

# Advantages and disadvantages of the health insurance system in us



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INSURANCE The current system of health insurance in the US has pros and cons in its structure. Basically, the US has a consumer rather than a community based healthcare system. Health coverage is not universal; insurance is either bought privately or provided by employers. For those in poverty, Medicare and Medicaid programs provide limited assistance. Consumer health care has drawbacks, but also brings benefits of increased technology, although community implementation is sometimes problematic. Accessibility is the key issue in the debate over healthcare. Managed care insurance systems, through PPOs and HMOs in America, hopes to influence the rules of supply and demand in consumer care, and Medicare provide programs that increase accessibility for the poor and elderly. But many think that healthcare organizations need to reach out to the community in terms of educational programs that seek to foster the health of the community as a whole, rather than treat ailments in a specialized manner and have it end at that. Accessibility, as well as education, is an important goal for the model healthcare program in terms of conceptual framework.

One of the main issues in the current social and political environment concerning

national healthcare is how the healthcare system in the U. S. affects individuals who are

under federal insurance-based programs such as Medicare. Managed care operations

seem to be a cure to Medicare problems, and in fact many individuals have been

encouraged to adopt a managed care platform in addition to Medicare. This is because

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many organizations under managed healthcare offer more services on an integrated platform and do not carry heavy deductibles and co-payments, which makes this an attractive alternative to many people who are facing financial challenges. The rapid growth of individuals from Medicare who have gone to managed care during the nineties is a strong portrayal of how popular managed care is in terms of what it offers, which is in many cases substantially more than Medicare. Many managed care insurance providers offer prescription drug coverage and other types of coverage that are not covered by Medicare. But many wonder whether managed care operations can keep cost effective with so many clients and so much liability and responsibility to individuals on Medicare and Medicaid.

The main variables as obstacles to the future are shown by insurance HMOs which dropped many individuals from coverage to remain cost-effective, and others which have adopted a marketing stance that appeals primarily to healthy individuals and denies those that are unhealthy the option of managed care. The diversity present in Medicare HMOs also has meant that despite a general trend towards simplification, in some areas the services have created a large number of options that tend to encourage overlap instead of making the process of managed care more efficient.

Problems like

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these will have to be solved for the future to look very bright. In the US insurance system, HMOs are a relatively new development, although some of them have roots in the mid-twentieth century. There are still application-based and ethical imperatives to ask the status of these programs, especially in terms of their relevance to government healthcare programs as supplementary services and their position in a dynamic healthcare economy that is becoming increasingly privatized. This reflects the essential debate between government control and interference in national healthcare. That is, the issue of national healthcare still tends to be divided.