumented immigrants can be especially harsh, revolving around the burden to U.S. taxpayers" (Becerra, et al., 2012, p. 112). While many believe that economically this negatively affects American taxpayers, the truth is that these costs remain minimal as costs to local and state budgets. Federal taxpayers spend $11.2 billion each year on average, although this equates to barely $34 per individual (Conover, 2019). Furthermore, concerns about immigrants contributing to higher crime rates are rooted in America's racist past and public opinionated perceptions (Becerra et al., 2012, p. 113).

A battle between misinformation and discriminatory practices has made access to healthcare difficult for many new Americans. This divide became apparent roughly 6 years ago during the Trump campaign which, "used anti-immigrant rhetoric to stoke economic and safety

fears among the electorate" (Haley, 2021, p. 1186). Fear of the strict citizenship status policies and increased detainment and deportation led many individuals to steer clear of medical treatment. This is evident through reports of medical providers throughout the United States who noted the following:

> "Those without documentation shunned health care services during the Trump administration. If they sought treatment, many avoided bringing family members for fear that if the person seeking treatment were to be detained, family members might also be subjected to immigration proceedings" (Haley, 2021, p. 1186).

It is evident that healthcare access has been made increasingly difficult for the undocumented in the United States, contributing to poor health outcomes.

COVID-19 and its Impact on Vulnerable Communities

With the COVID-19 outbreak, the challenge of receiving proper and safe healthcare has become even more apparent; this is seen particularly with the low COVID-19 vaccination rates in vulnerable communities. Refugee, Immigrant, and Migrant communities have consistently disproportionately been affected by the lack of adequate healthcare access. Even in years pre-pandemic, RIM communities presented with low numbers of vaccination status rates, contributing to the argument that this has been a long-standing issue for those residing in the United States that were not originally born in the U.S. This is a direct result of a, "historic lack of investment by many governmental bodies and public health agencies in developing and maintaining true community partnerships" (Thomas et al., 2021, p. 434). There is a myriad of reasons for this, and one particular perspective piece outlines a multitude of factors contributing to the difficulties in implementing higher vaccination status, including: "given limited information regarding knowledge, attitudes, and practices (KAP surrounding vaccines, historic

mistrust in certain communities, a turbulent U.S. political environment, and novelty of COVID-19 and associated vaccines, heightened hesitancy can be anticipated" (Thomas, et al., 2021, p. 433). In 2016, an abundance of immigration officers was hired, bans were placed on entry to the U.S. from Muslim countries, and threats of building a southern border wall all contributed to these valid heightened fears within RIM communities (Haley, 2021, p. 1186).

Ethicality in Responding to the Needs of the RIM Population

Change is necessary, but overcoming these barriers is difficult. RIM communities are full of unique individuals of different backgrounds; thus, remaining mindful in responding to the needs of the community and mitigating the spread of misinformation is imperative. For example, it has been noted that "there may also be specific vaccine factors (e.g., purported inclusion of pork products) or misinformation (e.g., purported risk of autism) that make a vaccine more or less acceptable to certain groups" (Thomas et al., 2021, p. 433). This is vital information to understand because a purported risk of pork would lead vegans and those of the Islamic faith not to receive a vaccine. It is critical to question where this misinformation has come from and wonder what leads to these conclusions so that misinformation is eradicated. Likewise, it is the American responsibility to respond to the needs of these communities by making access to vaccination accessible. Presenting information to one in their preferred language in a way that respects the dignity of their culture and beliefs is vital (Thomas et al., 2021, p. 433). Additionally, keeping in mind that access to transportation is not always available to those in RIM communities is why bringing the vaccines to people (i.e., pop-up vaccination sites) will help contribute to higher success rates via accessibility (Thomas et al., 2021, p. 434). Empathy, compassion, and respect is the best way to ensure ethicality by allowing each respective

individual to come to a well-informed decision. Establishing true care contributes to better results.

As a result, it is crucial that genuine caring is never underestimated, as it leads to improved health results. In a study conducted during the Trump administration, randomized participants (those who were uninsured and undocumented) were given access to primary care providers under a controlled experiment. Care was thoughtfully established, such as enhanced care for at-risk individuals as well as attention to detail being that each patient's primary/preferred language was used to provide ethical care (Haley, 2021, p. 1186). For more background on this study:

> "The ActionHealthNYC study randomized enrolled participants into either intervention or control groups, whereby intervention patients had appointments scheduled for them and were offered a standardized copayment (patients did not have to negotiate payments themselves, a written care plan was created, patients were provided an access handbook, reminders were sent for appointments, and follow-up calls were made for missed appointments (Haley, 2021, p. 1186).

Put simply, improved access to care was discovered. This is noted in that, "the intervention and control groups increased their primary care provider identification from approximately one quarter at baseline to 58% and 46%, respectively" (Haley, 2021, p. 1187). Despite fear from political leaders and policies, we can conclude that thoughtful care truly correlates with better healthcare access and outcomes.

Increasing Naturalization Rates to Improve Healthcare Access

This can be tied back to the Biden administration's efforts to increase naturalization efforts to allow official citizenship status for New Americans and greater expand healthcare

access. Statistics show that in 2019, “median household income was $25,800, or 27 percent, higher for the naturalized population, compared to the population that had not naturalized (after an average of 23 years in the United States for both groups” (Kerwin et al., 2021, p. 225). This indicates that citizenship status correlates with higher median household income. This could thus further be correlated with access to healthcare. For example, “in 2016, “noncitizens” were more likely to be uninsured than naturalized and native-born citizens (24.1% vs 5% and 3.8%, respectively) (Haley, 2021, p. 1187). In January of 2021, Biden issued the “Proclamation on Ending Discriminatory Bans on Entry to the United States” (Kerwin et al., 2021, p. 225). To comprehend exactly what this proclamation entails, it, “criticizes the previous administration’s bans on the entry of persons ‘from primarily Muslim countries’ and ‘largely African countries’ as a ‘stain on our national conscience’ and an affront to the United States’ ‘long history of welcoming people of all faiths and no faiths at all’” (Kerwin et al., 2021, p. 225). Here, Biden is setting the framework to undo the work of the Trump administration and develop a more inclusive nation, one that is undoing the barriers put forth by Trump which present barriers to naturalization (particularly for those of low socioeconomic status) (Kerwin, et al., 2021, p. 227). Efforts to implement naturalization and decrease the rates of uninsured have been beneficial. For example, “with the help of the Affordable Care Act (ACA), New York made considerable gains. The uninsured rate in New York State declined from 10.7% in 2013 to 5.2% in 2019” (Haley, 2021, p. 1187)

Connections Between Health Care Spending for Americans and “New Americans”

The need for healthcare reform in the United States is imperative. After compiling all the data, it becomes apparent that “Despite its higher spending, the United States performs poorly in areas such as health care coverage and health outcomes” (Papanicolas, et al., 2018, p. 1025). The

U.S. must determine ways to do better for all who live here so that better healthcare outcomes can be achieved, and excessive financial burdens are relieved for all Americans. Access to healthcare must also become more attainable and equitable for all the country's inhabitants. Put quite simply, the U.S. must abide by this statement:

> "As the nation awaits equitable immigration reform, health care organizations should immediately incorporate, amplify, or alter programs/practices to facilitate access among their undocumented clients. Focused organizational changes have the potential to reduce unmet health needs, minimize financial burdens for families, and curtail potential public health threats, the latter a particularly imperative goal within the current COVID-19 pandemic" (Doshi et al., 2022)

Additionally, "There is substantial evidence of a positive association between adult and infant health outcomes and an expansion of the health-care system coverage both in country-specific studies (most notably in the United States) and in the analysis of a large sample of countries over long time periods" (Jiménez-Rubio & Castello, 2020, p. 879). This suggests that expanding healthcare coverage is beneficial at large. Furthermore, "given that other high-income countries are able to spend less and achieve better health outcomes, a more nuanced, data-driven understanding of all aspect of health care cost are needed to assist in reform of the U.S. health care system" (Papanicolas et al., 2018, p. 1025).

It is also crucial to remember that insurance coverage reform is essential. Studies indicate detrimental health impacts for, "Children who lack adequate insurance coverage are less likely to have a medical home, less likely to receive a preventative health care visit, more likely to experience delayed or forgone care, and more likely to be reported in poor health as compared to children with adequate health insurance" (Jones et al., 2021, p. 482). Healthcare spending must

also be improved from the pharmaceutical aspect, as “It is estimated that over the next 10 years, evidence suggests $24.6 billion could be saved from one generic drug being available” and suggests that “with per capita healthcare spending rising neatly to 20 percent and Medicare funding dwindling at an alarming rate, it is necessary to consider all cost-controlling measures that do not reduce quality” (Bainer, 2016). This suggests the need for generic drugs, as it positively impacts the U.S. economy as well as consumers. Additionally, prior authorization for procedures is detrimental to both healthcare providers and consumers through the “inefficiency, strain, and risk that prior authorization procedures impose on providers and patients” (Kaplan & Abongwa, 2021, p. 37).

Expanding healthcare coverage and containing the costs is not an easy task, but change is necessary for the nation. Supporting both current and new Americans by presenting information on insurance eligibility and plans, vaccination facts, making convenience a priority, promoting generic brand drugs, and respecting the dignity of everyone will positively correlate with better health outcomes. Ultimately, it is the duty of Americans to hold the nation accountable for unjust practices and to act ethically in caring for all who live in the United States.

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