

Editorial

Victor Grech

“Our starting point is not the individual, and we do not subscribe to the view that one should feed the hungry, give drink to the thirsty, or clothe the naked...Our objectives are entirely different: we must have a healthy people in order to prevail in the world.”

—Joseph Goebbels, Minister of Propaganda, 1938

The United States (US) population is 323 million (as of 2016), and health care provisions are important not only to the populace but also to politicians who seek election or re-election. Historically, US administrations have experienced tremendous difficulties when attempting to institute a national health insurance system. Obstacles included opposition from the American Medical Association, the insurance industry and pharma/medical business.¹⁻² The spectre of socialized medicine and ailing foreign health systems were typical cautionary tales utilised by opposition to and vested interests against a nationalised health service.¹⁻² President Lyndon B. Johnson first managed to introduce a modicum of basic national health insurance in 1965 with Medicare and Medicaid.¹⁻² These were crucial for certain population subgroups as uninsured patients are required to pay at point of care.

Medicare is a federal health insurance program that covers the over 65s, selected younger individuals with certain disabilities, and patients with end-stage renal disease requiring renal replacement therapy. As of 2015, Medicare beneficiaries totalled 55.3 million (age criteria: 46.3 million; disability criteria: 9 million).³⁻⁴

Medicaid is a state-administered federal program for low-income Americans who qualify by meeting certain federal income and asset standards, and by fitting into a specified eligibility.³⁻⁴

Since 1965, further efforts to expand Medicaid coverage stalled until the enactment of President Obama’s Patient Protection and Affordable Care Act in 2010, so-called Obamacare.⁵ The Act’s major provisions were the expansion of Medicaid in order to insure more Americans, the establishment of state insurance exchanges, and the introduction of new federal subsidies to purchase private insurance for additional Americans. Moreover, Obamacare also strove to slow down the rate of growth of Medicare spending. Medicaid covered 50.9 million Americans in 2009 prior to the introduction of Obamacare and rose to 72.2 million in 2016.⁴

Unfortunately, Obama’s administration failed to continue to enjoy its initially strong public support for health reform. The administration also failed to persuade many insured Americans that this reform would benefit them. For example, it was typically argued that the Act did not constitute true reform if it merely added tens of millions of new customers to private insurers’ rolls. It was also argued that this legislation, while greatly expanding access to health insurance, still left circa twenty-three million Americans without medical insurance coverage. Other arguments levied against Obamacare were that it lacked reliable cost control systems and did not permit most already insured Americans from joining the new insurance exchanges. Obamacare was nicely summarised thus:

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The legislation does not so much create a new health system as fill in gaps in the existing system, since the first principle of feasible reform was to build on current arrangements. It is a product of our fragmented political institutions, which compel compromise, and our fragmented health care system, which limits reformers' options to move away from the status quo.⁵

President Donald Trump, who succeeded President Obama in 2016, vowed to repeal Obamacare, citing all of its perceived disadvantages. This stance comprises part of a Republican trend to reduce or eliminate government spending on health and social services. However, it is estimated that the repeal of the Patient Protection and Affordable Care Act would leave 32 million Americans bereft of medical insurance, overnight. Moreover, there is no extant plan to replace this legislation with any equivalent or substitute.⁶

Malta's National Healthcare is modelled on the United Kingdom's National Health Service, with free service at point-of-care against a contribution that is directly deducted from salaries, or as a monthly contribution for those who are self-employed. These two ways of contributing towards health and social services comprise a form of state-organised insurance. While arguably not perfect, in Malta, emergency and essential healthcare is available to all without additional payments. Poverty is thus not a barrier to healthcare access.

With regard to actual costs, Malta spends USD 307 per capita per annum on total health expenditure, thirty times less than the United States at USD 9403 per capita per annum (2015 data).⁷ Compared to the far more expensive American system, Malta's National Health System is cheaper, with a net that covers one and all, including our most vulnerable families and individuals.

References

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Cover Picture:

'Astral Birth'

Acrylic on Stretched Canvas

By Erika Zammit

Erika Zammit is a full time Artist specialising mainly in acrylic and oil paintings. She studied the Arts and History of Arts at Advanced level, and furthered her studies on her own. Her main specialisations are space paintings, portraits and figure drawings. At a young age she joined the NGO Special Rescue Group– St. Lazarus Corps as a volunteer. Growing up volunteering for this NGO was a major inspiration in her life, which lead her to study First Aid at Advanced level, and further become a lecturer in the subject. She is also a lecturer with the institute of Medical Emergency Education, and her subjects are Advanced First Aid, and basic life support.