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## STUDY OF PRELIMINARY RESULTS OF OBAMACARE: IS THE HEALTHCARE REFORM EFFICIENT?

### OBAMACARE HISTORY AND KEY FEATURES

On 23 March 2010 president Barack Obama signed the Patient Protection and Affordable Care Act (PPACA, ACA) into law and ‘Obamacare’ has changed the healthcare system in the USA forever.

Nobody can deny that the USA’s healthcare sector was badly in need of reform. The system was getting more expensive leaving millions of people uninsured. Obamacare was aimed to reach very clear goals: expand the coverage, decrease the costs of healthcare making it affordable for both individuals and the government, and improve the quality. The reform uses such tools as subsidies, mandates and insurance exchanges.

On 28 June 2012 the Supreme Court passed a final decision concerning the healthcare law. In January 2014 the majority of provisions came into effect. In 2020 the remaining provisions shall start to work. The federal statute consists of 10 separate legislative Titles with the Health Care and Education Reconciliation Act amendment. HealthCare.Gov is the official website – Health Insurance Marketplace, where Americans can purchase federally regulated and subsidized Health Insurance during open enrolment.

Since the beginning of the implementation, there have been 62 Republicans’ attempts to repeal the reform. But on the 25 June 2015 in a 6–3 decision, the Supreme Court saved the controversial healthcare law.

The basic Obamacare features areas follows:

- Insurance companies are forbidden to refuse to sell coverage or renew policies due to an individual’s pre-existing conditions. In the individual

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and small group market, the law forbids insurance companies to charge higher rates due to gender or health status<sup>1</sup>.

- Obamacare expands access to Medicaid. Americans who earn less than 133% of the poverty level can be enrolled in Medicaid.
- Tax credits will become available for middle class, people on income between 100% and 400% of the federal poverty level (FPL) who are not eligible for other affordable coverage. It is worth mentioning that the tax credit is 'advanceable'. Premium payments can be lowered each month, so it is not necessary to wait for tax return. Tax credit is refundable.
- Obamacare extends CHIP (the Children's Health Insurance Program) – young adults get the possibility to be included in their parents' plan until they reach the age of 26.
- Individuals who do not have coverage can buy a private insurance plan on the Health Insurance Marketplace during each year's annual open enrolment. Employer-based insurance and Medicare have their own set up enrolment periods. CHIP and Medicaid are available throughout the year. Medicare is not a part of the marketplace.
- The law prohibits new plans and existing group plans from imposing annual dollar limits on the amount of coverage an individual may receive.
- Under the law, all new plans must cover preventive services not subject to co-insurance, deductibles or co-payments.
- Companies with more than 50 employees should provide all full-time workers with job based health coverage. Otherwise, employers will pay a penalty per employee. Small businesses with fewer than 50 full-time employees can use a part of the marketplace called SHOP (small business health options programme) to purchase group health plans for their employees. Businesses with less than 25 full-time employees can purchase subsidized insurance for their staff in the marketplace.
- If a person does not obtain coverage and maintain coverage throughout each year or get an exemption, he/she must pay a monthly penalty on his/her federal income tax return for every month he/she is without health insurance<sup>2</sup>.

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<sup>1</sup> U.S. Department of Health & Human Services, *About the Law* [online], <https://www.hhs.gov/healthcare/facts-and-features/key-features-of-aca-by-year/index.html> [accessed: 21 October 2016].

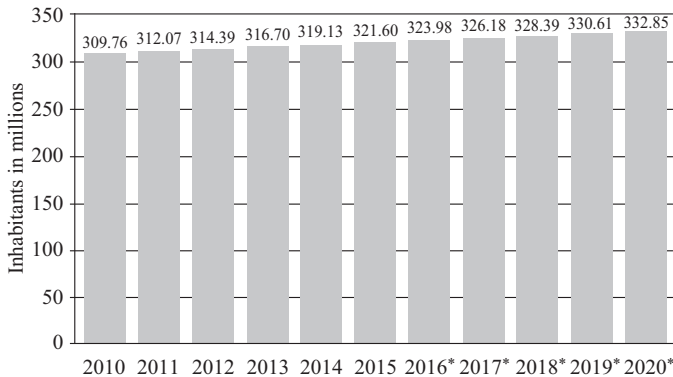
<sup>2</sup> *Ibidem*.

## 1. ACCESS: CHANGE IN THE SITUATION OF THE UNINSURED

As it was mentioned above, one of the aims of the Affordable Care Act (ACA, Obamacare) was to extend health insurance coverage. By 2013 more than 43 million people were still uninsured. Poor and low-income adults were particularly likely to lack coverage due to inability to afford it. In 2014 Medicaid coverage has been expanded to nearly all adults on incomes at or below 138% of poverty level in states that have adopted the expansion, and tax credits are available for people on incomes up to 400% of poverty level who purchase coverage through a health insurance marketplace. Millions of people have obtained insurance through new coverage enrolment options. The uninsured rate reached a historically lowest level by 2015. It can be seen in Fig. 2. The category of population that made considerable input in the increased number of those who gained the coverage included low-income people who lived in states that expanded Medicaid. As it can be seen in Fig. 1, the population of the USA has been growing. In the end of 2015, 28 million non-elderly people in the US remained without any coverage (see the Fig. 2). Low-income individuals, adults, and people of colour still were at highest risk. The cost continues to pose a major barrier to coverage to nearly half (46%) of the uninsured in 2015<sup>3</sup>.

Fig. 1

Total Population in the United States from 2010 to 2020 (in millions)

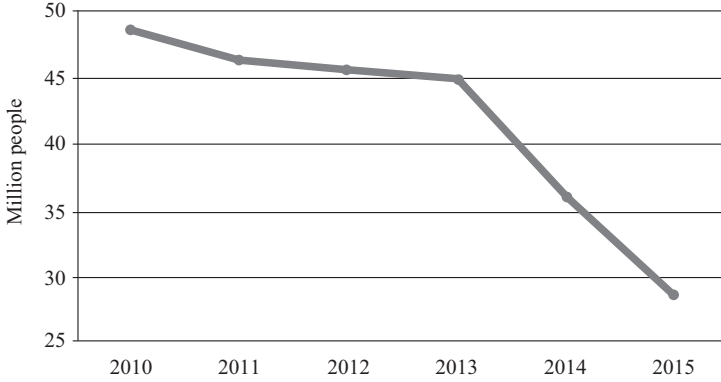


Source: Statista, The Statistics Portal [online], <https://www.statista.com/statistics/263762/total-population-of-the-united-states/> [accessed: 17 December 2016].

<sup>3</sup> Kaiser Family Foundation analysis of the 2013 Kaiser Survey of Low-Income Americans and the ACA, 2014 [online], <http://kff.org/uninsured/report/the-uninsured-a-primer-key-facts-about-health-insurance-and-the-uninsured-in-the-wake-of-national-health-reform/view/footnotes/#footnote-201979-2> [accessed: 5 October 2016].

Fig. 2

**Number of people without health insurance in the United States (2010–2015, in millions)**



Source: Statista. The Statistics Portal [online], <https://www.statista.com/statistics/200955/americans-without-health-insurance/> [accessed: 12 December 2016].

Over the last few years since ACA came into effect, the coverage of healthcare has been expanded. Shares in the distribution of healthcare can be seen in the diagrams (Fig. 3–5). Obviously, the governmental reform expanded Medicaid (with CHIP) and limited the private sector. During the period from 2010 (before ACA) to 2015, Medicaid coverage increased from 51.9 million people (17% of the total population) to 60 million (20%). The number of uninsured decreased from 48.8 million (16% of the total population) to 33 million (11%).

Fig. 3

**Distribution of insurance in the USA (2010, total population 305,2 million people)**

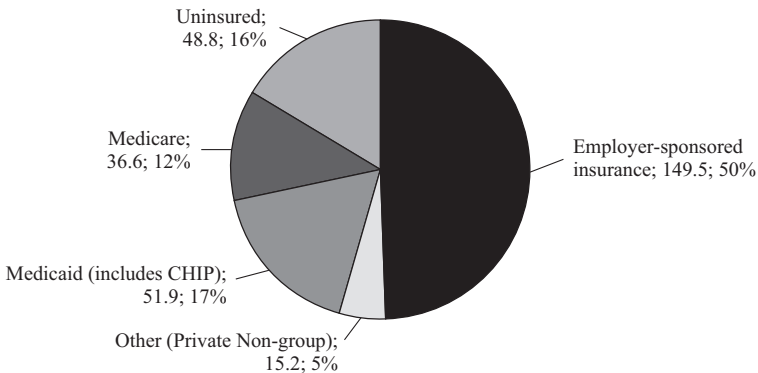


Fig. 4

Distribution of insurance in the USA (2013, total population 316,5 million people)

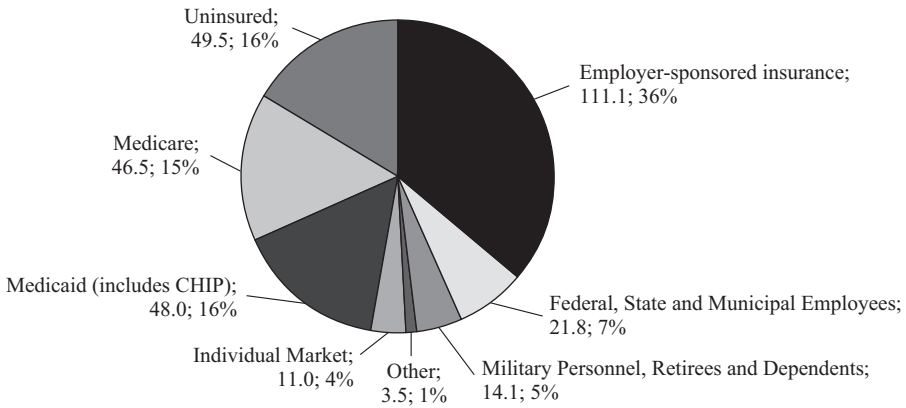
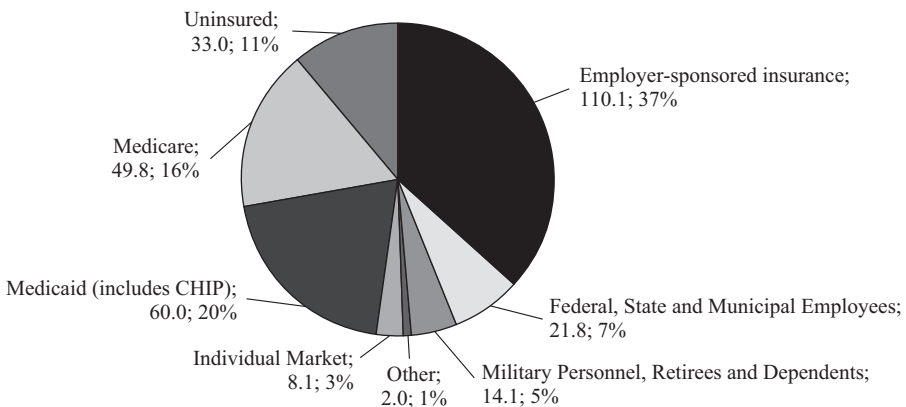


Fig. 5

Distribution of insurance in the USA (2015, total population 321,3 million people)



Source: Private research on the basis of: *Tracking Enrollments for the Affordable Care Act, Insurance Coverage Status between 2013 and 2015* [online], <http://acasignups.net/15/07/20/updated-x3-my-best-shot-tracking-change-total-us-insurance-coverage-status-between-2013> [accessed: 25 January 2017].

With the Supreme Court ruling of June 2012, the Medicaid expansion essentially became optional for states, and as of July 2016, 31 states and the District of Columbia had expanded Medicaid eligibility under ACA, while 19 states have chosen against expansion as of October 2016<sup>4</sup>.

<sup>4</sup> Health Network Group. *Obamacare Facts* [online], <https://obamacare.net/obamacare-facts/> [accessed: 20 October 2016].

Under the rules in place before ACA, all states already extended public coverage to poor and low-income children on a median income eligibility level of 255% of poverty level in 2016<sup>5</sup>.

As Obamacare enrolled the low-income people to get coverage via Medicaid, part of the population on incomes below FPL turned to be not eligible for Marketplace subsidies. Thus, in the 19 states mentioned above, a certain category of the population falls into a ‘coverage gap’: people earning too much to be qualified for Medicaid, but not enough to qualify for premium tax credits. In addition, undocumented immigrants are ineligible for Medicaid coverage and barred from purchasing coverage through Marketplace<sup>6</sup>.

The population was 325,301,049 as of 2 January 2017 based on the latest United Nations estimates. This number is growing. According to the forecast, it will be 333,545,530 by 2020, 345,084,551 by 2025, and 355,764,96 by 2030<sup>7</sup>. It is estimated that, in 2016, approximately 27 million nonelderly people lacked health coverage in the US<sup>8</sup>. Nationally, it is estimated that 43% of the population, or 11.7 million people, are eligible for financial assistance to gain coverage through either Medicaid or subsidized Marketplace coverage: 1/4 are either adults eligible for Medicaid (3.8 million, or 14%) or children eligible for Medicaid or the Children’s Health Insurance Program (CHIP) (2.6 million, or 10%). The category of population that is eligible to Medicaid includes previously eligible ones and those who became newly eligible under Obamacare. One in five (5.3 million, or 19%) of the nonelderly uninsured is eligible for premium tax credits to purchase coverage through Marketplace. One in ten uninsured people (2.6 million) falls into the coverage gap due to their state’s decision not to expand Medicaid, and 20% of the uninsured (5.4 million) are undocumented immigrants who are ineligible for ACA coverage under federal law<sup>9</sup>.

It is important to underline that patterns of eligibility are different in different states and depend on such factors as state decisions on expanding Medicaid, poverty rates, premiums in the exchange, access to employer coverage etc. In states that expanded Medicaid, 35% of the nonelderly

<sup>5</sup> The Henry J. Kaiser Family Foundation. *Estimates of Eligibility for ACA Coverage among the Uninsured* [online], <http://kff.org/health-reform/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/> [accessed: 25 October 2016].

<sup>6</sup> *Ibidem*.

<sup>7</sup> Worldometers. *US Population 2017* [online], <http://www.worldometers.info/world-population/us-population/> [accessed on 2 January 2017].

<sup>8</sup> The Henry J. Kaiser Family Foundation. *Estimates of Eligibility...*, *op. cit.*

<sup>9</sup> *Ibidem*.

uninsured population are eligible for Medicaid, compared to just 13% in states that have not expanded Medicaid. No one in Medicaid expansion states falls into a coverage gap; in non-expansion states, nearly one in five (19%) uninsured people falls into the coverage gap, a larger share than the share of those who are eligible for Medicaid under pathways in place before ACA. As adults on incomes from 100% to 138% of poverty level in non-expansion states can receive tax credits for Marketplace coverage, a larger share of the uninsured population in those states is eligible for Marketplace tax credits than in expansion states (23% as opposed to 16%)<sup>10</sup>.

No doubt health insurance has a big influence on whether, when and where people get necessary medical care. As a result, health insurance is responsible for how healthy people are. Uninsured people are those who postpone healthcare or even simply skip it facing dreadful consequences especially when preventable conditions or chronic diseases were not diagnosed in time. While the safety net of public hospitals, community clinics and health centres, and local providers provide a crucial health care safety net for uninsured people, it does not close the access gap for the uninsured<sup>11</sup>.

Moreover, uninsured people may be often charged for the full cost of healthcare when they use it and face problems with paying medical bills and, eventually, have medical debt. But even if providers and uncompensated care funds take a part of the healthcare cost of the uninsured, these funds are not able to absorb the total cost of care for the uninsured.

Despite the efforts of Obamacare, the American health insurance system still leaves millions of people without coverage. Throughout history, considerable part of the population was left without health insurance due to the gaps in the public insurance and lack of access to affordable private coverage. The number of the uninsured grew over time, especially during economic downturns. Over 57% of the uninsured are outside the reach of ACA either because their state did not expand Medicaid, they are subject to immigrant eligibility restrictions, or their income makes them ineligible for financial assistance<sup>12</sup>. As for the rest, the law provides the assistance. But still access to healthcare is expensive.

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<sup>10</sup> *Ibidem*.

<sup>11</sup> The Henry J. Kaiser Family Foundation. *Key Facts about Health Insurance and the Uninsured* [online], <http://kff.org/uninsured/report/the-uninsured-a-primer-key-facts-about-health-insurance-and-the-uninsured-in-the-wake-of-national-health-reform/> [accessed: 3 October 2016].

<sup>12</sup> The Henry J. Kaiser Family Foundation, *The Uninsured: A Primer Key Facts About Health Insurance and the Uninsured in the Wake of National Health Reform* [online], <http://kff.org/uninsured/report/the-uninsured-a-primer-key-facts-about-health-insur->

## 1.1. Costs of the reform

Costs are clear indicators of the efficiency of healthcare systems. My assumption is that the reform is much more expensive than it was projected. No doubt the United States has led the world in medical research-and-development spending by a very wide margin, and has typically produced more than half of the \$175 billion worth of healthcare-technology products that are purchased globally each year. In other words, there have been very large, beneficial returns on many of America's healthcare-related expenditures. Moreover, healthcare is expensive in various aspects. New pharmaceuticals are particularly expensive because, before reaching the marketplace, they must go through a rigorous and costly research-and-development process.

No doubt health expenditure share in GDP has continued to rise all over the world. Over the past decades, the situation in the USA has been similar even despite the efforts to control this trend. Empirical evidence suggests a non-linear relationship between health spending and outcomes, reflecting the impact of other factors, inter alia, historical expenditure patterns on health and other welfare policies, socioeconomic variables, lifestyle behaviour, and environmental factors. Thus, any methodology attempting to estimate the efficiency of health spending needs to take into account a wide range of relevant variables in the functioning of health systems to obtain unbiased and efficient estimates. But in practice, due to issues of causality and lack of data, this can be achieved only to a limited degree<sup>13</sup>.

### 1.1.1. Cost for the state

In 1970 the USA devoted 6.9% of its gross domestic product to total health spending (through both public and private funds). By 2014 (the actual year when ACA entered into force) the amount spent on health increased to 17.5% of GDP. Health spending, as a share of the economy, often increases during economic downturns and remains relatively stable during expansion periods.

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ance-and-the-uninsured-in-the-wake-of-national-health-reform/ [accessed: 3 October 2016].

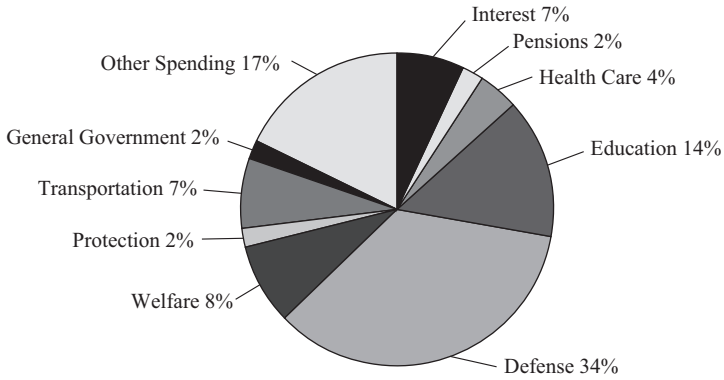
<sup>13</sup> *Ibidem*.



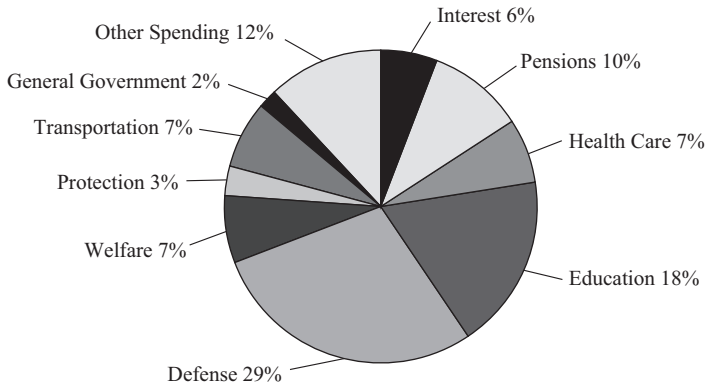
Fig. 6

**Total Government Spending for United States 1950–2017**

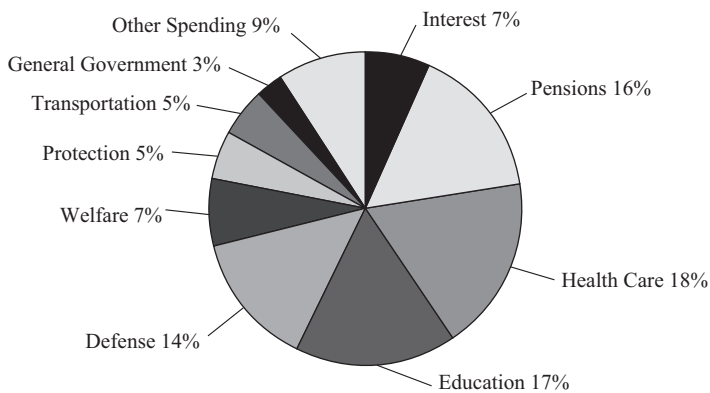
**Total Spending for United States – FY 1950**

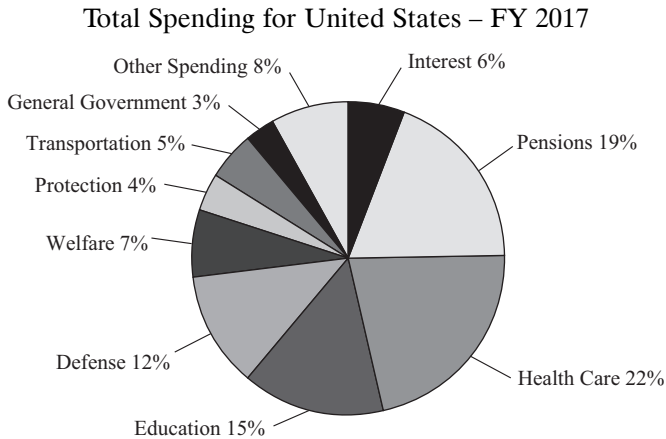
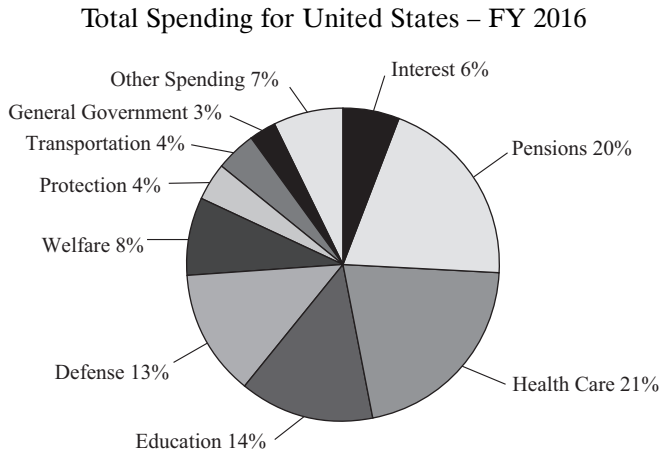


**Total Spending for United States – FY 1970**



**Total Spending for United States – FY 2008**





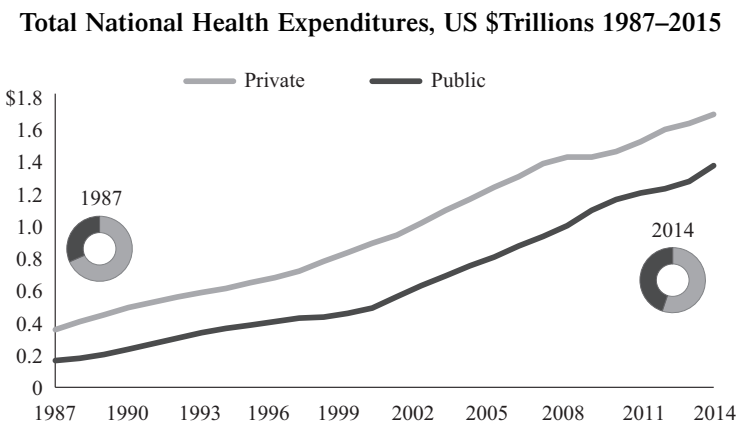
Source: Federal Spending Pie Chart [online], <http://www.usgovernmentspending.com/> [accessed: 12 December 2016].

The diagrams presented above show the rise in the share of spending on healthcare in respect of the total government spending in the USA. Total government spending includes: federal gross spending, intergovernmental transfers from federal to state and local, state government direct spending and local government direct spending. The USA currently (2016) spends 21% of GDP on health-related expenses (through both public and private funds), compared to 4% in the 1950s. During the 1970s and 1980s, the health spending as a share of the US economy widened considerably, with per capita health spending in the US growing by 10.0% annually on average. The situation stabilized in the 1990s but started to grow again during the

early 2000s, and once again has stabilized in recent years as health spending growth has slowed in the US<sup>14</sup>.

As the economy continues to recover, it is likely there will be upward pressure on health spending, though growth rates may not return to historical levels if the delivery system changes (spurred in part by the Affordable Care Act), continue to take hold and generate efficiencies. Medicare spending has grown particularly slowly in recent years, and there is evidence that Medicare is more immune to changes in the economy than health spending overall. As there has been a visible shift from private to governmental regulation of the healthcare sector, private and public spending is a matter in dispute. As it is shown below both public and private health spending grew during the past decades substantially, but public spending grew faster.

Fig. 7



Source: *Kaiser Family Foundation Analysis of National Health Expenditure data from Centers for Medicare and Medicaid, Office of the Actuary, National Health Statistics Group* [online], <http://kff.org/slideshow/health-spending-trends-slideshow/> [accessed: 23 December 2016].

The growth in public sector health spending in the US has been largely due to policy changes (expansion of Medicaid eligibility, creation of CHIP) and demographics (baby boom and, as a result, increase in the number of beneficiaries of Medicare).

<sup>14</sup> Peterson-Kaiser Health System Tracker, *Measuring The Performance of the US Health System* [online], <http://www.healthsystemtracker.org/insight/assessing-the-cost-and-performance-of-the-u-s-health-system/> [accessed: 14 September 2016].

Proponents of governmental involvement in governmental health insurance programmes claim that they have lower administrative costs and are more efficient in comparison with private health insurance. However, it is worth mentioning that Medicare dumps many of its administrative costs onto the private sector<sup>15</sup>. Private healthcare providers included all of these expenses in their administrative costs estimates. In the governmentally ruled healthcare systems doctors and other healthcare providers deal with an amount of governmental forms and regulations. Hidden costs include salaries of managers and administrators and marketing/advertising costs associated with promoting new policies. These costs affect healthcare providers who have to increase healthcare prices.

According to the study of the Council for Affordable Health Insurance, the administrative costs of Medicare and Medicaid are much higher (26.9%) than those in the private sector (16.2%)<sup>16</sup>.

It is worth mentioning that costs of healthcare increased due to the ‘third party’ involvement. When the government runs a healthcare system, the government and not the patient is the actual customer of health insurance. Providers have an incentive to over-bill the customers. There is no place for competition. When people do not pay directly for their own healthcare, they are psychologically and physically insulated from the true cost of that care. As a result, they tend to consume more, causing total expenditures on the product or service to rise.

#### 1.1.2. Cost for the average family: spending input per capita

According to the reform assumptions, the cost of healthcare assistance is based on income, but not on health status or gender.

As far as the costs are concerned, Obamacare provides lots of benefits. Many Americans qualify for lower costs on monthly premiums and out-of-pocket costs via cost assistance subsidies through the marketplace. Many families can get an opportunity to pay less under Obamacare and they will qualify for Medicare and Medicaid because of the expansion of the programmes. Post open enrolment data show that, after tax credits,

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<sup>15</sup> Discoverthenetworks.org, *Obamacare: Before and After* [online], <http://www.discoverthenetworks.org/viewSubCategory.asp?id=1957> [accessed: 18 December 2016].

<sup>16</sup> Discoverthenetworks.org, *Obamacare: Before and After* [online], <http://www.discoverthenetworks.org/viewSubCategory.asp?id=1957> [accessed: 18 December 2016].

the average marketplace plan costs less than \$100 a month for nearly 70% of enrollees and less than \$50 for over 45% of enrollees. If an individual's income of is below FPL, he/she will save on health insurance costs. Individuals who receive an annual gross income between \$50k and \$75k (9% of Americans) and do not want insurance, will have to pay a 2.5% penalty (in 2016) and will deal with the biggest premium increases under the law<sup>17</sup>.

No doubt Obamacare is expensive for employers. They may decide not to cover healthcare for spouses (United Parcel Service removed thousands of spouses from its plan because they were eligible for medical coverage elsewhere). Moreover, they may not offer dental policies or vision care, or may no longer subsidize those plans.

Currently, an average American family pays 20% of their income for health insurance, while Obamacare deems the insurance that costs 8% of a family's income 'affordable'. The average family's costs are projected to decrease between 7% and 9% due to Obamacare. Health insurance premiums make up a growing share of household health expenditures, while direct expenses for healthcare represent a shrinking portion of overall household spending on health<sup>18</sup>.

In 2015, the rate of growth in premiums declined. While the average national premium increase in the exchanges was 5.3 per cent, there was a wide variation among the states. Premium growth rates vary between group and non-group coverage. For group coverage, the CBO projects that premium growth will accelerate over the period from 2016 to 2025, increasing by 'nearly' 60 per cent. For non-group coverage in the exchanges, between 2016 and 2018, the CBO estimates that premiums for the basic 'silver' plans (the benchmark plans in ACA exchanges) will grow by about 8 per cent annually on average; after 2018, they are projected to rise in line with employment-based plans: roughly between 5 per cent and 6 per cent per annum on average.

To sum up, health spending rises constantly, but this increase has slowed recently. There is a debate among experts on whether the slowdown is tied to the continuing effects of the economic downturn, or it happened due to structural changes in the health delivery system. The economic factor (new medical technologies) should also be taken into account. The fact that the

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<sup>17</sup> Discoverthenetworks.org, *Before and After* [online], <http://www.discoverthenetworks.org/viewSubCategory.asp?id=1957> [accessed: 18 December 2016].

<sup>18</sup> *Ibidem*.

slowdown has occurred lends credence to the economic argument, though it could also be total spending growth flattened in 2014–2016, while the total spending per capita increased and continues to increase<sup>19</sup>.

Obamacare policy is the main cause of the share and tempo of public sector spending increase compared with private sector.

## 2. EFFICIENCY: TYPES OF EFFICIENCY

Efficiency of healthcare systems is a highly disputable issue these days. Technical efficiency is the one that can be applied in order to estimate the production of health care. Technically efficient production is achieved in case of producing most output from a set of inputs, or producing a set amount of output with the use of the fewest inputs<sup>20</sup>.

While technical efficiency takes into consideration the physical number of inputs, economic efficiency is defined in respect of the cost of those inputs. Economic efficiency is achieved if most output is produced for a given cost, or a set amount of output is produced at the lowest possible cost. Both technical efficiency and economic efficiency concern production, and if the supply side of the market achieves economic efficiency in every market, there is allocative efficiency in production for the economy as a whole. Equivalent concept for the demand side of the market is known as allocative efficiency in consumption. In this case consumers maximize their utility while given prices of goods. If both of these are achieved, then allocative efficiency in the economy as a whole, known as social efficiency, takes place.

Nowadays, the main concerns are: whether markets should be used in healthcare; to what extent markets are imperfect, whether there are alternatives, and whether government provision is a better option.

Health outputs are measured mainly in terms of outcomes. The following seven health outcomes are used: (adjusted) life expectancy at birth and at the

<sup>19</sup> R. Moffit, *Year Six of the Affordable Care Act Obamacare's Mounting Problems* [online], <http://www.heritage.org/research/reports/2016/04/year-six-of-the-affordable-care-act-obamacares-mounting-problems> [accessed: 6 February 2017].

<sup>20</sup> A.C. Clayton, *Assesing the Productive Efficiency of US Health Care: Comparison of Analytical Methods*, Illinois Wesleyan University, 2010 [online] [http://digitalcommons.iwu.edu/cgi/viewcontent.cgi?article=1105&context=econ\\_honproj](http://digitalcommons.iwu.edu/cgi/viewcontent.cgi?article=1105&context=econ_honproj) [accessed: 12 December 2016].

age of 65, (adjusted) healthy life expectancy at birth and at the age of 65, and standardised amenable mortality<sup>21</sup>.

As far as inputs are concerned, they are: total health expenditure per capita, PPP, number of physicians per 100,000 inhabitants, number of nurses per 100,000 inhabitants, and hospital beds per 1,000 population<sup>22</sup>.

Most studies contend that health outcomes are better if such measures of healthcare activity are used as the number of physicians' visits or CT scans etc. performed (Garber and Skinner, 2008; Joumard et al., 2008; Or, Wang, and Jamison, 2004). In their study of 2004, Wang and Jamison suggest that focusing efficiency analysis on measures of healthcare activity does not look at the goal of healthcare, which is to improve patient health. There is also a general consensus that healthcare activity analysis leads to negative incentives of overuse in healthcare as countries try to increase the quantity rather than the quality of healthcare provided.

Health outputs are measured by outcomes. Standardized amenable mortality, life expectancy at birth and at the age of 65 and healthy life expectancy at birth and at the age of 65 are the most widely used outcomes. But in this case there is the lack of specificity as to the inputs. Life expectancy is determined by such factors as lifestyle, pollution, accidents, etc. Obviously, it is not easy to separate the effects of the components mentioned above from the effects of healthcare. GDP per capita and average education levels influence health outcomes greatly.

In the context of achieving health outcomes, technical efficiency is achieved by applying cost-effective care procedures with the least inputs. Allocative efficiency is achieved by choosing a set of technically efficient health programmes to yield the greatest possible health improvements for the population<sup>23</sup>.

Healthcare efficiency is estimated in terms of outcomes achieved, not of outputs produced. The notion of the production frontier, which relates inputs to either outputs or outcomes while accounting for the effects of external factors on productive performance is central to the measurement of efficiency. Technical efficiency is measured as a distance to the frontier. Allocative efficiency is measured by comparing different points on the frontier of the extent to which they improve the health status of the population.

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<sup>21</sup> J. Medeiros, Ch. Schwierz, *Efficiency Estimates of Healthcare Systems*. European Economy, Luxembourg: Publications Office of the European Union 2015 [online].

<sup>22</sup> A.C. Clayton, *Assesing the Productive Efficiency...*, *op. cit.*

<sup>23</sup> J. Medeiros, Ch. Schwierz, *Efficiency Estimates...*, *op. cit.*

Inputs are defined in terms of: (i) total health expenditure per capita in purchasing power parities (PPP); (ii) physical inputs per capita, such as hospital beds, and the number of physicians and nurses; and (iii) environmental or lifestyle variables (smoking, alcohol consumption, diet, education, and income)<sup>24</sup>.

## 2.1. Healthcare outcomes: life expectancy, mortality/death rates and infant mortality

No doubt the US healthcare is an example of highly technological and fully equipped sectors. Since 1950, Americans have won more Nobel Prizes in medicine and physiology than people from the entire rest of the world combined<sup>25</sup>. Every year thousands of foreigners visit the USA in order to get medical treatment.

However, nowadays there is a quite strong opinion in the USA that with high and raising inputs the outcomes are quite uncertain. The situation in the healthcare system in the USA improves, but not in that tempo as it might do. It is also a disputable question if this improvement happened due to modern technologies or it is a matter of improvement in economy, or it is the effect of Obamacare policy (the results of which are mixed and not well evaluated due to a short timeline of the reform).

There are widely agreed opinions upon ways to measure spending on healthcare. Measuring the efficiency of the healthcare sector is a disputable issue due to the problem of choice of the best metrics and not many systematic data available. Moreover, there are different systems of measurement of outputs. Thus, all assumptions should be very careful due to the fact that measures of health outcomes are influenced by many factors.

### 2.1.1. Mortality

Many factors influence mortality rates. One of them is the quality of the healthcare system for diseases where mortality is amenable to healthcare. In general, the mortality rate (number of deaths per 100,000 people, adjusted for age differences across countries) was steadily falling in the USA during the

<sup>24</sup> A.C. Clayton, *Assessing the Productive Efficiency...*, *op. cit.*

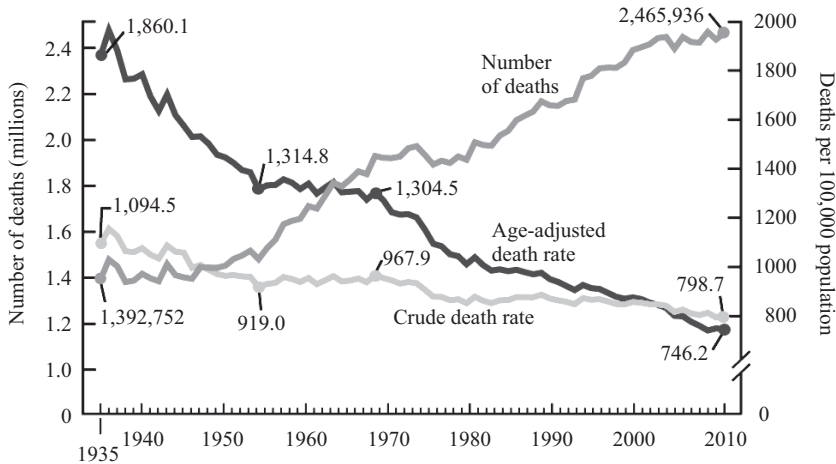
<sup>25</sup> Discoverthenetwork.org. *Obamacare: Before and After* [online], <http://www.discoverthenetworks.org/viewSubCategory.asp?id=1957> [accessed: 24 October 2016].



period from 1980 to 2010<sup>26</sup>. But this indicator should be evaluated separately for diseases and other factors.

Fig. 8

Numbers of deaths, crude and age-adjusted death rates: United States 1935–2010



Source: CDC/NCHS, National Vital Statistics System, Mortality [online], <https://www.cdc.gov/nchs/products/databriefs/db88.htm> [accessed: 12 December 2016].

As it can be seen in Fig. 8, while the total number of deaths increased by 1.1 million between 1935 and 2010, the risk of dying decreased. In the same period, the crude death rate fell by 27 per cent, from 1,094.5 to 798.7 deaths per 100,000 people between 1935 and 2010. The improvement in the risk of dying was actually larger than 27 per cent because the US population was getting older over the period. When the effect of the aging of the population was removed by calculating an age-adjusted death rate to examine the risk whether the population age distribution for all years was like that in 2000, the risk of dying decreased by 60 per cent from 1935 to 2010. Heart diseases and cancer remained the first and second leading causes of death, respectively, over the 75-year period – before and after the implementation of ACA<sup>27</sup>.

Over the last 30 years, there were periods when the death rates decreased or increased. However, in 2015 the death rate in the US jumped for the first

<sup>26</sup> G. Claxton, C. Cox, *Measuring the Quality of Healthcare in the US* [online], <http://www.healthsystemtracker.org/insight/measuring-the-quality-of-healthcare-in-the-u-s/> [accessed: 24 December 2016].

<sup>27</sup> Centers for Disease Control and Prevention, *75 Years of Mortality in the US, 1935–2010* [online], <https://www.cdc.gov/nchs/products/databriefs/db88.htm> [accessed: 24 October 2016].

time in a decade even when the aging American population was taken into consideration, a rare increase after years of declining death rates, according to the National Center for Health Statistics<sup>28</sup>.

In 2015, the death rate increased from about 723 deaths per 100,000 people in 2014 to nearly 730 deaths per 100,000 Americans, according to preliminary data of the Centers for Disease Control.

A bad flu season pushed death rate up in 2005, and AIDS and the flu contributed to a sharp increase in 1993. The death rate from heart disease stood at 167.1 in 2015, i.e. rose from 166.7 in 2014, though the rise was not statistically significant. It was the first time after 1993 when the rate did not decline. The death rate from suicides rose to 13.1 in the third quarter of 2015, from 12.7 in the same quarter of 2014. (The last quarter of 2015, data were not yet available for suicides.). The same was true for drug overdoses, which data the report had for only the first two quarters of 2015. The death rate for overdoses rose to 15.2 in the second quarter of 2015, compared with 14.1 in the same quarter of 2014. The rate for the so-called unintentional injuries, which include drug overdoses and car accidents, rose to 42 in the third quarter of 2015, up from 39.9 in the same quarter of 2014. The rate for Alzheimer's disease was also up, rising to 29.2 in 2015, compared with 25.4 in 2014, and was a continuation of some years of increases<sup>29</sup>.

In 2015 (12-month period ending with the fourth quarter of 2015), the crude death rate for all causes was 838.2 per 100,000 people, an increase from 823.6 in 2014. The age-adjusted death rate remained higher in 2015 than in 2014 (728.0 and 724.6, respectively).

The crude death rate for all causes was 899.1 in the first quarter of 2016, which is lower than the rate in the first quarter of 2015 (919.5). The age-adjusted death rate for the first quarter was also lower in 2016 than in 2015 (772.3 and 800.9, respectively). The 12-month ending death rate for all causes was 834.9 for the first quarter of 2016, similar to the rate in the same quarter of 2015 (835.4). After age-adjustment, the death rate was 721.5 for the year ending with the first quarter of 2016, lower than the death rate for the year ending with the first quarter of 2015 (731.2)<sup>30</sup>.

<sup>28</sup> L. Lorenzetti, *America's Rising Death Rates is a sign of Several Scary Trends* June 2016 [online], <http://fortune.com/2016/06/01/death-rate-increase-america/> [accessed: 2 January 2017].

<sup>29</sup> R. Bailey, *Good News: U.S. Death Rate Resumes Falling* [online], <http://reason.com/blog/2016/08/09/good-news-us-death-rate-resumes-falling> [accessed: 29 December 2016].

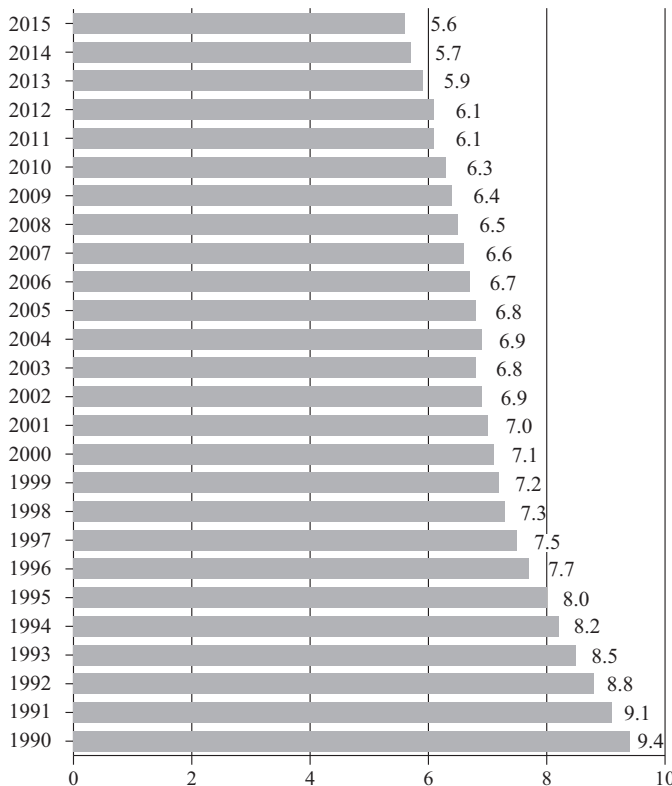
<sup>30</sup> S. Tavernise, *First Rise in US Death Rate in Years Surprises Experts*, „New York Times“ 2016/06/01 [online], <http://www.nytimes.com/2016/06/01/health/american-death-rate-rises-for-first-time-in-a-decade.html> [accessed: 30 December 2016].

### 2.1.2. Infant mortality

US infant mortality is improving in respect of time, but it is still high. Partially, this happens due to the system of measurement. The US counts ‘live birth’, i.e. the births of all babies that show any sign of life (heart, pulsation of the umbilical cord, or movement of voluntary muscles), regardless of low birth weight or prematurity. According to this method, the US had high infant mortality rate in comparison with other countries that have a different approach to counting (‘an infant must be at least 30 centimetres long at birth in order to be counted as living’ or babies born before 26 weeks of gestation are automatically registered as dead.)<sup>31</sup>.

Fig. 9

Infant mortality rate in the US in 1990–2015 (per 1,000 live births)



Source: Statista.com [online], <https://www.statista.com/statistics/195950/infant-mortality-rate-in-the-united-states-since-1990/> [accessed: 13 December 2016].

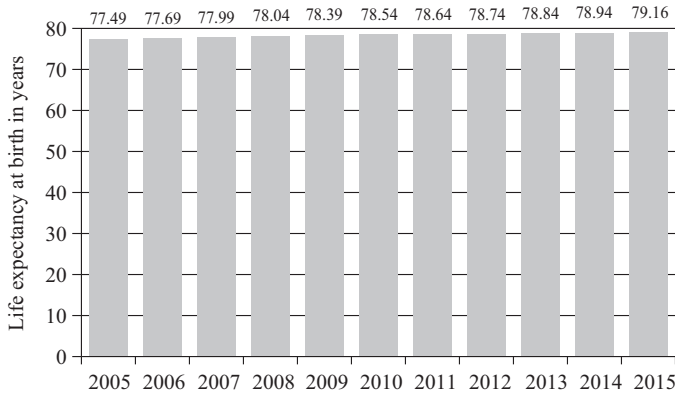
<sup>31</sup> Discoverthenetworks.org, *Obamacare: Before and After*, [online] <http://www.discoverthenetworks.org/viewSubCategory.asp?id=1957> [accessed: 25 October 2016].

2.1.3. Life expectancy

In 1980, life expectancy at birth in the US was 74 years of age. In 2015, life expectancy in the US was around 79,16 years of age. Indeed, social, environmental, cultural and behavioural factors influence life expectancy tremendously. It is important to underline that for about five decades prior to the 1980s, Americans had been the world’s heaviest smokers. These days they are the most obese populations on earth.

Fig. 10

The United States: Life expectancy at birth from 2005 to 2015



Source: The Statistics Portal [online], <https://www.statista.com/statistics/263724/life-expectancy-in-the-united-states/> [accessed: 23 December 2016].

It is worth mentioning that while the US performs relatively poorly on many of the available indicators of healthcare efficiency, there are signs of improvement. The US made notable improvement in general tendency in rates of mortality, maternity care, premature death, DALYs, surgical device retention, obstetric trauma, and lower extremity amputations in recent years (2015data)<sup>32</sup>.

<sup>32</sup> S. Gonzales, C. Cox, *Several Indicators of Healthcare Quality the US Falls Short* [online], <http://www.healthsystemtracker.org/2015/06/on-several-indicators-of-healthcare-quality-the-u-s-falls-short/> [accessed: 12 December 2016].

#### 2.1.4. How effective the system is at providing services: patients and doctors

In addition to health outcomes that change slowly in time and that can be influenced by many factors, some other indicators can be taken into consideration while estimating the quality of a health system's performance. Patient experiences can be assessed by looking at wait times and satisfaction and by conducting surveys of patient engagement and knowledge.

The quality and efficiency of a health system can be estimated by assessing the resources that are devoted in order to achieve better health. If the system has greater capacity (more hospital beds, more personnel), all else being equal, it will be able to provide better services to the public. As far as the USA is concerned, there are quite enough nurses per capita, but there is a lack of physicians and hospital beds.

As for the wait times, according to Vitals' annual 'Physician Wait Time Report', when Americans go to their physicians' office, they spend an average of 19 minutes and 16 seconds waiting to see their clinician. Wait time was dropping in 2015 – down by more than a full minute from 2014 year's average – despite increased healthcare coverage under Obamacare. However, wait times vary greatly, depending on speciality and location<sup>33</sup>.

I assume that it is very important to consider the doctors changing opinion on their profession that is under threat today due to various reasons. Obviously, it is a subjective indicator. Nowadays, doctors and other healthcare providers have to deal with a great amount of pages of governmental regulations and forms, administrative restrictions and barriers. But at the same time, physicians do not often receive timely information and have problems with coordinating care. Obamacare reform takes away the freedom of good quality practice and causes overworking and overtaxing of healthcare professionals. The medical clientele representing small businesses is seriously concerned about the quality of care for patients in the new environment, where 11 million new patients or so will have access to care with the same pool of physicians<sup>34</sup>.

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<sup>33</sup> E. Rappleye, *How Long is the Average Wait at a Physician's Office* [online], <http://www.beckershospitalreview.com/hospital-physician-relationships/how-long-is-the-average-wait-at-a-physician-s-office.html>) [accessed: 25 December 2016].

<sup>34</sup> *The Three Q's of ObamaCare: Quality, Quantity, and Quitting*, Forbes [online], <http://www.forbes.com/sites/thesba/2013/09/27/the-three-qs-of-obamacare-quality-quantity-and-quitting/#2fc420f665e8> [accessed: 8 January 2017].

In addition, there is a visible difference in payment for the personnel. Because of price controls, Medicare, on average, pays a physician only 81% of what a private insurer pays for the same care. For Medicaid the figure is just 56%. Because of this, many doctors have been limiting the number of Medicare and Medicaid patients they see. Whereas doctors are typically paid up to \$260 for an hour-long consultation with a privately insured patient, they often earn less than \$25 for an identical session with a Medicaid patient. Meanwhile, doctors who do accept Medicare and Medicaid patients are forced to charge their privately insured patients higher rates than would otherwise be necessary<sup>35</sup>.

#### 2.1.5. Obamacare crisis: problems and prognosis

Despite the fact that ACA has reached its goals to a certain extent, there are not only empirical, but also available data that prove it is too expensive for the economy to continue implementing the reform. According to many surveys, the US healthcare sector underperformed in comparison with OECD before ACA. Although today the situation in healthcare system in comparison with the rest of the world is improving, the American healthcare is still beyond the level even with the improvement that was reached in the last few years. New and new problems caused by the implementation of ACA are appearing as time passes. And the question is still open whether Obamacare is really 'affordable' and if the economy will handle further implementation of the reform.

Throughout its 'existence' Obamacare has been dealing with the functional and technical issues. In October 2013 healthcare.gov faced problems. A complicated system of insurance subsidies, health benefit mandates, rating rules, and doubtful arrangement that guarantees coverage despite pre-existing conditions are legislative problems that remain. To sum up, the reform, as it is looks today, is much different from the law that was passed in 2010.

The reform causes massive centralization of power in Washington. It causes the governmental control of healthcare decisions of the Americans. Recent statistics show that the cost of the reform will rise in the nearest

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<sup>35</sup> Discoverthenetworks.org, *Obamacare: Before and After* [online], <http://www.discoverthenetworks.org/viewSubCategory.asp?id=1957> [accessed: 25 October 2016].

future. From the beginning, Barack Obama's claim about a premium decline was unsupported by the data<sup>36</sup>.

In 2015, the rate of growth in premiums declined. While the average national premium increase in the exchanges was 5.3 per cent, there was wide variation among the states<sup>37</sup>.

For 2016, insurance companies forecast 'higher-than-expected' premium costs in the exchanges. Premium growth rates vary between group and non-group coverage. For group coverage, the CBO projects that premium growth will accelerate over the period from 2016 to 2025, increasing by 60 per cent. For non-group coverage in the exchanges, between 2016 and 2018, the CBO estimates that premiums for the basic 'silver' plans (the benchmark plans in ACA exchanges) will grow by about 8 per cent annually on average; after 2018, they are projected to rise in line with employment-based plans: 5 per cent and 6 per cent per annum on average.

The USA has experienced a further concentration of health insurance markets. No competition is possible. In 2013, there were 395 insurers operating in the non-group market; in 2015, there were 307; but in 2016, there are only 287. ACA has apparently accelerated further concentration of market power in healthcare delivery, increasing corporate control over private medical practice (insurance firms – Aetna, Humana, United Health Care, Cigna, and Anthem have already announced a serious cut in their Obamacare business).

It is obvious that ACA has a negative impact on job growth. For 2016, the employer tax penalty for each uncovered worker is from \$2,160 to \$3,240. Labour force participation was declining for many years, reaching a low of 62.5 per cent in 2015. The CBO projects that it will remain at that level in 2016 and fall again to 62.1 per cent in 2019. In February 2015, the CBO again told the Senate Budget Committee that the law would reduce labour, cut aggregate compensation, and reduce federal revenues proportionately. In December 2015, the CBO estimated that ACA would decrease the total labour supply by the equivalent of 2 million full-time workers by 2025<sup>38</sup>.

Obamacare affects the labour market due to provisions of the law that raise effective marginal tax rates on earnings. The health insurance subsidies that the Act provides through the expansion of Medicaid and the exchanges are phased out for people with higher income, creating an implicit tax on some

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<sup>36</sup> R. Moffit, *Year Six of the Affordable Care Act...*, *op. cit.*

<sup>37</sup> *Ibidem.*

<sup>38</sup> *Ibidem.*

people's additional earnings. The act also directly imposes higher taxes on some people's labour income. Because both effects on labour supply will grow, the CBO projects, they will subtract from economic growth over that period.

The reform imposes major tax increase on the middle class. Over the period from 2016 to 2025, the Americans will pay an estimated \$832 billion in taxes, including taxes on health insurance plans, drugs, and medical devices that will be passed on to the middle class<sup>39</sup>.

In 2020, when the provision takes effect, the CBO projects that unless employers change their plans, the tax will affect between 5 per cent and 10 per cent of employer group enrollees, rising to between 15 per cent and 20 per cent by 2025. As a result, employers will certainly take back health benefits and 'offer' to avoid the tax. As for the longer-term impact of ACA, the trends show that public spending will constitute a larger share in the healthcare economy in comparison with private spending. No doubt the rise will be visible in both public and private sectors. In 2014, private health insurance spending increased by 5.09 per cent, the largest jump since 2007. Public spending increased by 6.7 per cent. On a per capita basis, based on the CMS data, total spending on health insurance will rise from \$7,786 in 2016 to \$11,681 in 2024.

The reform imposes penalties. The tax penalty that comes with the individual mandate affects lower income and lower-middle income parts of the population in an unfair way. In 2014, the CBO projected that approximately 4 million individuals would face the mandate penalty in 2016 and generate an estimated \$4 billion in revenues. The CBO also estimated that 69 per cent of those persons would have incomes below 400 per cent of FPL, or below \$47,080 in today's dollars<sup>40</sup>.

The law requires that the tax penalty is to be greater than either a flat dollar amount equal to \$695 per adult plus \$347.50 per child, up to a maximum of \$2,085 for a family, or 2.5 per cent of a family income in excess of the 2015 income tax filing thresholds (\$10,300 for a single person and \$20,600 for a family). The main concern about this issue could be whether a person will prefer to pay the high tax penalty and stay without coverage or whether people will get enrolled in the coverage in the government's health insurance resources.

The reform will influence the future access of seniors to healthcare due to Medicare payment cuts. According to 2015 report of the Medicare Trustees,

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<sup>39</sup> *Ibidem.*

<sup>40</sup> *Ibidem.*



„By 2040, simulations suggest that approximately half of hospitals, 70 per cent of skilled nursing facilities, and 90 per cent of home health agencies would have negative total facility margins, raising the possibility of access and quality of care issues for Medicare beneficiaries.”<sup>41</sup>

Obamacare increases deficits and debt. President Obama stated that the health reform proposal would not negatively affect the federal deficit. And the CBO has insisted that ACA was an instrument for deficit reduction. But later the CBO stated: ‘The uncertainty is sufficiently great that repealing ACA could in fact reduce deficits over the 2016–2025 period – or could increase deficits by a substantially larger margin than the agencies have estimated.’

Independent analysts express doubts whether Obamacare will help to reduce the deficit. Medicare Trustee Charles Blahous concluded that ACA’s budgetary condition would continually worsen and projected a 10-year deficit that could range ‘somewhere between \$340 [billion] and \$530 billion.’ In January 2016, the US Congress enacted a repeal of ACA’s major provisions. This situation happened for the first time in six years. But President Obama vetoed the bill<sup>42</sup>.

On the edge of two presidencies, according to the Heritage Foundation, the top goal of the updated/changed reform should be to empower individuals and families as the key decision-makers in the healthcare economy giving all persons a direct and simpler system of individual tax relief for the purchase of health insurance of their choice, whether group or non-group coverage. With health insurance, the Congress should take specific steps by opening up the markets, ending official tax policy ‘discrimination’ against persons based on their employment status and adopting procedures that ensure ease of access to coverage for persons with pre-existing conditions<sup>43</sup>.

In any new health reform agenda, the Congress cannot ignore the major federal health entitlements. With Medicare, a reform agenda would build on the already existing defined-contribution financing systems for comprehensive health plans in Medicare Advantage and the broad range of drug coverage in Medicare Part D. With Medicaid, the Congress could likewise create a strong ‘premium support’ or defined-contribution system that would mainstream low-income persons into the private health insurance markets. Intense market competition driven by consumer choice in an environment characterized by transparency of price and performance would not only control costs, but also ensure value.

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<sup>41</sup> *Ibidem.*

<sup>42</sup> *Ibidem.*

<sup>43</sup> *Ibidem.*

To sum up, reasonable points for the public dissatisfaction of Obamacare reform are the following: higher costs; arbitrary rulemaking; bureaucratization of the healthcare sector of the economy; incompatibility with personal freedom; governmental control that restricts competition; rise in spending and heavy taxation.

New elected Republican president's rough opinion on Obamacare was clear during the 2016 presidential elections. On 2 March 2016, Trump released a seven-point plan for a healthcare reform, which he described as based on 'free market principles'. He stated that he would repeal Obamacare, reduce barriers to the interstate sale of health insurance, institute a full tax deduction for insurance premium payments for individuals, make health saving accounts inheritable, require price transparency, block Medicaid grant to the states, and allow for more overseas drug providers through lowered regulatory barriers. Trump added that enforcing immigration laws could reduce healthcare costs<sup>44</sup>.

The nearest future will show if the new president will be able to offer a clear alternative to Obamacare and whether he will be able, as president, to fulfil his campaign promises to repeal the law. Changing and repealing the reform will be very difficult as the law increasingly rooted in the American healthcare system<sup>45</sup>. Thus, the future of Obamacare reform is uncertain, but it is obvious that serious changes are coming.

## CONCLUSION

To sum up, the reform of the healthcare sector is considered to be one of the major achievements of Barack Obama's presidency. It was obvious for the reform founding fathers that the healthcare system was in need of reform. Healthcare had to be 'affordable', of 'good quality' and to give 'access' to a wide part of the population. The reform achieved access, but at an enormous price. It was transformed and changed over time and it is

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<sup>44</sup> Ballotpedia. The Encyclopedia of American Politics. *Donald Trump Presidential Campaign. 2016/Healthcare* [online], [https://ballotpedia.org/Donald\\_Trump\\_presidential\\_campaign,\\_2016/Healthcare](https://ballotpedia.org/Donald_Trump_presidential_campaign,_2016/Healthcare) [accessed: 7 December 2016].

<sup>45</sup> E. Whitman, *2016 Republicans on Obamacare: For GOP Presidential Hopefuls, Repealing of Affordable Care Act* [online], <http://www.ibtimes.com/2016-republicans-obamacare-gop-presidential-hopefuls-repealing-affordable-care-act-1885065> [accessed: 14 December 2016].

very different from what it was planned to be. Despite functionality issues, widespread dissatisfaction and speculations, it is still functioning.

With increased and constantly large inputs, the level of outcomes is doubtful and could be better. In general, since 2010 the indicators (infant mortality, life expectancy, death rate) that are considered to be a reflection of the efficiency of the healthcare system, either did not change, or these changes are not visible. Although it is obvious that only the first results of ACA efficiency can be provided, the evidence mentioned in the article can be a reflection of the tendency towards inefficiency. As it was mentioned above, inputs of the reform are high in comparison with the same ones from the period when ACA was introduced. The outcomes were better for lower total spending and spending per capita. They are much lower than it could be expected from the inputs, which the reform constantly requires. Today, only the first results of the reform can be assessed and they show a visible tendency toward inefficiency of the healthcare system.

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## STUDY OF PRELIMINARY RESULTS OF OBAMACARE: IS THE HEALTHCARE REFORM EFFICIENT?

### Summary

There is ample evidence of widespread inefficiency in health care systems in the early 2000s. The article is an attempt to find a balanced view on the efficiency of the Obama Healthcare Reform before it is reshaped by the new administration and the US Congress. No doubt Obamacare is a unique example of a healthcare reform. But is the reform really efficient? According to preliminary results, it achieved its goals to a certain extent, and at the same time it created a lot of new problems that should be solved. One of them, still open, is the issue of who should be in charge of the regulation of the healthcare system: to what extent the government should take part in this process; whether the shift from private to public regulation was an effective step in the development of the healthcare system; and if a free market should take place in case of such a good as healthcare. Nowadays, Obamacare is a burning topic. During his presidential campaign, Donald Trump notified that he would dismantle and/or restructure the Obama healthcare reform. Whatever the final outcome of his attempts to replace and/or to change the Affordable Care Act is going to be, it is worth assessing the health reform, which has attracted so much attention in the US and the world. The application of efficiency concepts to health care systems is a challenging topic, which raises both theoretical and practical problems. A review of input and output variables is carried out in the article. My assumption, which I will try to prove, is that the healthcare system in the USA is too expensive, and as a result it is less effective and, actually, not so 'affordable' as it was supposed to be.

## STUDIUM WSTĘPNYCH WYNIKÓW OBAMACARE – CZY REFORMA OPIEKI ZDROWOTNEJ JEST SKUTECZNA?

### Streszczenie

Istnieje wiele przykładów powszechnej nieefektywności w systemach opieki zdrowotnej na początku XXI wieku. Artykuł jest próbą znalezienia zbilansowanego obrazu skuteczności reformy ochrony zdrowia Obamacare zanim zostanie ona przekształcona przez nową administrację i Kongres Stanów Zjednoczonych. Bez wątplenia Obamacare jest unikalnym przykładem

reformy systemu opieki zdrowotnej. Ale, czy reforma ta jest rzeczywiście skuteczna? Zgodnie z wstępnymi wynikami, w pewnym stopniu osiągnęła swoje cele, a jednocześnie podniosła wiele nowych spraw, które należy rozwiązać. Jedną z nich, wciąż otwartą, jest kwestia, kto powinien być odpowiedzialny za regulację systemu opieki zdrowotnej: w jakim stopniu rząd powinien wziąć udział w tym procesie; czy przejście od prywatnej do publicznie regulowanej służby zdrowia było skutecznym krokiem w rozwoju systemu opieki zdrowotnej; czy powinien istnieć wolny rynek w przypadku takiego dobra jak opieka zdrowotna. Obamacare jest obecnie bardzo ważnym tematem. Podczas kampanii prezydenckiej Donald Trump deklarował, że będzie likwidować i/lub reorganizować reformę systemu opieki zdrowotnej Obamacare. Niezależnie od tego, jaki jest ostateczny wynik jego prób zastąpienia i/lub zmiany ustawy Affordable Care Act, warto ocenić reformę systemu opieki zdrowotnej, która przykuła uwagę w Stanach Zjednoczonych i na całym świecie. Zastosowanie koncepcji efektywności do systemów opieki zdrowotnej jest wyzwaniem, które powoduje zarówno problemy teoretyczne, jak i praktyczne. W artykule omówiono zmienne wejściowe i wyjściowe. Moim założeniem, które spróbuję udowodnić, jest to, że system opieki zdrowotnej w Stanach Zjednoczonych jest zbyt kosztowny i w rezultacie jest mniej efektywny, a właściwie nie tak „dostępny cenowo”, jak to było zaplanowane przez autorów reformy.

## ИССЛЕДОВАНИЕ ПРЕДВАРИТЕЛЬНЫХ РЕЗУЛЬТАТОВ ОБАМАКЭР: ЭФФЕКТИВНА ЛИ РЕФОРМА ЗДРАВООХРАНЕНИЯ?

### Резюме

Существует множество примеров широко распространенной неэффективности систем здравоохранения в начале XXI века. В статье предпринята попытка создать сбалансированную картину эффективности реформы здравоохранения Обамакэр (Obamacare), прежде чем она будет преобразована новой администрацией и Конгрессом США. Вне всяких сомнений, Обамакэр является уникальным примером реформы системы здравоохранения. Однако действительно ли эффективна эта реформа? По предварительным данным, она в определенной степени достигла своих целей; но в то же время привела к появлению множества новых вопросов, которые должны быть разрешены. Одним из них, по-прежнему открытым, является вопрос о том, кто должен взять на себя ответственность за регулирование системы здравоохранения – в какой степени правительство должно участвовать в этом процессе; явля-

ется ли переход от частного до государственного управления здравоохранением эффективным шагом в развитии системы медицинской помощи; может ли иметь место свободный рынок, если речь идёт о таком благом деле, как медицинская помощь? В настоящее время вопрос об Обамакэр является чрезвычайно важным. В ходе президентской кампании Дональд Трамп заявил, что он будет менять и/или реорганизовывать реформу здравоохранения Обамакэр. Независимо от того, каков конечный результат его попыток замены и/или изменения закона об Обамакэр, следует отдать должное реформе системы здравоохранения, которой уделено так много внимания в Соединенных Штатах и во всем мире. Применение концепции эффективности в отношении систем здравоохранения является задачей, которая связана с проблемами как теоретического, так и практического характера. В данной статье рассмотрены входные и выходные переменные. Моё предположение, которое я попытаюсь доказать, заключается в том, что система здравоохранения в Соединенных Штатах является слишком дорогостоящей, и в результате менее эффективной, и, собственно, не настолько «доступной», если речь идет о ценах, насколько это предусматривали авторы реформы.