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POLICY FINANCING HEALTH INSURANCE AND HEALTH CARE IN THE UNITED STATES

Tax the fees you pay to have lived in organized society, with what he does not give

anyone the right to taxpayer destroy but to preserve life.

(Franklin Delano Roosevelt)

Abstract: Human Health in each country depends on the government's official policy and strategy, and then of health policy and the results in terms of implemented health goals, programs and proper handling of the available resources. This paper is actually affirmed the role of the United States of America because it is crucial in determining the programs and measures of health policy and control and evaluation of realized strategic objectives. The objectives related to increased coverage of citizens with health insurance, raising the overall quality of health care, employing the available and finding new resources and to prevent upward flow of medical expenses. Timely implementation of the goals can be achieved by increasing the value of health, a detailed analysis of the results of specific health programs, rational use of the factors involved and the preparation of materials for taking the next action. Although a relevant indicator, high-quality health fails to free the citizens of the United States a permanent and unconvincing assurances that in reaching its greatest credit goes to insurers and their unselfish effort. It is not and can not be true, and the goal of this work is to prove it. Assurances of its kind covering the truth because the quality of the health of every citizen in the largely depends on his attitude towards personal and other people's health and the impact of political, social, social, technical and economic factors. This is why contemporary analysts believe that the United States should leave philosophy to all valued money, and especially the life and health of citizens.

As for large-coverage of citizens with health insurance probably not be a particular problem, however, it is even greater as the settlement of the dispute does not want to in the right way. Inequality in health treatment

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insured because they belong to individual, particularly on vulnerable would not be a problem if there were greater willingness to masse people an equally valued. United States of America have long remained only a highly developed, industrial country that is not secured by the conditions in which all citizens have health care (state insurance or some kind of private insurance). A deeper analysis of this and similar problems it shows that critics of the current health policies are beginning to themselves to bother. In fact, they are concerned that the health of the United States older and sicker populations extensively using compensation of employees (and wealthy) layers of the population which, in their opinion causes irregular distribution of budget funds. If so (things are fine or OK), but the question is, why is there so much concern and imperative desire for an increased life expectancy of their citizens?

Key words: health care, finance, funding programs, costs, strategies

INTRODUCTION

In the United States a large number of problems, including those in the health industry can be solved by fiscal policy measures with what even many solutions may not always be considered feasible. They are responsible understand the political structure and began seriously to deal with important issues, and first issues of fiscal policy and its impact on the functioning of the health sector. Discussions are going in the direction to employers to exclude from tax liability to sponsored health care and help finance the costs incurred due to higher health coverage. Insightful and skillful analyst can miss a signal, that the cost of health care in the United States and universal kind of problem. For example, in 1990, amounted to $ 714 billion US, to 2008, reaching $ 2.3 billion US, an increase of over three times. Podesćanja works in 1980, amounted to "only" $ 253 billion US, or eight times less than in 2008. It is evident that the increase in costs has become a major political priority, and the government, employers and consumers frantically struggling to stop, restrain or to slow their expansion. Health policy in the United States if there is a clear goal, and should have, must at least answer the following questions, which are the main drivers of growth in health care spending, how to effectively suppress its expansion, which is the government's role in its growth and how easiest to implement austerity measures? Questions will most likely remain for a long time without a proper response, given that the soil of the United States sowed the seeds from which the nickel current economic crisis. Therefore, it is apparent that the dissatisfaction with the North American citizens continue to grow first, due to the insufficient quality of health care and secondly, because of corporate greed, high unemployment rates, the seizure of their homes and other property by the insatiable banks intents on their property.

Nevertheless it is certain that in the United States receive health care system continues to have a market model that provides quality only if it is expensive to pay, although even then there are not enough guarantees that the quality of health care to be in line with allocations. Therefore, it is suspected in the health care reform because the prevailing opinion (to many to be believed), that they have not fundamentally enforced or had importance when it comes to quality health insurance. No one disputes that the market will continue to be the moderator of the relationship and the events and that over 15 million citizens of the United States to be without any vision of health insurance. To be an American citizen given the opportunity to be insured must attach medical certificates of all kinds of diseases (or that they are not), that the insurance company offered him a contract of insurance and determine the premium that should be paid. In American practice, a larger number of insurance companies do not want to enter into any type of health insurance agreements with individuals according to their criteria, have the status of high-risk clients, and that no reform can never be done in the interest of citizens. The model of private health insurance in the United States until recently characterized by low coverage of the population and a large number of uninsured persons and financing of health services from the private insurance funds. Funds of funds are formed by premiums paid customers-customers regardless of whether they are paid by employers on behalf of their employees or citizens themselves.

A lot of elitists who think that the US health policy and health systems are better equipped, more rational and economical system in which human health and humane kept realistic values. This is a hint to the reader not to expect as the evidence of neither great nor glorification expressed odium, as the United States space in which the health security of citizens crowning achievement. This aspect should not be ignored even though he critics have forgotten that opposing the relevant facts is the only undeveloped spirit, does not mean much. Many of these often present the information to the health care system in theUnited States realized lower results than others also developed health systems, but does not propose adequate solutions and existing simply considered catastrophic. However, lightly over the fact that though her health policy implemented flawlessly, that the health service and excellent work that is involved in the American health care the most qualified and most professional medical and other staff in the world.

Health programs and the financing of health insurance or coverage of the population as one of its forms is a burning issue in the United States. That is why the federal government is taking serious steps towards the formulation and implementation of programs to increase the coverage of citizens with health insurance. According to official reports, uninsured residents, about 38% live in households where at the level of the realized revenue of 50, 75 or thousands of US $. Certainly the most challenging task is over Medicare, Medicall and Medicaid programs were organized for health

care consumers. Medicare the federal health insurance program designed in order to include persons 65 years of age and older and younger people with disabilities or who are the largest consumers of health $ US. Most people are Medicar-users at retirement because of rights to social security or the beneficiaries of some kind contributions related to the disability insurance. Those users additional income, for example, financial support for refugees and help foster, automatically acquire the right to protection under the Medical program, except that it applies also to some users Medicare program (the elderly, the blind, the disabled, pregnant women, Parents under 21 years and residents of rest homes).

Aim

Objective is a discussion about the position of the insurer, the government of the United States in the public sector provides between 60 and 65% of funds for financing of health care spending. If the funds were directed to fund various programs predominantly Medicare, Medicall and Medicade programs, the health insurance program for children and Program Administration for health care of war veterans. Health policy is still the most developed economy in the world, based on relevant indicators that pressure on the government but also the private sector, to conceive and adopt concrete programs for health care, and therefore is considered to be the policy of the future. It is firmly resting on the achievements of modern medical science, the rigorous control of financial flows and the proper application of pharmaceutical and techno-economic procedures.

Health policy and health care

Total health policy not only in the United States but also abroad, must be shavćena as conscious and responsible activity aimed at achieving specific goals of health care by applying adequate instruments and effective measures, the involvement of professional executors and rational use of available resources. Despite the wide range of opinions that is because word on the complicated politics, it should be noted the opposite, because things are quite different. Before we could talk about the specific requirements for the implementation of precise decisions taken, plans and actions that officials of the World Health Organization (WHO) to promote a vision of the future, but a complicated policy that creates an additional burden. Given that it is a vision, it should be noted that it highlights the priorities and expected participation of different groups, provides a consensus among a large number of questions and informs people about the possibilities for accessing all forms of health care. Therefore, health policy is not a world for themselves, regardless of what is one of the most vital components

of the global policy of the United States. It is in keeping with its nature and content, large palette structure a second, narrower policies and / or their specific parts. Either way it is understood in theory or in practice, it can be anything other than enumerated list of desires, desires that often and not, with respect to their true meaning. If wishes were unattainable or hard to follow, and in many cases they are, then this approach is further eroding the concept of complete health care policy. It is therefore of great importance to health policy your bank assumes technology assignment and enjoyment of the right to health care, a large coverage of the population, the smooth process of financing the healthcare industry and consumption, actively meeting the health needs and the correct pharmaceutical care.

Of health policy in such a developed country, the center of the group G 5 (known KVINTA) as United States of America are, with the right to expect that its active function is performed in order to preserve public health and promote programs that include methods and principles of management of quality of life of citizens. For example, let it be the implementation of activities in the fight against the consumption of tobacco, alcohol and opiates devastating, with equal treatment of different users of health care. Let it be with immunization procedures, the fight against modern diseases, proper breastfeeding, environmental conservation, and by creating the conditions necessary for the proper development and cultivation of biological and human capital. During the first decade of the XXI century, health policy action on the soil of the United States was the subject of various debates, among which the most intense one that is at least necessary, political. Why? Because the results of health policy recently evaluated through a political prism, regardless of how it is as a measuring instrument really precise. Political mark comes down to the edge of the convergence gap as a consequence of reduced scope of financing and increased health spending, due to the expanded scope of rights to health care and the increasing demands of the insured.

In terms of the way they are, it is expected that all the problems solved health policy for which they receive new, according to most sources more difficult tasks. Its fate is to fight financial problems, painstaking initiative in finding ways to runaway health spending caused by the action of various factors undisturbed funded and when funds are insufficient for that purpose. And to what extent such attempts are legitimate, and what results are expected since the Great Depression of the 2008 earthquake in the world and not only not subsiding, but threatens to significantly expand, we can conclude. During the last decades of the twentieth century, the growth of health care spending in the United States, as in most other industrialized nations of the world, has become a major problem of health policy. But it was not only the struggle with financial problems (the list is much wider), it is about the other distinctive shortcomings whose presence devastates its value and makes it difficult to realize the goals.

Health care is in large part because of that became a subject of lively, at times heated debates that often go beyond polite behavior. Many participants in the dis-

cussions on it have only one goal, to challenge the concepts and disavowal of the achieved results. Programs, measures and objectives of the health policy all are valued differently, but common practice is to be critical of the scope of rights to health care, access, equity, efficiency, cost, choice of equivalent value, and in general to its overall quality. Critical analysts believe that in many ways it is inconsistent and because of its vagueness current US health care system, except that stumbles and falls significantly behind other developed systems in the world, especially in Canada. Therefore, they say, its concept is not hopeful that they can expect better conditions in which to function better health care. Are firmly convinced that many projections and intentions are not in line with the real needs and tasks. In their opinion thus conceived health policy lacks capacity which would constitute an adequate logistics to health care with the responsibility to be the equivalent of funds spent. Considering that the Congress of the United States of America a narrow majority (219: 212) passed a new law on compulsory health insurance which is the crown of healthcare reform President Barack Hossein Obama, many citizens of the United States health insurance has become more accessible and shall apply to low-income people condition.

To aim of health policies in the United States were set realistic and realized their protagonists as few in other countries should be aware that the necessary multidisciplinary approach factors (contribution to medical, social, economic and institutional) operating within the national health system and that they have no alternative. With regard to the aforementioned factors for the implementation of effective health policy, it is important to establish which of them 4 more clearly than the other determines the scope of health care spending. Promoters health policy can sometimes ignore the premise, as far as their state should set aside for health care. Although it is not released from the obligation to approximate the operating funds of the financial resources that are a precondition for the functioning of the health system and how to dispose of a range of emerging variables influencing the aforementioned funds. Their commitments in the framework of health policy is determined by the knowledge of the structure of disease, the tendency to get sick, and then differentiating the impact of social, economic and geographical conditions as well as evaluating the expected lifespan of the population.

Health programs and funding

Health insurance or coverage of the population as one of its forms is a burning issue in the United States. That is why the federal government is taking serious steps towards the formulation and implementation of programs to increase the coverage of citizens with health insurance. According to official reports, uninsured residents, about 38% live in households where at the level of the realized revenue of 50, 75 or thousands of US $. Certainly the most challenging task is over Medicare, Medicall and

Medicaid programs were organized for health care consumers. Medicare the federal health insurance program designed in order to include persons 65 years of age and older and younger people with disabilities or who are the largest consumers of health $ US. Most people are Medicare-users at retirement because of rights to social security or the beneficiaries of some kind contributions related to the disability insurance. Those users additional income, for example, financial support for refugees and help foster, automatically acquire the right to protection under the Medicall program, except that it applies also to some users Medicare program (the elderly, the blind, the disabled, pregnant women, parents under 21 years and residents of rest homes).

Practically, the citizens of the United States at the same time can be the beneficiaries of both programs, because their providers have identical interests, cooperate closely and resulting health care costs are paid according to the established order. Medicare program due on the first and second Medicall. When using health services must always show both legitimaceije insurance for identification and categorization of services and the order of payment. Medicare program covers four sections (or areas) of health insurance, so that gives users the opportunity to comply with the financial capabilities of selected part:

1. *A,* which provides hospital services and hospital care under certain conditions;
2. *B,* which provides outpatient medical benefits and laboratory fees;
3. *C,* that provides the advantages of the various health plans that patients can receive in hospitals and elsewhere in accordance with the selected program and
4. *D,* which provides coverage of costs zdravstne protection prescribed pharmacological procedures and drugs on a prescription.

Parts *A* and *B* Medikar-progrm cover expenses for necessary medical services, including mental health care, but not the expenses for services in dentistry. Medicare program is in the competence of the Federal Government mandated that under the relevant postulates conceived and implemented health policy. Its users have broad rights to information and advice on how to ensure, 5 volume and quality of health care, advocacy and / or the provision of expert assistance in solving problems. In line with the users have the ability to appeal adverse decisions, for example, in relation to the payment or non-compliance with the provisions of the established health plans that are selected on the basis of proposed guidelines. In the event that some users Medicaid program for some reason use health insurance in Medikar-program in addition to the premium payments can not cover their health care costs, Medicaid program can stand behind them and pay the corresponding premium. Medicaid program includes people who are not able to afford the right to health care because they do not generate finan-

cial revenues or do not exercise enough. This program is usually characteristic that often makes concessions to certain categories of insured persons (pregnant women, children, the poor) and that enables them to use a certain volume of health care, but only in dedicated clinics and / or hospitals.

If the user under certain circumstances (loss of employment, reduced working engagement, extended leave, etc.) Lose the right to security Medicaid program does not end with the payment of benefits and coverage of medical expenses in his favor. Medicaid program can pay to health services even if he can not do so because of age, poor financial circumstances, unenviable family situation or changing the way life is organized. Across the Roof, where users are able to save Medicaid program offers them and that solution. They pay their premiums, and Medikar program pays the premiums and deductibles. Persons covered Medicaid program have an absolute right to his privacy, so that information about their health, private activities, marital and property status can be obtained and used only with their consent or, if absolutely necessary, for example, for legal disputes.

Financing health care of American citizens is extremely important question. The competence of theFederal Government to regulate the health care system whose main goal is the provision and distribution of funds to cover the cost of health care. Although not available with any form of health insurance that would absolutely cover all citizens of the United States, its government health policy focuses problem of financing health services on the basis of economic risk that threatens to expand due to their low level of health. Given that 84.7% of the citizens of the United States have some form of health insurance (through an employer, spouse or parent) Federal government for their funding model used:

1. general taxation at the state, district or municipality;
2. of social health insurance;
3. voluntary / private health insurance;
4. direct payment or payment services from their own pockets and
5. donations from various benefactors.

However, in many federal states in addition to the above models are applied a combination thereof, and the model mix-financing. In such cases, the method of distributing funds to specific cost centers varies from one federal state, and often the variations over time can meet and within each of them. The health policy of each federal state, but in accordance with its jurisdiction created the technique of financing. Jurisdiction refers to the relevant regulations and their strict application and encourages the government and the private sector to make decisions concerning health policy and adoption of specific programs, measures, techniques and the level of funding. For example, the social health insurance implies a model in which the entire population is

entitled to health care coverage, with being the scope and manner of providing health services regulated by law. In such circumstances, the insured would be the best form of protection of their health experienced universal health care, which would free them to pay insurance premiums and / or personal participation in health care costs. This has highlighted the importance of commitment to preventive health care, which, in a long time, decrease various diseases, reduce health care costs and greatly restricts the expansion of health care spending.

The health care system of the United States in particular question the relationship jvnog and private (voluntary) health care financing system. There are allegations that public funding of health care improves the quality and efficiency of health care personal contact because public (government) expenditure is essential when it comes to affordability and sustainability of health services and programs. Publicly funded health care (state), which is free by the way, proverbially cause demanding medical procedures and services, which results in an increase in total health expenditure. Allocated public funds, whether limited or not, do not deprive citizens uninsured liabilities from their own pockets to pay the costs of health care services used. The objection is that public funds could be rationally used, for example, the provision of services within the scope of emergency where the status or financial ability of the insured upon payment of such treatment would not be particularly significant. On the other hand private systems or insurance companies reduce waste and eliminating unnecessary bureaucracy perpetrators-provider business, reduced waiting times for specialist services and greater possibilities for the use of modern technology in medical procedures. In parallel reduces the voluminous documentation to professionals, contractors insurance process and thus increase the concentration on the needs of the insured. These are the arguments of those who believe that private funding has organized protection and thus increases the quality of health at a higher level and for those who have a dilemma, how privately funded health care achieves better results and higher efficiency. In addition, private financing of health care and effective management of resources (funding), prevents the federal government to increase tax rates and with increased taxes cover the costs of health care. It is also the best way to avoid conflicts between government agencies and to prevent an increase in bureaucratic influence.

Health care costs in the United States

Health care costs in the United States, compared to economic resources, economic strength and gross domestic product (GDP), exceeding the same in all the other countries in the world. Total US health

spending has a tendency to grow in the coming years to an alarming height. Each US $ spent on health care in the United States, can be viewed individually and valorized. Thus, 31% goes to hospital care, 21% for physicians who provide clinical

services, 10% for drugs, 4% cover dental services, 6% of the accommodation and care homes, 3% goes for home care, 3% on retail products, 3% of the government's public health activities, 7% settled administrative costs, 7% of their investment, and the remaining 6% covering other professional services. In 2009, United States (local governments, corporations and individuals) for the provision of health care spent 2.5 trillions US $ or US $ 8,047 per person or 17.3% of gross domestic product (GDP), and in 2010 . year, allocated je17,9% of gross domestic product (GDP), or US $ 8,362 per insured.

The conclusion is that health care costs are rising faster than wages and inflation, and that more than half of the growth in health care spending that marked the last decade of the twentieth and the first decade of the twenty-first century, a consequence of technological progress, changes in health insurance and the material and human resources. Health care spending grew in line with revenues that are certain categories of citizens to exercise the insurance terms dictated by the service providers in accordance with the salaries of health professionals. Besides an increase in consumption is a consequence of heavy use of pharmaceutical products which is typical for the sick and elderly. This is a serious signal for savings, however, its advocates argue that it is only possible in the implementation of measures and procedures in preventive health care and that in other respects can not expect significant results. Although the result of serious research, that the savings possible in preventive health care that does not mean that it reduces the level of healthcare spending, or at least generate significant savings in the long run.

When the preventive health care in question, must take into account that the provision of health services for people in old age significantly contribute to rising costs. This will increase the cost of health care (particularly the prevention of) companies that pay their different types of its employees to bring in an untenable position, and the American health care system as an economic organism will eat a tapeworm. These conclusions are drawn after the expressed wishes of the United States to cover the health care spending of its gross domestic product (GDP) set aside more than 18%, and after a report that private health insurance the United States with a 35% share of total health expenditure has the greatest share among the countries of the Organization for Economic Cooperation and Development *(Organization for Economic Cooperation and Development-OECD).*

According to data from 2004, in which health spending had a moderate flow, private medical insurance personal funds financed 36% of the insured, the Federal Government of the United States has funded 34% funding from their own pockets amounted to 15%, from the budgets of state and local government financed 11%, while other private funds financed the approximately 4% of health care spending. In spite of all the frequent complaints of users of health services and premium payer, that the health system in the United States on its way to literally mimic some European

or Latin American health systems that do not leave room for optimism. In recent years, there is a practice that appear inflated bills, sometimes ten times higher than the actual value provided / used health services which causes suspicion and matched by the rules. In addition ineffective and with it also incorrect and unfair health care system should not even an American citizen, regardless of whether or not the victim was paying artificially increased medical expenses.

Despite the fact that the health system in the United States includes several thousand different health insurance carriers, their number can not be accurately determined. Even very hard and approximately

indicate how much insurance companies in them now exists. But it is absolutely certain that the healthcare system in the United States The American has significant administrative costs, much larger than Canada's or any of the European health systems (UK, Germany, France). By far the sound data from the study Harvard Medical School and the Canadian Institute for Health Information System, that the administrative costs per year take about 31% of US healthcare $ US, or more than a thousand US $ per insured. This amount of health and administrative costs nearly twice as much as any that can be found in most developed health systems in the world. Because of this, and because of other circumstances, many complaints that the system 8 health care in the United States "dysfunctional" and that the patient, as the main participants unjustly removed from the events concerning the determination of funding policy. The following table presents data from several countries of the Organization for Economic Cooperation and Development *(Organization for Economic Cooperation and Development-OECD),* the appropriations for health care per capita and their percentage share in the gross domestic product (GDP) for 2009 and for 2010. a year.

Table 1. Per capita consumption of the insured in some countries of the Organization for Economic Cooperation and Development *(Organization for Economic Cooperation and Development-OECD)* **and allocations from the gross domestic product (GDP) for 2009 and for 2010.**

Serios number	Country OECD	2009*		2010**	
		Consumption per insured	% of GDP	Consumption per insured	% of GDP
1	United States	7.960	17,4	8.362	17,9
2	Norway	5.352	9,6	5.426	9,5
3	Swicerland	5.144	11,4	5.394	11,5
4	Netherlands	4.914	12,0	5.038	11,9
5	Luxembourg	4.808	7,8	6.743	7,8
6	Canada	4.363	11,4	4.404	11,3

7	Denmark	4.348	11,5	4.537	11,4
8	Germany	4.218	11,6	4.332	11,6
9	France	3.978	11,8	4.021	11,9
10	Australia	4.453	8,7	3.441	8,7
11	United Kingdom	3.487	9,8	3.480	9,6
12	Japan	2.878	8,5	3.209	9,5
13	New Zealand	2.983	10,3	3.022	10,1
14	South Korea	1.879	6,9	2.035	7,1
15	Mexico	918	6,4	916	6,2

* Source: Making the author according to the OECD Health Division (June 30, 2011).”The OECD Health Data 2011-Frequently Requested Data”. Paris: OECD.

** Source: Making the author according to the World Bank, World Development Indicators 2012th.

All who wish for it and have options can buy private health insurance at group level (for example, the company covers insurance of their workers) or as individual customers with specific insurers-provider (company, agency, dealer, broker). Individually purchased health insurance according to the nomenclature of health services similar to insurance provided by the employer. They make a significant contribution to cover the cost of health care and pay an average of about 85% of insurance premiums for their employees, and about 75% of the premiums for those whose security depends on employees, while the remaining part of the premium paid by the employees. When health insurance that employers pay their workers have witnessed a decrease of coverage from 68% in 2000 to 61% in 2009. The economic crisis that struck in 2008 the United States and the domino effect of the rest of the world, has created a high degree of insecurity, poverty, rising prices of health services and the army of uninsured persons-workers who lost their jobs. Only in March 2009, about 270 thousand workers because of job loss, lost their right to health insurance and the year 2010, nearly 50 millions people, or over 16% of the total population, welcomed without health insurance.

The political dimension of health insurance-case Obamacare

“We do not want taxes to net earnings of US middle-class families are increased ... we all want to further economic development, we all want to return to their jobs and constantly insist on new employment,” the eternal leader of the attitude of the Republican Party. They are 40 times tried to prevent the adoption of the 2013 budget, due to disagreement with the policy of financing of the compulsory health insurance,

known as "Obamacare". This is the official start of the financial blockade of the Federal Government on October 1, 2013, because of the hours-long political drama in the Senate and in the House of Representatives of the Congress of the United States by members of the Democratic Party and the Republican Party have failed to reach an agreement or to find common, appropriate solution for the financing of state for the current financial year. The resulting misunderstanding led to the interruption of a series of government and budget-funded activities which automatically block of functioning of the US Federal government. Research firm IHS argued that the financial blockade of the government daily cost economy, and the United States at least $ 300 millions US. In the case of a week-long blockade of the government, the projected economic growth of 2.2% for the last quarter dropped to 0.2%, a three-week blockade of government would reduce the US gross domestic product (GDP) between 0.9% and 1.4%. In the said blockade represents a serious threat to the global economy and agreed to the director of the International Monetary Fund (IMF), Christine Lagarde, speaking to students of the University George Washington. The blockade is a serious and bad, and if you can not find a solution for US sovereign debt, it could seriously jeopardize not only her, but the entire global economy which would make this problem had to be solved as soon as possible. Because of the blockade on forced leave should have gone more than 825,000 employees in the federal administration.

Sounds impossible but it is true that several dozen deputies has so much power that practically the entire system of holding hostage, just because they are on health reform seen as a painful and expensive move president Barack Hossein Obama, who wanted to include additional health system over 40 million new insured. Such coverage is required enormous expenditures and the Republicans wanted to save the money and to block the implementation of the necessary health care reform. However, the health reform law is constitutional and is recognized by the Supreme Court of the United States has become a key part of the policy of Barack Hossein Obama. Had he prevented by the Republicans, it would certainly cause a huge political uproar and health. In the end, when the reform is still carried out all efforts Republican makeup are the most ordinary fencing with the wind. A large number of representatives of the Republican Party requested the delay of "Obamacare", then a reduction in the jurisdiction of the Agency for environmental protection as members of the Democratic Party, refused, arguing for a "clean" decision relating only to the threshold of borrowing.

The Republicans did not miss the opportunity to remind the policy of more than thirty years that relate to Ronald Reagan who was at his first inauguration, said that the government is not the solution to our problem, government is the problem, "which they say practically began dismantling the concept of economic system that was created after the "Great Depression" of the thirties of the last century. She was supposed to replace the "invisible hand" of the free market, however, there was that productivity continued to grow, but the middle-class incomes stagnated or have even

decreased in real terms. Despite all the resistance to the US administration has continued its work and began the implementation of a key element of health care reform. Now a citizen of the United States got the opportunity to special markets buys health insurance policy, and for people with lower incomes the law provides for certain types of subsidies

Conclusion

In the world there is a great respect for the current leading political, military and economic power, and through the lens of curiosity, it is a challenge to seeking even the slightest weakness in any sphere of its national activities. Possible weaknesses should be used as an argument, that the pillars of belief that in the United States really all works seamlessly pretty shaken up and strive collapse. Therefore surprising that in the United States until the end of 2009, almost 50 millions people (or 16.7% of the population) were out of all forms of health insurance, and that total public health expenditure took a very high third position in the world. This was disclosed to the United States for health care annually allocate more funds per insured ($ 8,362 US), than any other country in the world. In particular, the high cost of the provision of direct medical services, with the use of pharmaceutical products in bulky administration. They are the cause of frequent bankruptcy of insurance companies and health insurance funds as well as increased number of uninsured citizens.

In the United States the situation is that some private companies on one side of any tax breaks for health insurance, or it can be purchased with additional tax relief and on the other, the majority of consumers in the individual market do not receives any benefits because premiums vary considerably depending on the diagnosis, diseases or of age. Today, Blue Cross Association (Blue Cross) and Blue Shield (Blue Shield) in combination, directly or indirectly provide health insurance to more than 100 million citizens of the United States. In its operation, and the insurance companies have become similar to commercial companies for health insurance. It is considered normal because the health insurance market has become the field of high concentrations of capital and competition, so that the leading insurers in 1990 and 2000, conducted over 400 fusion. On the eve of 2005, the company Wellpoint and United Health, had a membership whose insurance amount to approximately $ 67 millions and US together account for over 36% of the national market in the commercial health insurance.

Otherwise, in the United States the term health insurance is used to describe the program, which was enacted to help with the cost of health care. It is irrelevant whether it is a private or purchased insurance or social insurance or social program funded by the US federal government. In technical terms, this term is used to describe any form of health insurance that provides cover the costs of services / used health care

services. In addition, it explains the coverage of health care private health insurance and social insurance

programs, which provide coverage of medical expenses incurred due to disposal of old and vulnerable populations and people with severe forms of the disease (Medicare). It includes social programs that provide for covering the costs incurred or to be incurred as a result of care of people with low material base and the people who are not able to themselves and their family members provide health insurance (Medicaid).

Analysts, critical and those that are not, do not answer the question, why in spite of their population with such allocation for the health care of the long life span of only 42 in the world. If in fact the United States compared with other industrialized countries (Japan, France, Germany, United Kingdom), then you are far behind them, even as far behind countries that are less developed, for example, Chile, which occupies 35 or 37 a place Cuba. Residents of the United States of America can not conceive that the longest in the world lives in a small Andorra or Macau and that in them the life expectancy of the population long ago exceeded 83.5 years.

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