Uninsured in America: problems and possible solutions

Failure to ensure access to health care for all lies at the heart of the US failure to achieve value for money, says **Karen Davis**

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The United States is the only major industrialised nation without universal health insurance, and coverage has deteriorated in the past six years. The consequences are increasingly well known: inequities in access to care, avoidable mortality and poor quality care, financial burdens on people who are uninsured or underinsured, and lost economic productivity. The US spends twice as much on health care as the median industrialised nation but does not systematically achieve the best quality care (table). What are the prospects for reform?

Trends in uninsured and underinsured

The US has a mixed public-private system of health insurance. It comprises:

- Federal Medicare programme, covering people aged 65 and over and those who have been disabled for two years or more (12% of population)
- State Medicaid programmes—covering children from low income families and in some states their parents as well as providing long term care and cost sharing for acute care for Medicare beneficiaries with low incomes (13%)
- Voluntary employer based private insurance—covering many working families (54%)
- Individual insurance (5%).

The remaining 16% of the population is uninsured.[1] The number of uninsured people has increased from 40 million in 2000 to nearly 47 million in 2005.[2] Coverage varies widely between states and has deteriorated in recent years (figure).[3]

Nearly all of the growth in the uninsured is among people aged 18 to 64, most of whom are working. The average family premium for employer based cover is $11 480 (£5900; €8800) a year.[4] Employers have cut back on coverage and benefits in response to rising healthcare costs and adverse economic circumstances. Enactment of a state children's health insurance programme in 1997 has provided insurance for five million children from low income families, offsetting the fall in cover of dependants through voluntary employment based insurance.

Healthcare indicators for eight countries

	Australia	Canada	France	Germany	Japan	New Zealand	United Kingdom	United States
Health expenditures per capita ($)[w1]	2876	3165	3159	3005	2249	2083	2546	6102
Life expectancy at age 60*[w2]	18.2	17.7	18.4	17.5	19.6	17.1	16.9	16.6
Deaths amenable to medical care/100 000 population[w2]	88	92	75	106	81	109	130	115
Access problems (%)†[w3]	34	26	n/a	28	n/a	38	13	51
Breast cancer 5 year survival (%)[w1]	80.0	82.0	79.7	78.0	79.0	79.0	80.0	88.9
Myocardial infarction 30 day hospital mortality (%)[w1]	8.8	12.0	8.0	11.9	10.3	10.9	11.0	14.8
Deaths from surgical or medical mishaps/ 100 000 population (2004) *[w1]	0.4	0.5	0.5	0.6	0.2	n/a	0.5	0.7

*Average of male and female healthy life expectancies. †Percentage of adults with health problems who did not fill prescription or skipped doses, had a medical problem but did not visit doctor, or skipped test, treatment, or follow-up in the past year because of costs.

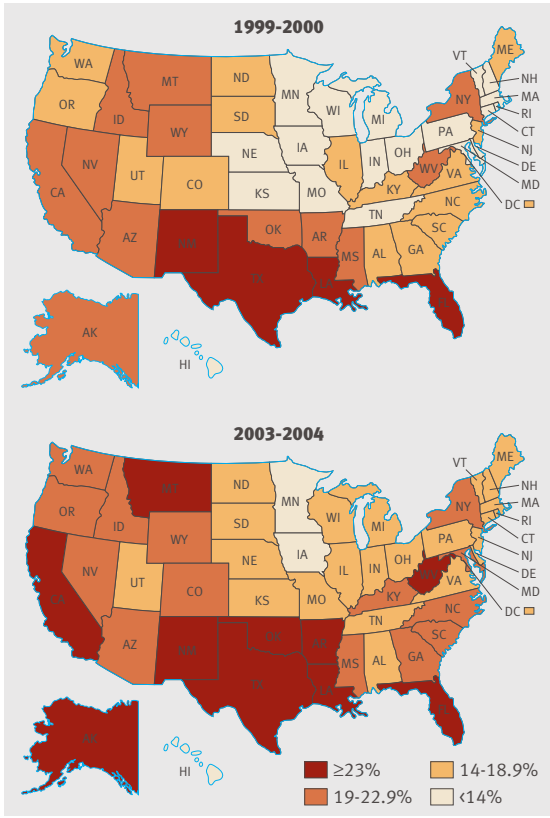
Access, quality, and equity implications

The hidden consequences of failure to ensure universal coverage in the US are well documented.[5] The Institute of Medicine estimates that 18 000 lives are lost annually as a consequence of gaps in coverage. It calculates the annual cost of achieving full coverage at $34bn- $69bn, which is less than the loss in economic productivity from existing coverage ($65bn-$130bn annually). Expanding coverage would disproportionately help people on low incomes, who make up two thirds of the uninsured, thus increasing equity in access to health care and health outcomes.[5]

In the US market based system, gaps in health cover contribute to underuse of effective services.[6] People who are uninsured or underinsured are more than twice as likely to report going without needed care because of costs.[7] When they do receive medical care, they often spend a high fraction of income on out of pocket medical expenses and face financial difficulties.[7] Uninsured people are often the only ones charged full price for health care; they do not benefit from discounts from providers negotiated by managed care plans, further raising access barriers and debt burdens for those who become sick.

What is less well known is that the uninsured are also less likely to receive high quality care and efficient care. Those who are uninsured are more likely to report poorer quality care, and chronic conditions are less likely to be properly managed.[8] Use of emergency rooms and inpatient hospital care is twice as high for those with chronic conditions who are uninsured as for those who are continuously insured (35% *v* 16%).[8]

Low income and uninsured people are less likely to have a regular source of care, and when they do



Percentage of people aged 18-64 without insurance by US state[3]

receive care it is less well coordinated.[9] For example, uninsured people are more likely to report receiving duplicate tests. Their medical records are less likely to be available when they seek care, and they are more at risk of receiving poor quality care, such as delays in notification of abnormal laboratory test results.

Prospects for action

Public and healthcare opinion leaders, including business, labour, and managed care executives, unsurprisingly put expanding health insurance coverage at the top of their healthcare priorities for the US President and Congress.[10 11] Despite this, there is little prospect that the federal government will legislate. This partly reflects the fact that uninsured people are less likely to vote and have no organised advocacy.

Another barrier is that Congress is deeply divided along political party lines, making bipartisan action difficult. Democrats favour comprehensive solutions expanding public programmes and employer based coverage whereas the President and many Republican leaders favour a market based solution, moving towards increased out of pocket payments to encourage consumers to be cost conscious and shop for cheaper health care.

The federal budget is in deficit, and tax revenues as a percentage of the gross domestic product are at their lowest point in 40 years as a result of deep tax cuts over the past six years. Funding universal coverage is likely to require tax increases. National reform of health care cannot be achieved unless the federal government makes health care a higher priority than tax cuts or other spending priorities.

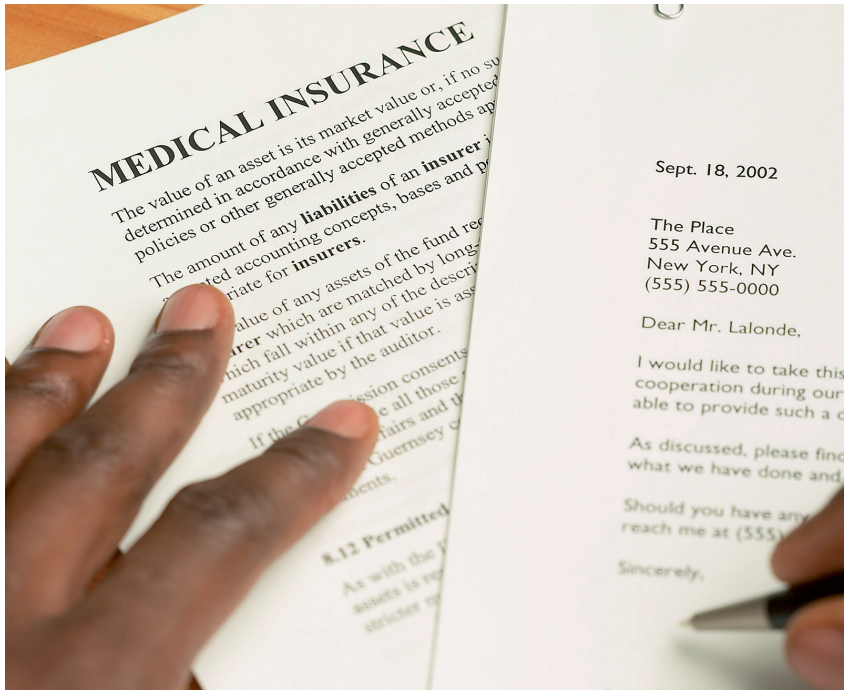
The US will have to tackle the perplexing problems of access, quality and cost

Another way of helping to fund expanded cover is to reinvest savings made through increased efficiency. One increasingly favoured strategy is to reform payment of providers so that it rewards efficiency as well as clinical quality and patient centred care.[12] Although the evidence supporting pay for performance is limited, it would begin to align financial incentives for providers with the desired results. If designed appropriately, it would move away from fee for service to population based or episode based payment.

State initiatives

Some encouraging signs are coming from selected states. A mixed strategy for covering different groups of uninsured people is beginning to emerge. This includes expanding existing state programmes to cover low income adults as well as children; creating an insurance pool for small businesses and the self employed, with premiums subsidised to make cover affordable for workers on low wages; and requiring employers to either provide cover for employees or contribute to a fund to finance cover for working people.

In April 2006, Massachusetts enacted a plan to make cover affordable for all uninsured residents. It adopted the principle of shared financial responsibility, mandating that everyone must purchase health insurance and requiring employers to provide health benefits to workers or pay an admittedly modest $295 a year into a fund to help finance cover. State and federal funds are used to subsidise care for the poor; the Medicaid programme was expanded to cover children from families with an income up to three times the federal poverty threshold. The plan also created an insurance pool for small businesses and individuals. The big question is whether



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Uninsured people are less likely to receive efficient care

Suggested government actions to achieve universal health cover

Federal

Legislate to match state funding for cover of adults on incomes up to 1.5 times the federal poverty threshold

Allow small businesses and uninsured people to purchase cover through the Federal Employees Health Benefits programme

Require all businesses to either provide health benefits to all employees or contribute $1/hour of work towards cover under public programmes and require everyone to purchase cover

Extend Medicare programme to uninsured adults aged 55 to 64 and eliminate two year wait before disabled people are eligible

Revise Medicare's payment system to reward higher quality and greater efficiency, with savings used to expand coverage

Dedicate tax of 1% of income to financing expanded cover and use existing subsidies for low income charity care to finance expansion

States

Revise the children's health insurance programme to include adults on incomes up to 1.5 times the federal poverty threshold and children up to 3 times the threshold

Revise Medicaid's payment system to reward higher quality and greater efficiency, with savings used to expand cover

states will adequately fund cover in the long term without a commitment of substantial federal revenues.

The Massachusetts experience has triggered interest in other states. California's Governor, Arnold Schwarzenegger, has proposed universal cover including a requirement that everyone obtain cover with premium subsidies provided by the state government for people on low incomes and a requirement that employers either provide health insurance or pay a fee equal to 4% of employee earnings. Vermont has established governmental subsidies for uninsured people on low incomes to purchase private health plans and requires employers to contribute $365 for each fulltime uninsured employee.

Maine implemented a similar plan to that in Massachusetts in January 2005. It established an insurance pool for small businesses, with employers required to contribute 60% of each worker's premium, and the state's Medicaid programme was expanded to cover all poor adults. The plan has had a slow start, partly because participation by employers is voluntary and partly because only one private insurer has agreed to participate and premiums are high. Earlier schemes in Minnesota and Rhode Island that provide insurance to lower wage families have been shown to improve health outcomes.

SUMMARY POINTS

The number of people without health insurance is growing in the US

Gaps in coverage produce inequities in access to care, avoidable mortality and poor quality care, and lost economic productivity

Several states have enacted innovative programmes to provide cover for the uninsured

Federal legislation is needed to make insurance affordable and mandatory for all

Key to success

Although these efforts are encouraging, most are taking place in states with relatively small uninsured populations. The plans all draw on federal funding through matching contributions under the state Medicaid programme and, in the case of Massachusetts, a waiver that provides additional federal funding. It will be difficult for states with much higher proportions of uninsured people to follow without specific federal funding to help cover the cost, but it will be interesting to follow the recent expansion proposal in California with this state's relatively larger population and higher uninsured rate.

Recognising the need for federal financing and leadership (box), bipartisan bills have emerged in Congress that would provide federal funding for state expansion efforts. These proposals build on the Aaron-Butler proposal to test various strategies for achieving universal coverage in different states.[13] Although these bills have not yet gained momentum, they are probably the most realistic possibility of success given that Congress is narrowly divided.

What is clear is that the problem is getting worse, not diminishing. The fragmented, uncoordinated healthcare system is plagued by high administrative costs and missed opportunities to control chronic conditions and prevent life threatening conditions. If the US hopes to achieve a high performance health system that is value for money, it will have to tackle the perplexing problems of access, quality, and cost and overcome considerable political and economic obstacles, as well as institutional resistance to change.

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