**The Societal Supportive System**

The paper will delve into the impacts of the consumption of health services, complex reimbursement system, demand for or access to care, and malpractice on the possible reform of the American Healthcare system. Increased use of health services has increased the Gross Domestic Product (GDP) of the nation. In the 1970s 7.1 percent of America’s GDP was allocated to health care. This value was 2.1 percent more compared to the weighted average spending of other countries. Since this year, the amount of the GDP used in healthcare has been increasing by 0.26 percent every year (Stoddart & Evans, 2017).

Higher income profoundly influences the high spending and consumption of health services in the United States of America; for instance, in the year 2009, the country experienced an increase of the share of income that the citizens devote to health consumption (Stoddart & Evans, 2017). For this reason, the United States of America has to use a higher proportion of the revenue it acquires on the provision and improvement of health services.

America consists of a healthcare reimbursement system that is complex. One of the most significant issues in this system is that the rules set forth to govern the healthcare reimbursement in the system change frequently. Sometimes the government payers may change every day. People who pay health insurance consist of a couple of healthcare reimbursement plans and carry with them contracts that are renegotiated occasionally.  The renegotiated contracts mean that the health insurance could offer a specific price for the services rendered within the health care system but alter the price for the services provided outside the given system.

Payers in the system have a maximum allowed payment for all the CPT (Current Procedural Terminology) codes which predicts the amount of money that they will pay. The Payer can then use claim edits to adjust the maximum allowed payments so that they can avoid payment of services that might not be useful to them. The claim edit, therefore, is one of the factors that affect payments in the healthcare system. For instance, the claim edit disqualifies payment allocated in the administration of a given vaccine when the health physician bills for it (Busch, 2012). The complexity of the system, therefore, make it hard for different practices to get an insight of the payer rules, adjust to the changes brought forth by such rules and keep up with the healthcare reimbursement world that is fast moving.

The demand for access to care continues to increase as the years elapse. In the contemporary world, approximately 400 million individuals lack access to essential health services (Stoddart & Evans, 2017). Most people also stand the risk of being pushed into extreme poverty as a result of the search for good health care access. Making sure that individuals can be able to gain proper access to the crucial health services required without being pushed further into poverty or financial hardship is core to improving the American healthcare system.

Health care access consists of four dimensions including geographical accessibility, affordability, availability, and acceptability. Several barriers that hinder access to these four dimensions of healthcare access do exist. For instance, geographical accessibility can be affected by obstacles such as the mode of transport. Affordability is affected by the cash flow within the country, a factor like stigmatization can impact acceptability, and lastly, availability is influenced by factors like education.

The malpractice system in the American healthcare has developed in the past four decades, and both the costs of the malpractice claims and the number of malpractice claims have been increasing between the 1960s all the way to the 1980s. However, in the 2000s there was evidence that the frequency of the malpractice claims had started to reduce (Ferrara, 2013).

The medical malpractice liability system in the United States of America consists of two objectives which are to provide proper compensation to the patients who might acquire any form of health harm resulting from the negligence of the healthcare givers and to discourage the healthcare providers from practicing negligently. The malpractice system is however expensive to manage and administer. It is also slow making it fail to achieve its objectives. Research conducted on the malpractice system shows that it comes up with incentives to take on cost-ineffective treatments because it fears legal liability.

Most healthcare providers have the malpractice insurance that is significant in covering the defense expenses of the claims and the process paid. The price of the malpractice insurance, however, defers significantly across different specialties and geographical regions. For instance, the premiums for the malpractice insurance in Suffolk County in New York for the specialist in obstetrics were 178,000 dollars, and that of the specialist in internal medicine was 33,000 dollars. However, the premiums of the same specialists in Colorado were about one-third of the costs in Suffolk County (Ferrara, 2013).

The state laws determine the malpractice claims in different geographical regions across the country. A successful claim consists of three crucial elements including a patient who must have gone through an adverse event, the healthcare giver must have been the reason behind the event, and lastly, the provider practiced negligently. The three elements are responsible for testing the validity of the malpractice claim, and together they are referred to as the negligence rule (Ferrara, 2013). Checking the validity of the malpractice claim enhances the quality of the American healthcare system.

Several measures and initiatives can be used to improve the entire health care system in the United States of America. For instance, new approaches to health financing can be embraced to increase healthcare accessibility and take care of the demand. Demand-side financing techniques like the voucher schemes can be used to subsidize the expenses in the health care system consequently improving the demand and access to care to reduce the chances of pushing people further into poverty.

Conducting and disseminating research is also crucial to understanding the impacts of the health consumption achieving enough evidence that can be used to provide health services that are of high quality. Methods like the PEER (Participatory Ethnographic Evaluation Research) can be used to get an insight of the needs and wants of the communities and also carry out pilots to examine the effects impacts of health consumption (Busch, 2012).

Raising awareness regarding malpractice systems, and reimbursements are crucial for the well-being of the people. Also, the society should be empowered to make decisions and prioritize actions based on participatory learning. Systems such as the cloud-based medical billing system can be adopted in many health facilities to help keep up with the complexity in the healthcare reimbursement world. Such a system is updated continuously and simultaneously which offers a considerable advantage in the reimbursement system. In summary, the application of the recommended approaches will help in the improvement of the health care system, reducing the chances of adverse effects on the health care system and increasing quality and sustainable care.

**Reference**

Busch, R. S. (2012). *Healthcare fraud: auditing and detection guide*. John Wiley & Sons.

Ferrara, S. D. (2013). Medical malpractice and legal medicine.

Stoddart, G. L., & Evans, R. G. (2017). Producing health, consuming health care. In *Why are some people healthy and others not?* (pp. 27-64). Routledge.