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## US health care. I: The access problem

Jennifer Dixon

*The crisis in health care is looming large in the presidential campaign in the United States, which is now approaching its climax. This is the first of three articles analysing the profound problems and proposed solutions*

The "issue from hell" and the "lose-lose issue" are how health care in the United States has been described over the past year. After two decades of crisis the American health system represents a policy problem which, despite much impressive analysis, refuses to be solved. The twin problems of increasing costs and decreasing access have prompted a myriad of proposals for health care reform to which President Bush recently added his own. But its staying power as a domestic problem reflects the fact that reform of American health care is a complex political issue, not simply a technical one. This year's presidential election provides an opportunity for politicians to come up with a reform strategy which offers more than the "look concerned but do nothing" policy of the current administration.

This series of three articles examines why reform is necessary and what form it should take. Part I examines access to health care and changes over recent years. Part II considers the costs of American health care and the impact of key cost containment strategies. Part III looks at the proposals on offer and the likely course of health care reform.

### Access

It is a stark fact that access to health care in the United States is rationed by ability to pay. In 1990, although 83% of all non-elderly Americans (those under 65) were covered by some form of health insurance, some 16.6%—that is, 35.7 million people—had none at all (see table I).<sup>1</sup> Though uninsured people face the most difficulty obtaining care, access is a growing problem for all Americans. This paper examines why access is such a concern for three groups—namely, people without health insurance, those with public insurance through the Medicare and Medicaid programmes, and those covered by private health insurance. The paper also examines federal initiatives to expand access.

### Uninsured people

Without insurance to cushion the costs of care uninsured people face steep bills for health services. As

TABLE I—Non-elderly and elderly Americans with selected sources of health insurance coverage in 1990

Source of coverage	Non-elderly No (millions) (%)	Elderly No (millions) (%)
Total population	215.9 (100)	30.1 (100)
Total with private health insurance	158.3 (73)	20.6 (68)
Employer coverage	138.7 (64)	10.0 (33)
Other private coverage	19.7 (9)	10.6 (35)
Total with public health insurance	29.2 (14)	28.9 (96)
Medicare	3.5 (2)	28.8 (96)
Medicaid	21.6 (10)	2.6 (9)
CHAMPUS/CHAMPVA*	5.9 (3)	1.1 (4)
No health insurance	35.7 (17)	0.3 (1)

Source: Employee Benefit Research Institute.<sup>1</sup>

Figures may not add to totals because individuals may receive coverage from more than one source.

\*Includes Civilian Health and Medical Program for the Uniformed Services and Civilian Health and Medical Program for the Department of Veterans' Affairs.

a result they delay or avoid seeking care<sup>2</sup> and tend to use a patchy network of health services that are free or cheap—mainly hospital emergency rooms, outpatient clinics, and publicly funded health centres. However, in recent years hospital emergency rooms have become more crowded<sup>3</sup> and public health centres have become scarcer,<sup>4,5</sup> as have the primary care physicians to work in them.<sup>6</sup> Since hospitals and physicians must foot the bill when uninsured people can't or won't pay for their health care, providers have taken steps to reduce their financial risk. Some hospitals have cut back on services uninsured patients use the most (such as emergency room, outpatient, and obstetric care) or relocated out of neighbourhoods where they tend to seek care.<sup>7</sup> Outside hospitals private physicians can and do refuse to treat uninsured people rather than risk picking up the bill. The lack of access to even basic preventive care has contributed to the current epidemic of preventable childhood infectious disease<sup>8</sup> and the high infant mortality that persists in the United States.<sup>9</sup>

Not surprisingly, Americans with no health insurance use fewer health services than Americans who have insurance. Studies show that uninsured people receive less ambulatory and inpatient care,<sup>10,11</sup> and utilisation differences persist even after adjusting for race, geographic location, and health status.<sup>12</sup> Once

**Health Services  
Research Unit, London  
School of Hygiene and  
Tropical Medicine,  
London WC1E 7HT**  
Jennifer Dixon, *honorary  
lecturer in public health  
medicine*

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in hospital uninsured patients are treated differently<sup>13</sup> and inpatient mortality has been shown to be greater.<sup>14</sup>

As access to care decreases, the number of uninsured people increases. In 1988, 33.6 million Americans (15.9% of the non-elderly population) were uninsured compared with 34.4 million (16.1%) in 1989 and 35.7 million (16.6%) in 1990 (table I).<sup>1</sup> In addition to the 16.6% of non-elderly Americans who were uninsured during all of 1990, roughly a quarter of the rest would have been uninsured for shorter periods<sup>15</sup> and still more would have been underinsured.

Annual surveys such as the current population survey paint a consistent picture of uninsured people.<sup>1</sup> In 1990 more than half were working, mostly in small businesses and in industries such as agriculture, construction, and retailing (table II). Two thirds are in households where the income is greater than a federally defined poverty level (almost \$14 000 for a family of four in 1992), and as a consequence they are not poor enough to qualify for Medicaid (the publicly financed programme for the poor). Lack of insurance is more prevalent among Hispanic and black people, among men, in the southern states, and in rural areas. In 1990 almost one third of uninsured people were aged between 18 and 24 and 15% were under 18.<sup>1</sup>

Concern is rising not only because uninsured people are more numerous but because a growing proportion are working middle class Americans whose employers no longer offer insurance. Uninsured people are now a significant economic problem<sup>16</sup> as well as a moral and political one. As the editor of *JAMA* recently observed, "a long term crying need has developed into a national moral imperative and now into a pragmatic necessity as well."<sup>17</sup>

#### Medicaid and access

Around 14% of non-elderly Americans have some form of publicly funded health insurance.<sup>1</sup> In most cases this is Medicaid, which is a health programme for the poor. Medicaid covers poor families with dependent children and long term nursing home care to low income elderly and disabled people. States can set their own eligibility rules for Medicaid and therefore control the number of people who are enrolled. In the early 1980s these rules became tougher.<sup>18</sup> As a result poor families had to be poorer to qualify, and many of those disqualified added to the ranks of the uninsured.<sup>19</sup>

Concerned by the number of uninsured children, in the late 1980s congress passed laws which extended Medicaid to cover more uninsured pregnant women and children. These laws act incrementally and aim to provide Medicaid cover to everyone in poverty aged 18 and under by just after the turn of the century. Congress also granted transitional Medicaid cover for the unemployed who start a new job. Partly due to the expansions the number of people enrolled with Medicaid jumped from 18.5 million in 1989 to 21.6 million in 1990,<sup>1</sup> but this increase was not large enough to reduce the rise in the number of uninsured people.

Once on Medicaid, individuals are entitled to a range of health care benefits. Federal laws spell out which services are available to recipients that states cannot skimp on without federal approval. Benefits are generous and include inpatient, outpatient, and physicians' services—prompting facetious reference to the Medicaid card as the "gold card" to accessing care. However, the states set the reimbursement rates payable to providers for services to Medicaid recipients. These rates are usually much lower than the rates offered by private insurers and other public programmes such as Medicare. For example, the Medicaid reimbursement rate for a total hysterectomy in New York state was \$240 in 1989 whereas the Medicare rate was \$1448.<sup>20</sup> Unsurprisingly, this has led to low

provider participation in Medicaid in most states<sup>21</sup> and decreased the quality of care available.<sup>22</sup> Signs in private physicians' offices saying "No Medicaid here" are not uncommon, and Medicaid patients often end up using a similar uncoordinated array of providers as uninsured people.

Nevertheless, Medicaid has gone some way to achieving one of its initial purposes—to increase the access of poor people to medical care. Medicaid services are free to recipients, who use health services at a similar or greater rate to those who are not poor, even after adjusting for health status.<sup>12</sup> If the other initial purpose of Medicaid—to provide medical care in the mainstream of American medicine<sup>23</sup>—has not been realised recent legislation encouraging states to enrol Medicaid recipients into health maintenance organisations may improve this.

#### Medicare and access

Virtually all elderly (age over 65) Americans have some form of public or private health insurance (table I). Some 96%<sup>1</sup> are covered by Medicare, which is available to elderly people regardless of income or wealth. Apart from age, eligibility for Medicare is linked to the level of social insurance payments made during a person's working lifetime, and only a minority of elderly people do not qualify. Most of these are covered by other public or private insurance, but 1% of elderly people remain uninsured.<sup>1</sup> Medicare also covers a small proportion of non-elderly disabled people. The Medicare programme is administered and financed by federal government, which determines eligibility, the reimbursement rates paid to providers, and the benefits that are offered. Compared with Medicaid, Medicare funding was protected during the 1980s.<sup>24</sup> As a result the numbers enrolled increased and stood at almost 30 million in 1990.

Medicare is as near as the United States gets to a universal comprehensive programme for any section of the population. Like Medicaid, Medicare offers a wide range of benefits, including inpatient, outpatient, and physicians' services. But, unlike Medicaid recipients or uninsured people, the elderly on Medicare enjoy greater access to care. Providers are more willing to offer services to Medicare beneficiaries, partly because the large size of the elderly population means significant income for providers and partly because Medicare reimbursement rates are more generous than Medicaid.

But there remain important access problems. This is because Medicare does not provide free care: elderly people must contribute towards the costs of the services they use. Out of pocket payments are required for care inside and outside hospital and can be steep. Medicare reimbursement rates for physicians' services are often less than the bill charged by physicians, leaving elderly patients to pay the difference. Also Medicare does not cover some essential services at all—most notably, long term care and prescription drugs—for which the elderly must pay. To plug the gaps left by Medicare two thirds of the elderly population take out private insurance—so called "medigap" insurance. Despite this, elderly people with low incomes use fewer of the services where they are liable to pay more, such as physicians' services or nursing home care.<sup>25</sup> Since roughly a quarter of elderly people are poor or near to being poor and the costs of care are rising, the differences in use of health services between low income and high income elderly people who depend on Medicare will merit scrutiny in future.

Congress has tried to improve access to care for the elderly. In 1988 the Medicare Catastrophic Coverage Act was passed, which lowered the payments elderly people had to make for hospital care, added cover for

TABLE II—Proportion of people uninsured among workers aged 18-64 by industry group 1990

	%
Total	16
Self employed	22
Government	7
Agriculture	39
Construction	31
Retail trade	24
Services	17
Other industries*	11

Source: Employee Benefit Research Institute.<sup>1</sup>

\*Include mining, transportation, communications, utilities, finance, real estate, manufacturing, and wholesale trade.



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Businesses that can no longer afford health insurance are responsible for rising numbers of uninsured workers

prescription drugs, and made it easier to obtain nursing home and hospice care. However, the law required that the increased access would be financed by the elderly themselves through an extra tax on income. Many elderly groups lobbied hard against the extra tax and the law was eventually repealed.

#### Privately insured groups

Almost three quarters of all Americans have some form of private health insurance cover mostly obtained through their workplace or the workplace of a family member. Though businesses foot most of the insurance bill, employees contribute to the cost of the premium and are liable for out of pocket payments for the health services they use. But as costs have risen, the employer based system of health insurance is under strain. More and more businesses (particularly small businesses) do not offer health insurance due to cost,<sup>26</sup> a policy which is the main reason for the rising numbers of uninsured people. Consequently, between 1980 and 1988, though the number of Americans in employment grew by 15 million, the number covered by private insurance fell by 5 million.<sup>27</sup> Faced with rapidly rising premium costs, other employers have tried to limit optional health benefits to workers and their dependants<sup>28</sup> and require employees to pay more. Some businesses are bypassing third party insurance altogether and deciding for themselves which benefits they will offer employees. For example, Rockwell—a multinational corporation providing health benefits to 350 000 Americans—decided to eliminate coverage of in vitro fertilisation services for economic reasons.<sup>29</sup>

To keep costs down other employers offer health insurance policies which exclude cover for pre-existing medical conditions such as diabetes and cancer.<sup>30</sup> Increasingly this means that employees are reluctant to change employers for fear that treatment of a chronic illness will not be covered in the insurance policy offered with a new job. Such employees are effectively locked into their existing employment, a situation which has reached Hollywood executives and molecular biologists<sup>31</sup> as well as blue collar workers. A contributing factor to "joblock" has been the fear of requiring costly health care during the initial period of new employment (usually one month) before the new insurance policy begins. Interlinked is the widespread problem of

underinsurance, particularly for care of chronic diseases and catastrophic and long term care.<sup>32</sup> Generous media coverage of middle class Americans who have been almost bankrupted by health care costs due to gaps in coverage has fuelled the pervasive anxiety about access.

#### Conclusion

The United States health care system leaves over 36 million Americans out in the cold. While the number of people without health insurance rises, the capacity and willingness of the health system to absorb their needs are decreasing. Federal action has concentrated on expanding Medicaid benefits to more of the poor groups. But access is also an increasing concern among middle class groups, who traditionally were well served by the existing system. Access to care is falling because the costs of care are rising.

In next week's issue we shall examine the cost problem and its effect on access.

Much of this study was carried out in the United States in 1990-1 while I was in tenure of a Harkness fellowship.

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