Classical Conversations

The Healthcare Industry Is Demoralizing The Practice of Medicine And The People They Care For.

By

Kristen A. McGhie

Mr. Don Splain

April 12, 2023

Kristen A. McGhie

Mr. Don Splain

English Composition II

March 27, 2023

The Healthcare Industry Is Demoralizing The Practice of Medicine and the People They Care For.

Is Health insurance for people's benefit, or is it for their downfall? Would you believe it if the answer is both? Health insurance's original purpose was to support those busy staving off an illness or disease. The people who created it intended it for the good of the community. Although the original intent was for a good cause, the healthcare system eventually became a manipulative money scheme where the insured would be taken advantage of instead of being given quality care. Now the same is not to be said of highly devoted doctors, nurses, and other medical staff who genuinely care about the patients they attend to. This terrible misfortune affects medical professionals too. Medical professionals often find themselves in a situation where they have to choose between earning a paycheck or helping someone in need. The healthcare system has severed the ties between having a great relationship with your doctor and

getting treatment that would fix the problem. The healthcare industry is demoralizing the practice of medicine and the people they care for.

What is Health Insurance?

Discussing the healthcare system's negative influences without first explaining what health insurance is would be futile. Health insurance is the compensation for medical bills, especially bills of astronomical amounts ("What is Health"). How much a particular health insurance is willing to cover depends on its policies and the types of plans it offers ("What is Health"). Nevertheless, the insured person will most likely have to pay the rest of the medical bill through co-pays, deductibles, and coinsurance ("What is Health"). Many doctors and practices in America are unwilling to take in patients without health insurance since they would not get paid. There are different types of health insurance, such as public and private health insurance ("What is Health"). Public health insurance would be something like Medicare and Medicaid for patients that fall under specific criteria that the government funds ("What is Health"). Some examples of private health insurance include companies such as Cigna and Humana. The U.S. healthcare system comprises these public government-funded programs and privately financed health insurance plans (ISPOR). Healthcare is primarily funded through, 'Out-of-pocket payments and market coverage provisions. (ISPOR)" If one wants to sign up for health insurance, one will research which company would fit their needs and wait for the enrollment period to sign up ("What is Health"). Once signed up, the now-insured person must pay a monthly premium to keep the insurance going. Having insurance can be beneficial, especially for those with chronic diseases or consistently large medical bills, as it can

significantly reduce the burden of the cost off of the insured patient. Additionally, if one were to sign up with a particular company, one would find a doctor or practice that will accept the health insurance one is paying for.

History of the Healthcare System

Over a century ago, before the early 1900s, health care simply meant a patient getting treated for their illness by a doctor (Rosenthal 14). Doctors cared for their patients at dispensaries and charged minimal fees for their services (Rosenthal 14). Back then, the medical treatments offered by doctors were not nearly as effective as today, but they were basic and cheap to buy (Rosenthal 14). Doctors were also paid little to nothing for their work and were sometimes employed by companies to keep their staff fit and healthy (Rosenthal 15). At this time, doctors were not collectively working out of fancy hospitals or practices. Religious charities founded and ran makeshift hospitals (Rosenthal 14). These hospitals were often named after the religious sect of Christianity their charities were affiliated with, such as Baptist, Mercy, Methodist, Trinity, Presbyterian, and Mount Sinai (Rosenthal 25). For example, Providence Portland Medical Center was founded by a group of nuns from Montreal called Sisters of Providence (Rosenthal 25). In 1858, they opened the doors of St. Joseph's Hospital in Fort Vancouver in the Pacific Northwest (Rosenthal 25). By 1902, the nuns ran 30 hospitals, orphanages, and schools in the northwest (Rosenthal 25). However, there was little a makeshift hospital could do then, so many people went there if they were severely ill or to pass away (Rosenthal 14). The first form of medical insurance that resembles the system that is present today started at Baylor University Medical Center in Dallas, Texas (Rosenthal 15). This medical

center was founded in 1903 in an empty fourteen-room mansion, and it was organized and run by the local Baptist church (Rosenthal 15). A cattleman funded the hospital's initial startup and efforts by generously donating fifty thousand dollars (Rosenthal 15). As this center was up and running, Baylor's vice president, Justin Ford Kimball, noticed that the hospital was acquiring many unpaid bills (Rosenthal 15). He then solved this problem by offering the local teachers a deal (Rosenthal 15). If the teachers could pay the hospital six dollars a year, or fifty cents a month, in exchange, they would be able to stay in the hospital for a maximum of twenty-one days for their ailments (Rosenthal 15). The teachers agreed (Rosenthal 15). Then people of other professions started to notice and signed up for this newly created insurance (Rosenthal 15). This model was known as the Baylor Plan, and in 1929 was founded under the name of Blue Cross (BCBS)(Rosenthal 14) ("An Industry Pioneer."). As this Blue Cross health insurance concept started gaining momentum, employers began implementing it in their companies (Rosenthal 15). Workers of lumber and mining companies often faced terrible health problems due to their line of work (Rosenthal 15)("An Industry Pioneer."). Thus, the employers decided to provide medical care by paying physicians a monthly fee (Rosenthal 15). For instance, a lumber company in Tacoma, Washington, had two doctors on their staff to help alleviate the ailments of their lumber workers (Rosenthal 15). These two doctors were paid fifty cents a month (Rosenthal 15). The concept of Blue Shield came about through similar pacific northwest companies ("An Industry Pioneer."). Early health insurance policies like these were meant to compensate low-income workers dealing with an illness (Rosenthal 15). This method was the predecessor of employer-based insurance (Rosenthal 15).

By 1939, three million people had registered for health insurance under the Blue Cross Plans nationwide (Rosenthal 16). Blue Cross and Blue Shield were the only major health insurance at the time (Rosenthal 17). Blue Cross Blue Shield officially became one company in the 1940s ("An Industry Pioneer."). Blue Cross covered hospital bills, and Blue Shield covered doctor's visits (Rosenthal 17). Blue Cross and Blue Shield was also a non-profit organization (Rosenthal 16). Blues members were getting charged the same rates, which were not affected by a person's illness or age (Rosenthal 17). John Kimball and the Baylor University Medical Center did not create Blue Cross plans with the intent to gain a profit (Rosenthal 16). Health insurance became more expensive as medical treatments advanced (Rosenthal 16). Before the start of World War II, treatments were very cheap and unsophisticated (Rosenthal 16). At the beginning of WWII, new inventions were created to help combat illnesses such as polio and to relieve injured WWII soldiers (Rosenthal 16). Abbott Laboratories was the first to make an intravenous anesthetic in the 1930s (Rosenthal 16). A general hospital in Massachusetts became the first hospital in the U.S. to have an anesthesia department in 1936 (Rosenthal 16). Inventions such as ventilators, and new sectors, such as ICUs, saved more lives (Rosenthal 16). At this point, six dollars a year for a maximum stay of twenty-one days per patient would no longer cover the costs for all of the hospital's needs (Rosenthal 16). Therefore, prices began to rise.

After WWII, many countries decided to let the government be in charge of healthcare to distribute and regulate it (*Money-Driven)*. However, in the U.S., doctors strongly condemned the idea of government involvement as far as being in control of a national healthcare system (*Money-Driven)*. At this point, people could have created a health insurance system similar to

auto or life, where it would be a private industry selling their plans directly to the patients (Rosenthal 16). However, accomplishing this would be difficult because everyone was used to employer-based health insurance (Rosenthal 16). To further encourage this system, the National War Labor Board froze salaries during and after WWII causing companies to face labor shortages (Rosenthal 16). In order to fix this, these companies decided to offer health insurance as an incentive to acquire more employees (Rosenthal 16). The government recognized this and decided the money used for employees' health insurance would not be taxed (Rosenthal 16). This was not an excellent plan for the long term (Rosenthal 16). As medicine became increasingly better in quality, millions of people wanted to ensure they had access to it, thus the vast demand and expectation for employers to insure their employees (Rosenthal 17). From 1940-1955, the number of insured people in America grew from 10% to 60% (Rosenthal 17). Americans viewed health insurance as a tremendous benefit (Rosenthal 17). Boy Scouts and preachers spread the word about the goodness of health insurance (Rosenthal 17). Unfortunately, this new demand for health insurance spawned a business opportunity for people with other, less pure motivations (Rosenthal 17). This was around the time For-Profit health insurance companies came about (Rosenthal 17). These companies only accepted younger and healthier people into their plans (Rosenthal 17). They also provided different rates for people of different ages (Rosenthal 17). This resulted in different policies for differing amounts of money with different protection (Rosenthal 17). For Profit companies were very involved in marketing their services, and as time went on, they became increasingly popular (Rosenthal 17).

After Congress and three presidential administrations contemplated the idea and tried implementing a public health care system for about 50 years, the Social Security Amendments law was finally passed in July 1965 under Lyndon B. Johnson's administration ("Medicare Signed). This law declared that Medicare would be health insurance for older people, and Medicaid would be health insurance for low-income people ("Medicare and Medicaid Act). Senior citizens were now getting much better care since they were not always eligible for particular plans because of their age ("Medicare and Medicaid Act). Medicare used and still uses a DRG payment system based on a patient's diagnosis (Rosenthal 31). This DRG system would create cost amounts depending on the diagnosis (Rosenthal 31). If the hospital thought it would not be paid enough from Medicare, they would charge the smaller private insurers more, creating this predicament where some people would pay less while others paid way more for the same procedure (Rosenthal 31). This was also when the business side of health care took off (*Money-Driven)*. From 1968-1980, the number of Americans under 65 with good private health insurance peaked at a staggering 80% (Rosenthal 26). Patients would no longer be giving cash and checks to hospitals for their services (Rosenthal 26). The greatest years of hospitals were from 1967-1983 because, at least back then, they had set rates for the patient or their insurance to pay (Rosenthal 309). Also, during that time, medical payments to hospitals skyrocketed from 3 billion to 37 billion across the country (Rosenthal 30).

In the 70s and 80s, for-profit health insurance plans became very popular (Rosenthal 17). Sadly, it was difficult for nonprofit organizations like Blue Cross and Blue Shield to compete

(Rosenthal 18). In the 70s, people realized how much money was involved in healthcare (*Money-Driven*). It became a popular decision that it would not be a good idea for doctors to be the managers of other doctors when there was so much money involved (*Money-Driven*). Surely people in business should be the ones to manage the funds of these practices instead. In addition, hospitals were generating so much income now they needed to hire people to manage it all (Rosenthal 26). This was when healthcare went from physician-led to corporation-led (*Money-Driven)*. Although this significant change in financial leadership was made, spending still got worse. Hospitals were spending more money on cosmetic expenses like fancy lobbies, marble finishes, and gardens (Rosenthal 23). There was more spending on the executive level as well. Hence, Congress passed a law in 1974 declaring that state health planning agencies would approve building new facilities or adding expensive technologies because spending was getting so out of hand (Rosenthal 33). If they received approval, the hospital would obtain a "certificate of need" to show that the community would use and benefit from this upgrade (Rosenthal 33). Progress was being made. However, in 1987 the law was rescinded (Rosenthal 33). A year before, in 1986, a statute called the Emergency Medical Treatment and Labor Act (EMTALA) reminded hospitals of their moral purpose (Rosenthal 70). It enforced that if a patient was in distress or dire need, they should be treated regardless of if they had the means to pay for it (Rosenthal 70). During the 80s, new medical positions opened up in hospitals; one major position was a CMO or Chief Medical Officer (Rosenthal 30). The CMO is the highest-ranking physician in the hospital, but it used to only be the physician in chief and surgeon in chief in that high position (Rosenthal 30). They would review different cases throughout the whole hospital

(Rosenthal 30). The CMO position is usually filled by someone who used to be a physician (Rosenthal 30). Their job is to use their professional influence on other doctors to help the hospital run as a profitable business (Rosenthal 30). They also have deputies to help the doctors "realize efficiencies," like cutting the length of hospital stays or convincing the doctors to give their patients generic drugs (Rosenthal 30). While working at a series of hospitals, a woman named Peg Graham witnessed how things were changing (Rosenthal 29). Peg Graham was a special assistant to a CMO (Rosenthal 30). In the 80s, Peg Graham watched as "head nurses" "turned into "clinical nurse managers"(Rosenthal 30). 'What disappeared was the head nurse who fiercely protected the patients on her ward and didn't care about the financials," (Rosenthal 30) A perfect example that encapsulates all of the major hospital, medical, and financial changes of the 70s and 80s is the career of Dr. Mcullar (Rosenthal 25). When Dr. Mculllar came to work at Providence Medical Center in the late 70s, only one administrator paid the bills, hired staff, and dealt with patient complaints (Rosenthal 26). As several years went by, the administrators seemed to double (Rosenthal 26). In the 80s, the Providence administrators started to change the hospital's core values by adding " stewardship of resources" (Rosenthal 26). By the late 80s, providence hired coders to interpret doctors' exams and translate them into medical bills (Rosenthal 26). Physicians were told to use certain phrases to describe their exams and were told to use certain procedures to ensure a certain amount of revenue (Rosenthal 26). This became commonplace in many hospitals (Rosenthal 26). Doctors began receiving monthly statements of the amount of money each of their examinations brought in compared with their colleagues (Rosenthal 27). The relationship between the administrators and the doctors became not so great

(Rosenthal 27). Physicians in Dr. McCullar's group wanted to know what the hospital had billed Medicare on their behalf (Rosenthal 27). Some were genuinely concerned about overcharges (Rosenthal 27). Providence refused to disclose that information and threatened to fire anyone who wanted disclosure (Rosenthal 27). Once Dr. McCullar joined Providence in 1977, there were only two sister hospitals; the Providence Medical Center and St. Vincent (Rosenthal 27). Once he retired, Providence bought out more small hospitals and practices (Rosenthal 27). Providence Health Services is the country's eleventh gigantic nonprofit hospital system as of 2023, with fifty-two hospitals (beckershospital). As Providence Health continued to buy out hospitals and practices, the old places' new affiliation with them changed medical and financial procedures, escalating bills (Rosenthal 28).

During the 1990s, old-fashioned health insurance was disappearing (Rosenthal 18). The Blue Cross Blue Shield lost a lot of customers, and they were stuck with the sickest of patients (Rosenthal 18). In 1994, the board of Blue Cross Blue Shield decided to turn the nonprofit into a For Profit (Rosenthal 18). Their goal was not to raise the rates on their current customers (Rosenthal 18). Instead, they wanted to gain access to the stock market to raise money to erase their deficits (Rosenthal 18). In 1993, a year before the Blues went for profit, insurers spent 95 cents out of every dollar (ie.. 95%) from premiums on medical care expenses (Rosenthal 19). This action is called a medical loss ratio (Rosenthal 19). The rest was spent on administrative costs (Rosenthal 19). Insurers wanted to increase their profits, so the 95% got lowered to 80% so it could be used for marketing, lobbying, administration, and dividends (Rosenthal 19). In the 90s, hospitals began to end the salaries of ER and clinical doctors and instead hired them as

independent contractors (Rosenthal 27). Also, premiums increased exponentially during this time, and employers wanted to move their employees into health maintenance organizations, or HMOs, to contain costs (Rosenthal 31). HMO doctors receive fixed payments for each person they see per month (Rosenthal 31). While this did work, U.S. health spending was increasing faster than the cost of living (Rosenthal 32).

From 2010 on, new medical charges began to arise (Rosenthal 224). Doctors charged longtime patients $2000 to stay at the same practice (Rosenthal 224). $150 for same-day answers to questions and $20 just to write a prescription (Rosenthal 224). Doctors and medical centers were turning their patients to billing services, collections, and credit rating agencies (Rosenthal 224). Insurers' priorities were not the patients they insured but the shareholders and investors (Rosenthal 18). For-Profit executives were compensated exceptionally for performing well financially (Rosenthal 19). For example, Joe Swedish, the Ceo of Wellpoint California (a major subdivision of blue cross blue shield at the time on the west coast), in 2013 had a starting salary of five million dollars (Rosenthal 19).

Traditionally, doctors were devoted and proud to be a part of only one establishment. The first initial Blue Cross Blue Shield plan required that a patient be charged per week in the hospital (Rosenthal 16). Now hospitals like Providence are charging patients for each service and each encounter. A quote from the documentary *Money Driven Medicine* says, ' This is not a healthcare system, it's an industry, and at every point, there's a way to make money," (*Money-Driven)*. The healthcare system became a money chase, and no one no longer cared about the health and well-being of the patients (*Money-Driven)*.

How has the government affected the Health Care System?

According to the World Health Organization, the government plays ten essential roles in ensuring the Health Care system functions correctly on a national level (“The Role of Government).

It is the role of government to support health and well-being, including by:

- ‘Provide good-quality health services that are accessible and affordable to all who need them,
- Ensure policies, frameworks, and standards for health and well-being are in place and acted on,
- Ensure health services are well-funded and run by professionals, who are well-trained,
- Ensure roads and infrastructure are in place and in good condition so people can travel to use health and social services,
- Make sure the cost of using services does not put people at risk of financial harm,
- Give benefits to people who need them as this can help to protect against financial harm,
- Enforce laws to protect people from violence and other unfair treatment,

- Make sure people have the opportunity to be part of making decisions, such as about health services" ("The Role of Government).

The government has undoubtedly played a role in getting the healthcare system where it is today through various laws and acts that have been passed over the years. The government's main job, which pertains to all of the ones listed above, is to allocate money from the federal budget to ensure all these tasks are taken care of ("The Role of Government). The government also has dedicated staff for each state responsible for ensuring that insurance companies are financially viable, operating by the laws and regulations in place, and ensuring that the insurance company is offering services at fair rates ("Insurance Commissioner). These staff members are called State Insurance Commissioners ("Insurance Commissioner). However, government staff in this field cannot legally deny health insurance companies' rates (Rosenthal 19). In order to prevent and fix current problems with the health care system, laws, and acts are passed to try and help the situation. For instance, the Patient Protection and Affordable Care Act was passed in March 2010 to prevent wasted spending and curb the higher percentage spent on nonmedical undertakings (Assistant Secretary)(*History of Health)*. To correct this, the assemblers of the Affordable Care Act required that 80-85% of the premium dollar be spent on patient care (Rosenthal 19) . The Obama administration had three different goals with this act. One was to make health insurance more affordable for more people ("Affordable Care). The second was to broaden the Medicaid program to every adult that earns below the federal poverty level ("Affordable Care). The third was to cover innovative delivery services for medical care that would essentially try to reduce the cost of healthcare in the long run ("Affordable Care).

Although these were the intentions, these were the actual results and effects of the affordable care act on society. It reached its goal of insuring many people throughout the country (Examining the Affordable Care). Nevertheless, it ended up costing way more per enrollee than initially expected, and billions of dollars in net subsidies were paid to private health insurance plans with no net gain back because many people switched from employer coverage to individual coverage (Examining the Affordable Care). Therefore, the policies that lawmakers and people in the government create affect the healthcare system. Thus politics has played a significant role in America's healthcare.

Whoever one votes for can have the potential to make healthcare in one's area or country beneficial or worthless. Also, some health insurance companies use the money they receive from insurers to contribute to political campaigns (Rosenthal 19). For example, members were fed up with Anthem Blue Cross because they were using the money they were getting on political campaigns and were not disclosing the money spent on those campaigns (Rosenthal 19). The members decided to sign a petition that said, " Anthem Blue Cross stop playing politics with our premiums" (Rosenthal 19). The members wanted the company instead to lower their rates with the money being used on political campaigns (Rosenthal 19). Hence, as the government has been involved in healthcare for decades, they have definitely had a role to play as far as where it is today and how it has affected medical staff and their patients.

How has it affected the practitioners of medicine?

Healthcare in America has negatively affected medicine practitioners, particularly in how they choose a profession, work, and treat their patients. The practice of medicine should involve developing a relationship with one's patients, but this is not the case today. The healthcare system generates revenue from people's illnesses; thus, it makes it near impossible for a doctor or nurse to develop a genuine relationship with a patient, depending on their field. One of the most prevalent problems that practitioners of medicine face, especially doctors, is student debt. The average medical student graduates with a total debt of $250,990 as of 2023, depending on whether the school is public or private (Hanson, Melanie). This amount includes undergrad, pre-med and medical school (Hanson, Melanie). This incredible amount of debt is seven times more than what the average college student graduates with today (Hanson, Melanie). What is more astonishing is that there has been a 1561% increase in the average medical school debt for the past thirty years (Hanson, Melanie). These vast debts influence what fields students enter to pay off all the debt. 56% of residents said their debt slightly affected their decision (Rosenthal 58). 36% of residents said the debt was very influential (Rosenthal 58). Another study was done by the authors of an online thesis from the National Library of Medicine using a cross-sectional national online survey (Park Chulwoo). After 203 alums and student Doctors of Public Health (DRPH) participants responded to the study, the authors found that 59% of DrPH students and 29% of DrPH graduates made a decision in field choice based on the debt they had incurred (Park, Chulwoo). The massive increase in debt has translated to more doctors in certain fields than others. For instance, there is a lack of primary physicians in Family Medicine and

Pediatrics compared to Cardiology, and Plastic Surgery because the pay is significantly lower (Moore, Christine). Maggie Mahar, the author of *Money Driven Medicine,* said, 'We do not value primary care doctors, generalists, family doctors highly at all. The compensation is relatively low and that is why we have fewer and fewer of them," (*Money-Driven)*. Thus, the debt received after a long schooling period correlates to a medical student's career choice. If one had to choose between taking a more extended amount of time to pay off their debt in one specialty versus a shorter amount of time in another, oftentimes, people will decide on the shorter amount of time (*Money-Driven)*.

Once a doctor finally starts their career, they could be paid through productivity-based compensation, which is ' a percentage of either billings or collections or… the resource-based relative value scale (RBRVS) units assigned to procedures or patient-visit types," according to NEJM Carer Center (Parent, Andrea). They could be paid by salary with bonuses or incentives (Parent, Andrea). They could also be paid in an equal shares system in which a group of physicians in the same practice divide the money earned amongst themselves after necessary expenses for the practice are paid (Parent, Andrea). Nevertheless, in order to charge for certain procedures, CPT (Current Procedural Terminology) codes and DRG (Diagnosis Related Group) codes are used to calculate how much a particular service or medical procedure should cost (Bookmark)(Rosenthal 31). DRG codes are mainly used in the circumstances of hospitals for Medicare and some privately insured patients (Dr. Lackey). Meanwhile, CPT codes can be used across various fields and areas of medicine (Bookmark). CPT codes may also be used in administrative claims processing (Bookmark). Although these organized systems of payment

work fairly well for doctors and practices, doctors typically come across some administrative difficulties in terms of certain paperwork and pre-authorizations to receive the go-ahead to either accept patients' insurance or do certain procedures (Dr. Lackey)(Tice, Alan,). In addition, these problems often occur in certain fields of medicine, such as primary care (Tice, Alan,). A quote from the Hawaii Medical Journal states,' Administrative burdens including payment delays, inadequate reimbursements, and complex rules and regulations as to how claims should be filed are affecting the majority of primary care practitioners," (Tice, Alan,). Private practice doctors in Hawaii participated in a survey where they were studied to see if a patient's insurance affected the chances of those doctors seeing them (Tice, Alan,). The survey discovered that the physician's willingness to accept a new patient directly correlated with their insurance and the limitations that insurance placed on them (Tice, Alan,). Private practices had a dilemma on their hands. Primary care specialists and doctors were burdened by the time they had to take out of their day to take care of medical billing procedures (Tice, Alan,)(Miller, Desiree). It was routine for the primary care physicians from the survey to spend at least two uncompensated hours a day dealing with managed care pre-authorizations, work with pharmacy benefit managers, formulary restrictions, confidentiality requirements, and care coordination (Tice, Alan,). Many of these Hawaiian plans at the time would not pay for services without pre-authorization forms that the physician could only do (Tice, Alan,). Even physicians who joined larger practices to avoid these administrative tasks still had to handle pre-authorization requirements and formulary restrictions (Tice, Alan,). It can be frustrating for a doctor to keep up with this on top of seeing their patients. Because of these difficulties, practices tried to make it easier for themselves by

only accepting a few insurance plans that offer reasonable reimbursement (Tice, Alan,). Nonetheless, practices today hire people who work on the administrative work as a separate job, giving the doctor more time to see patients (Dr. Lackey). However, because some practices limit complex insurance, patients need help finding access to the health care they need in their area, despite having insurance (Miller, Desiree). This is especially true for those with Medicare and Medicaid and select private plans (Rubin, Lillian). I spoke with Dr. Brian Thornburg Do. FAAP, who is a concierge doctor (Dr. Thornburg). He illustrated the difficulties of dealing with insurance from a doctor's perspective, saying, ' They are very cryptic. You do not know what they are looking for when you're submitting billing, so they'll deny claims, they give an inadequate explanation, and then it takes you or takes someone in your staff time to figure out why the claim was denied. There can be a lot of manpower put into recovering money that you have earned, and they are not being very clear with what the rules are and they can change their rules of how to submit claims for visits without notifying you, and then you find out later that it's been denied,"(Dr. Thornburg).

There are also pressures from guidelines doctors in practices and hospitals have to follow that prevent them from giving patients more holistic options. When asked if doctors in a traditional healthcare establishment are allowed to prescribe holistic medicine, Dr. Thornbug exclaimed, ' If they are working for a corporation or they are working as an employee physician for a company, like a hospital, they may not be allowed to because they represent the corporation, and the corporation may not be interested in the kind of service or advice given to

patients. If they are a solo practitioner in the traditional model, they can do whatever they want [regarding holistic medicine]," (Dr. Thornburg).

Not only has health insurance and the health care system put pressure on completing tedious administrative tasks and following specific guidelines on doctors and their practices in order to make a living, but it has also encouraged hospitals to make as much money as possible. Once health insurance became popularly accepted, hospitals became complacent with their financial incentives, altering how doctors practiced medicine (Rosenthal 21). A doctor from the *Money Driven Medicine* documentary compared the current environment of a hospital to an industrialized corporation (*Money-Driven)*. Dr. Churchill pointed out that a physician seeing each patient only for about 12-15 minutes, no matter their condition, problems, complicated diagnoses, or reassurance they might need, is similar to operating a production line in a warehouse (*Money-Driven)*. Doctors are seen as the workers, patients are compared to materials, and the hospital is the warehouse where things are conducted (*Money-Driven)*. Thus, for consistent money to be made, patients need to be temporarily fixed so they can return and keep the "warehouse" or hospital going (*Money-Driven)*. I also delved into this subject with Dr. Thornburg and he gave this analogy to better explain this concept, ' If I have a sick patient and they have to come in more often, then I make more money. I do not really have an incentive to get them well because the sicker they are the more I get to make," (Dr. Thornburg).

Over the years, hospital services have skyrocketed in costs compared to other areas of the healthcare system (Rosenthal 23). Between 1997-2012 alone, hospital services costs rose 149%, and physician services rose 55% (Rosenthal 23). Hospitals have few market forces to combat

them, so they can raise prices on anything needed for essential procedures as much as they can in the following ways (Rosenthal 23). Most hospitals are profit organizations with no shareholders and legally cannot show whatever profit they make (Rosenthal 23). They can spend their income however they see fit, especially in areas like executive compensation (Rosenthal 24). At some point, hospitals will usually eliminate departments that are not making them money (Rosenthal 39). They will instead enhance what is profitable, such as orthopedic centers, cardiac care, stroke centers, and cancer centers due to scans and infusions (Rosenthal 39). Some hospitals implement what is called strategic billing (Rosenthal 35). For example, the Deloitte & Touche firm advised hospitals to stop billing for individual items like gauze to try to seek reimbursement from insurance (Rosenthal 34). They advised to bill and boost charges for oxygen therapy and prescription drugs (Rosenthal 34). $17 for Tylenol pills that sell for way less anywhere else is a consequence of strategic billing (Rosenthal 35). Just about every hospital has strategic billing, which health advisory firms support (Rosenthal, Elisabeth). Seeing a patient for observation has become a billing construct manipulated by hospitals, nursing homes, and insurers (Rosenthal 35). Medicare started implementing a policy where patients could not stay at a hospital for observation purposes for more than two midnights in a row (Rosenthal 53). Once hospitals and medical centers become huge corporations, they start to regionalize large areas of states (Rosenthal 214). For example, ‘At one point, Blue Cross Blue Shield refused to sign with Sutter [Health], noting that its rates were 60 percent higher than the statewide average… but they had to go with them, or else many people would have nowhere to go for care,” (Rosenthal 214-215). In addition, ‘ Big hospitals hold enormous leverage in setting the terms of insurance contracts

because insurers need them in their networks," (Rosenthal 215). Hospital conglomerates will also buy out regular doctors' offices and then charge visits as hospital visits (Rosentha 207l). Therefore, one dominant healthcare system is capable of increasing prices by 40-50% (Rosenthal 207). When it comes to hospitals pushing for these expenses, they really only care about the business, money-making side of things. When referring to the administrators at his hospital, Dr. McCullar said: ' They paid more attention to the bottom line than to the tradition of medicine," (Rosenthal 26) He further explains how difficult it was for him to talk to the administration about outcomes that mattered as well as the finance (Rosenthal 27). ' I tried to get the administration to look harder at quality outcomes - like infection rates- but they didn't, and that's more expensive," (Rosenthal 27).

In the end, doctors and medical professionals deserve to treat their patients in an environment that is not profit-driven but rather health-driven, physically and mentally. Maggie Mahar, the author of money-driven medicine, explained that they all seemed concerned about the same thing when she was interviewing doctors (*Money-Driven)*. ' They were concerned about the quality of care, about what was happening to their profession, and how little power they had to do anything about it," (*Money-Driven).* The joy of actually getting to know patients is mostly gone. I mean, what can be meaningfully said in ten minutes (*Money-Driven)*? Even if one can, one won't have time to do it with everyone.

How insurance and the practice of medicine have affected people in our society?

Patients have been having a rough time in the Healthcare Industry between the increasing insurance premiums and hospital costs. Dr. John Nixon: ‘ Healthcare costs keep going up, up, and up, and up, but the access seems to be going down,” (*Money-Driven).* America is one of the world’s wealthiest countries, and there are still quite a few people who cannot afford an assigned doctor (*Money-Driven)*. Due to their dilemma, they rely on the emergency department to be treated by a physician (Miller, Desiree). Nevertheless, even patients with insurance coverage get themselves into debt due to medical services and procedures (Rosenthal 224). In fact, one-fifth of Americans have medical debt on their credit cards (Rosenthal 224). An issue that contributes to many people being in medical debt other than the prices of medical services is their mentality. Some patients think that procedures are the end all be all for their problems, not realizing the severity, or non-severity, or not even wanting the knowledge of their condition (*Money-Driven)*. They just want whatever the problem is to be fixed by the doctor (*Money-Driven)*. Other patients do not know the full extent of the medical coverage they have signed up for and do not ask their doctors questions regarding inpatient and outpatient facilities in their area (Rosenthal 248).

Apart from this, patients also have difficulty finding care or certain practices that will take their insurance in their area. I spoke to a physician assistant who works at Medexpress named Desiree Miller (Miller, Desiree). Ms. Miller told me, ‘ 20-30% of the patients do not have insurance, are outpatient, or pay out of pocket,” (Miller, Desiree). An example of this is given by Lillian B. Rubin (Rubin, Lillian). Lillian and her husband had the same physician for two decades (Rubin, Lillian). One day an announcement came in the mail that said that the

doctor's office was closing (Rubin, Lillian). The four doctors in that practice were either leaving or retiring (Rubin, Lillian). Lillian began her search to find a new primary care doctor (Rubin, Lillian). Who knew it would be so hard? She went down the list and called familiar-looking numbers (Rubin, Lillian). She asked if the doctor of that practice was talking in any new patients, and the receptionist responded with, 'Yes," (Rubin, Lillian). They worked together to make an appointment, and the receptionist asked, ' What insurance do you have," (Rubin, Lillian)? Lillian responded with, ' Medicare and AARP," (Rubin, Lillian). There was a long pause, and the receptionist said, ' Oh, you should have told me before that you're Medicare;n doctor isn't taking new Medicare patients," and that's where the phone call ended (Rubin, Lillian). She still was not worried (Rubin, Lillian). She lived in San Francisco, where there should be plenty of physicians (Rubin, Lillian). It is not like she lived in the middle of nowhere. She went down the list of doctors she had and even asked for referrals from friends, but to no avail; no practice would take her medical insurance (Rubin, Lillian). Some would ask her about her insurance first, and others would wait till they had all of her information before asking what kind of health insurance she had (Rubin, Lillian). With twelve rejections, Lillian took advantage of the fact that she knew many people in the area and wrote to doctors personally (Rubin, Lillian). She disclosed her credentials, accomplishments, job, health status, and how much she exercised to see if she could win over a doctor (Rubin, Lillian). Two weeks went by without a response (Rubin, Lillian). She eventually got a callback, but it is insane how she had to go through that to find a doctor (Rubin, Lillian). Something significant could have happened in those weeks, and she and her husband would have had no doctor to care for them (Rubin,

Lillian). She wondered about all the ordinary people that did not have connections and did not think to make an effort to send these doctors letters to finally get an appointment (Rubin, Lillian).

Some patients may be set up with insurance and primary care but have high costs to pay when going to the hospital (Rubin, Lillian). Here is a horrific example of hospitals charging bills absurdly. A family was charged $21,000 after the father had a heart attack in his house (Rosenthal, 34). By the time got into the hospital, he was declared dead, sitting in a wheelchair (Rosenthal 34). No tests or anything occurred and yet the family was charged so much money after facing such devastation (Rosenthal 34). Hospitals profit off of one's illnesses. There was a woman who had a burned husband victim (*Money-Driven)*. Her husband was kept in the hospital for weeks (*Money-Driven)*. In those weeks, he was neglected by doctors and specialists almost to the point where he was close to death (*Money-Driven)*. His wife made a statement about what she realized all those weeks he was there (*Money-Driven)*. 'The Hospital is generating more revenue because the longer he's there, the more money they're making. The more complicated procedure they have to do, the more money they're going to make," (*Money-Driven).*

Many people are aware of the high costs one can encounter when going to a hospital and try to figure out why by asking for some form of receipt for the charges (Rosenthal 22). It can sometimes be difficult to find a hospital willing to give their patients a breakdown of the costs they are being billed (Rosenthal 22). Heather Pierce Campbell had surgery done where one of her fallopian tubes was removed along with the embryo and part of her uterus because she was experiencing a hazardous ectopic pregnancy (Rosenthal 22). After the surgery was completed in

less than a day, she went home and was billed $44,873.90 (Rosenthal 22). Interestingly, the hospital labeled the procedure done to her as miscellaneous (Rosenthal 22). Her health insurance, Aetna, negotiated the price down and offered to pay $17,264.56, while Ms. Campbell was expected to pay $875 (Rosenthal 22). Surprisingly, after Ms. Campbell asked the hospital for the breakdown of the charges, she was told, 'We don't normally send those," (Rosenthal 23). Now she did this because she knew it was her right as an American citizen to receive an itemized bill if it is requested, but sadly she never received one from the hospital (Rosenthal 23).

What is the current situation in America?

After reviewing the healthcare industry's history, how the government is involved, and how medical professionals and patients are affected, one should now examine the current situation in America. According to a Peter G. Peterson Foundation article published in 2023, ' Approximately 25 percent of healthcare spending in the United States is considered wasteful," ("Almost 25%). This wasteful spending contributes to harmful or unnecessary services and uses the more expensive alternatives for products and services ("Almost 25%)(*Money-Driven)*. The most considerable portion of this wasted spending is $266 billion for administrative costs ("Almost 25%). As far as the average health insurance premium price, according to the ValuePenguin website, ' In 2023, the average cost of individual health insurance for a 40-year-old on a silver plan is $560 – a 4% increase from the 2022 plan year," (Average Cost). Multiple insurance payers greatly complicate the healthcare system and increases administrative

costs (“Almost 25%). In addition to this, the average per-day hospital stay cost is $2,883 (Hospital and Surgery). Lastly, as of 2023, the average doctor’s visit without insurance can be $300-$600 (Slobin, Jacqueline). Regarding the moral state of the current healthcare system, Dr. Chruchill worded it perfectly when he said,‘ The current healthcare system is not designed to meet the population’s health needs (*Money-Driven)*. It’s designed to protect the interests of insurance companies, pharmaceutical firms, organized medicine… It’s designed to turn a profit… It’s designed to meet the needs of the people in power,” (*Money-Driven).* Therefore, even though more money is involved in the healthcare system as time passes, it is not beneficial for the patients and medical professionals involved. Rashi Fein, Ph.D., proclaimed, ‘Rashi Fein Ph.D., ‘ We spend more money and we are not healthier. We don’t live longer. We don’t seem to be getting as much value for money,” (*Money-Driven)*.

How can we combat this?

Based on all of the information written above, one might feel discouraged and think there is nothing one can do to combat this current healthcare system. Actually, one does not have to be discouraged. There are many things people can do that they have not thought of, or maybe have not tried to implement into their lives. For starters, patients and voters should pay attention to the people they vote for as they can greatly impact or negatively impact one’s healthcare experience.

Patients also can try to become more precise when it comes time to choose a health insurance plan. If people become more thorough when signing up for health insurance plans, then it will mitigate confusion when prices are higher than expected or certain services are not

covered. Additionally, patients should research to determine what hospitals, medical centers, practices, and specialist facilities are in their area and an inpatient network if one's doctor does not provide those recommendations (Rosenthal 248-252). Another aspect of the healthcare system that can help improve things is if doctors engage their patients more in making their own decisions as to what to do for their health rather than telling them what to do and giving them limited options (*Money-Driven)*. Dr. Berenstein has stated, ' Patients make more frugal choices, they make more effective choices than the healthcare system does," (*Money-Driven).* If one thinks about it, patients know their bodies and financial situation better than anyone else. Thus if they were given more options to find cheaper or more effective alternatives, then that should be their call, as well as what the doctor recommends. Unfortunately, Dr. Weinstein points out, ' Doctors are trained... to think about what is best for the person that they're taking care of. They're trained to give medications, to do operations… they are not really trained well in this decision process of giving information to patients to empower them to make decisions," (*Money-Driven).* Doctors should be taught to enact this method in their practice of medicine so that patients would get much more value out of their visits (*Money-Driven)*. Patients with more knowledge about what is going on with their health can share in the decision-making about what action to take, creating better outcomes for themselves, lower costs, and higher satisfaction (*Money-Driven)*.

This leads to the next point: doctors should develop an amicable, reliable relationship with their patients (*Money-Driven)*. Doctors need to have a report with their patients so that a relationship can develop and the patient can trust the doctor (*Money-Driven)*(Dr. Thornburg).

Dr. Thornburg stated, ‘ Research shows spending more time with your patients certainly reduces the need for medicine or additional health services in the long run,” (Dr. Thornburg). He also made a statement on the system of how doctors should be paid instead of how they are paid now by saying, ‘ I think the measurement should be how well are you doing at getting [the patient] out of your office? How well are you doing at reducing the medicine?... The focus should be on wellness and the reimbursement of the wellness model, not on the sick model,” (Dr. Thornburg).

Many of these suggestions to improve the healthcare system will not change unless the rules doctors follow to meet their quotas change. Many of these changes will also not occur unless the average total medical student debt is lowered. In this way, med students will not feel pressured to go into one field to pay off all of their debt faster than the other field. In terms of making changes to the entire healthcare system, that would be somewhat difficult. There have been many beneficial outcomes of having a more nationalized healthcare system, most often referred to as universal healthcare, instead of having various public and private insurance plans. This would require the executive branch to implement new federal laws. Nevertheless, many countries have made this sort of healthcare system work (Countries with Universal). Australia, Argentina, Brazil, Canada, China, Costa Rica, Egypt, France, Germany, India, Israel, Italy, Japan, Mexico, and South Korea are just a few countries that participate in a Universal healthcare system (Countries with Universal). In countries like these, severe problems, like wasting a quarter of the federal health care budget due to administration costs, are not an issue (Countries with Universal). Under a single-payer system, there is only one health insurance to direct one’s insurance, and there is no hassle regarding multiple pre-authorizations and practices

not accepting specific insurances ("A Comprehensive Guide). Therefore, in this area, the country saves money. Additionally, the most significant advantage of having a universal healthcare system is that all citizens have access to health insurance, and no bankruptcies can occur on the part of the patient because of high medical costs ("A Comprehensive Guide). Also, medical service prices are lowered since everything is under the government's care ("A Comprehensive Guide). However, there are prevalent issues that come from a universal healthcare system ("A Comprehensive Guide). Countries with universal healthcare systems are known to have long wait times for doctor visits and limited care for rare, complicated, or terminal diseases ("A Comprehensive Guide). They make their citizens pay more taxes ("A Comprehensive Guide). In some cases, funding for other essential programs may be cut in order to pay and fully enjoy the benefits of a "free" healthcare system ("A Comprehensive Guide). Any healthcare system a government decides to go with can have some negative qualities, but one should not be complacent in all the negatives one comes across in their healthcare system. There is always room for improvement.

I did my own survey to see what people today think about the current healthcare system in America. I asked thirty people a series of three questions (1) on a scale of 1-5, how satisfied are you with the American healthcare system, (2) how did you choose the current insurance you have now, and (3) what is your view on American health insurance? Twenty-two out of the thirty answered the questions, and these were the conclusions that were drawn. Seven out of the twenty-two people that answered said three, six out of the twenty-two people said two, five out

of the twenty-two people said four, and four out of the twenty-two people said one. When they answered the second question, eight out of the twenty-two people said that they received their insurance from their employer(this included VA insurance), six out of the twenty-two people relied on their partners' insurance, six out of the twenty-two people did research to choose their insurance, and two out fo the twenty-two people did not have health insurance. As far as the last question, everyone seemed to agree that the current healthcare system needs improvement and that it is necessary to cover the cost of medical bills. They believed that healthcare could improve in these ways: by giving people more options to choose from for health insurance plans, by being less expensive, by covering more preventative care, by offering proper nutritional advice, by providing more holistic alternatives instead of pushing for drugs, and by having the patients best interest at heart instead of the business of health insurance.

Refutation

There are many different opinions about the notion that the healthcare industry has demoralized the practice of medicine and the people they care for. Many would say there is nothing inherently wrong with the current system as it is. In fact, the people that answered four said that this healthcare system is the best in the world because you get the care and treatment when you need it versus in other countries that are not as advanced. When people get sick, they can see doctors, get an ambulance, get treatment, and take medication. There have also been many improvements to the healthcare system regarding access to mental health. This was something that was not available just a few decades ago. Should one ignore these advances and advantages one already has in this country? There are plenty of third-world countries that would

dream of having the ability to implement these kinds of services in their country. However, this is not the inherent problem. The real problem is the money and the quality of care. Dr. Weinstein articulated the thoughts he got from another doctor on the subject by saying, ' According to Dr. Donald Berwick, America is pretty good at rescue care services compared to other countries, but as far as services like chronic disease care, community-based care, primary care, and preventative care, America is not that great compared to other countries that do well in those areas," (*Money-Driven)*. At this point, there is so much to be gained by health insurance companies that the health of others is no longer the real priority when it should be.

Some others might argue that if the country were to look at options, such as a universal health care system, it would put many administrative workers out of their jobs. Quote from It's Up to Us.org has stated, 'Job losses in health insurance administration and billing are offset by gains in health care provider jobs," ("A Comprehensive Guide). While this is true, it would be much simpler for doctors to practice medicine without having the burden of dealing with multiple insurance companies and trying to get pre auhtirizations approved or doing unnecessary tests and procedures just to fulfill the wishes of the health insurance company. Administrative workers are dedicated individuals just like any other medical staff. Nonetheless, the complications that are involved in administrative work would be better off not being an issue rather than being such an issue that separate personal have to be hired to take care of it.

Thirdly, some might argue that the current health care system has contributed to the longer life expectancy that we have today. This statement is in valid. A quote from

Commonwealthfund.org states, ‘ The U.S. spends nearly 18 percent of GDP on health care, yet Americans die younger and are less healthy than residents of other high-income countries. Not only does the U.S. have the lowest life expectancy among high-income countries, but it also has the highest rates of avoidable deaths," ("U.S. Health Care from a Global Perspective). The current life expectancy is much longer than it was in the past; this is primarily due to all of the medical research that has been done and the new technology that has been developed over the years. The longer life expectancy is not related to health insurance. Health insurance is a means to get coverage for care; it does not get credit for the improved care itself.

Conclusion

In conclusion, the Health industry has demoralized the practice of medicine and the patients that they care for. It is important to bring awareness to this subject to inform those of the full extent of what the healthcare system is all about. Each area's true intentions, actions, and results are as follows. Health insurance started as a beneficial way for said medical centers to get paid as well as giving the patient ample time to recuperate, but it was taken over by business-minded individuals and had become an industry in which people became numbers instead of patients. Dedicated Doctors, physician assistants, nurses, nurse practitioners, etc., began as earning workers with minimal restrictions that have been taken advantage of and now are inconvenienced by protocols. Patients, most of all, started with minimal treatment with reasonable prices charged for their care, then became the industry's least cared about factor. Considering this, the American healthcare industry needs some improvement. The only way that can happen is if people raise awareness of the issues, vet their insurance and doctors about how

care will be received, and look into various means of treatment to see what seems like the best option. Although morals have been taken out of the meaning practice of medicine by healthcare, one still has the capability to implement them once again.

Works Cited

"A Comprehensive Guide to Understanding Universal Health Care in the US." UpToUs, 17 June 2021, https://www.itsuptous.org/blog/Universal-Health-Care?gclid=CjwKCAjwitShBhA6EiwAq3RqA7m2HxQGnBL6kfuNrXy90QuPDwpChCckyfepTpjp-eisw9DdRo7ctBoCMwQQAvD_BwE.

"Affordable Care Act (ACA) - Glossary." Glossary | HealthCare.gov, https://www.healthcare.gov/glossary/affordable-care-act/.

"An Industry Pioneer." *Blue Cross Blue Shield*, https://www.bcbs.com/about-us/industry-pioneer.

"Almost 25% of Healthcare Spending Is Considered Wasteful. Here's Why." Peter G. Peterson Foundation, https://www.pgpf.org/blog/2023/04/almost-25-percent-of-healthcare-spending-is-considered-wasteful-heres-why.

Assistant Secretary for Public Affairs (ASPA). "About the ACA." HHS.gov, 15 Mar. 2022, https://www.hhs.gov/healthcare/about-the-aca/index.html.

Average Cost of Health Insurance (2023) - Valuepenguin. https://www.valuepenguin.com/average-cost-of-health-insurance.

Bookmark. “CPT® Overview and Code Approval.” American Medical Association, https://www.ama-assn.org/practice-management/cpt/cpt-overview-and-code-approval#what-is-a-cpt-code.

Countries with Universal Healthcare 2023, https://worldpopulationreview.com/country-rankings/countries-with-universal-healthcare.

Dr. Lackey, Thomas, Personal Interview, April 6, 2023

Dr. Thornburg, Brian, Personal Interview, February 12, 2023

Examining the Affordable Care Act’s Effect on Coverage. https://www.healthaffairs.org/do/10.1377/forefront.20210715.739918.

Hanson, Melanie, and Fact Checked. “Average Medical School Debt [2023]: Student Loan Statistics.” Education Data Initiative, 1 Jan. 2023, https://educationdata.org/average-medical-school-debt.

History of Health Insurance in the United States H - Ache. https://account.ache.org/iweb/upload/Morrisey2253_Chapter_1-3b5f4e08.pdf.

"Hospital and Surgery Costs – Paying for Medical Treatment." Debt.org, 30 Mar. 2023, https://www.debt.org/medical/hospital-surgery-costs/.

"Insurance Commissioner: Who Are They & Why Contact Them." CreakyJoints, 29 Oct. 2018, https://creakyjoints.org/support/insurance-issues/insurance-commissioner/.

"Medicare and Medicaid Act (1965)." National Archives and Records Administration, National Archives and Records Administration, https://www.archives.gov/milestone-documents/medicare-and-medicaid-act.

"Medicare Signed into Law." U.S. Senate: Medicare Signed into Law, 12 Dec. 2019, https://www.senate.gov/artandhistory/history/minute/Medicare_Signed_Into_Law.htm.

Miller, Desiree, Personal Interview, April 6, 2023

Money-Driven Medicine, Andrew Fredericks, California Newsreel, 2009, date accessed February 15, 2023

Moore, Christine. “Highest and Lowest Physician Salaries by Specialty.” Healthgrades, Healthgrades, 10 Mar. 2023, https://www.healthgrades.com/pro/highest-and-lowest-physician-salaries-by-specialty.

Parent, Andrea. “Physician Compensation Models: The Basics, the Pros, and the Cons.” NEJM CareerCenter Resources, 19 Jan. 2023, https://resources.nejmcareercenter.org/article/physician-compensation-models-the-basics-the-pros-and-the-cons/#iLightbox[gallery1034]/0.

Park, Chulwoo, and Eric Coles. “The Impact of Student Debt on Career Choices among Doctor of Public Health Graduates in the United States: A Descriptive Analysis.” International Journal of Environmental Research and Public Health, U.S. National Library of Medicine, 15 Apr. 2022, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9028539/.

Rosenthal, Elisabeth, *An American Sickness: How Healthcare Became Big Business and How You Can Take It Back.* Penguin Books, 2018

Rubin, Lillian B. “ The Untold Health Care Story: How They Crippled M<edicare.” *The Untold*

Slobin, Jacqueline. “How Much Does a Doctor's Visit Cost without Insurance in 2023?”

Mira, Mira, 20 Feb. 2023, https://www.talktomira.com/post/the-cost-of-a-doctor-visit-without-insurance.

Slobin, Jacqueline. "How Much Does a Doctor's Visit Cost without Insurance in 2023?" Mira, Mira, 20 Feb. 2023, https://www.talktomira.com/post/the-cost-of-a-doctor-visit-without-insurance.

"The Role of Government in Supporting Health." World Health Organization, World Health Organization, https://www.who.int/tools/your-life-your-health/a-healthy-world/people-s-roles/the-role-of-government-in-supporting-health.

Tice, Alan, et al. "Access to Care: The Physician's Perspective." *Hawaii Medical Journal,* U.S. National Library of Medicine, Feb. 2011, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3071212/.

"U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes." U.S. Health Care from a Global Perspective, 2022 | Commonwealth Fund, 31 Jan. 2023, https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022.

"US Healthcare System Overview." *Ispor.org*, https://www.ispor.org/heor-resources/more-heor-resources/us-healthcare-system-overview.

" What Is Health Insurance?", Healthinsurance.org, June 23, 2022, https://www.healthinsurance.org/glossary/health-insurance/.