What Is Wrong with the U.S. Health Care System?: It Does Not Effectively Exist for One of Every Five Americans

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ROBERT EVANS AND NORALOU ROOS OFFER EVIDENCE to support the general and specific contentions that the Canadian health care system is among the world's most successful, surpassing even the system that exists in the United States. They succinctly debunk the pervasive mythology of an inefficient and ineffective Canadian system that cannot compare with the "bigger and better" American one. First, by expanding on the central issue of the prevalent lack of health insurance among Americans, and second, by describing in more detail the research on one exemplary outcome of the Canadian system with which my colleagues and I are familiar, cancer survival (Gorey, Holowaty, Fehringer, et al. 1997; Gorey, Holowaty, Laukkanen, et al. 1998a; 1998b), I hope to complement their thoughts on the related matters of what is right with the health care system in Canada and what is wrong with the U.S. system.

Insurance Matters

Evans and Roos noted that a staggering number of Americans have no health insurance; the uninsured are a prevalent risk group that currently approaches 15 percent of the U.S. population. This barrier to health care

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access is well known; however, the problem of effective health care access is really far more complex. The U.S. system is arguably the world's most multi-tiered, as it includes both the chronically and periodically uninsured and those covered by a number of categorical health insurance programs: Medicaid for the means-tested poor; Medicare for older people, who may or may not supplement its coverage with various so-called Medigap insurance packages; and a diverse offering of private fee-for-service or HMO insurance plans. Moreover, this minimally 10-tiered health care system is further complicated by its interactions with place; that is, each categorical program does not, in practice, operate the same across regions or locales. For example, areas with ample health care service endowments, including public and teaching hospitals, may better serve the poor than less resourceful areas can. Although this patchwork of health care programs serves millions of Americans well, it does not effectively serve millions of others. Indicative of its injustice, the U.S. health care system's beneficiaries are not randomly distributed. Health insurance status, particularly the lack of any insurance or the experience of being insufficiently insured, is closely linked with other indicators of one's life chances. For example, people of color, the uneducated, and the poor are two to four times more likely to experience such barriers to effective health care (Blendon, Aiken, Freeman, et al. 1989; Seccombe and Amey 1995). Most will agree that race and class matter in the United States (Wilson 1987; West 1993); they are intimately related to a diverse array of health statuses and outcomes experienced from the cradle to the grave. Similarly, the type of health insurance one has also matters.

America's patchwork of private and public health insurance is often inferred to be an effective blanket coverage. However, millions of Americans covered by each of the major private and public insurance programs, even by Medicaid or Medicare, have trouble paying their medical bills; what may be deemed necessary care is never wholly covered (Blendon, Donelan, Hill, et al. 1994). Contrary to rational and humanistic ideologies, the greatest difficulties encountered by Americans with health insurance tend to arise when such coverage is needed most: when a serious or catastrophic health problem is experienced. At such times, typically, one of every twelve Americans finds themselves underinsured and facing the prospect of paying out-of-pocket expenses in excess of 10 percent of their incomes. In conjunction with the oft-cited estimate that one of every seven Americans is uninsured, one of every five Americans may be defined as inadequately insured, that is, uninsured or

underinsured, and therefore effectively barred from being a full beneficiary of the American health care system (Bodenheimer 1992; Donelan, Blendon, Benson, et al. 1996; *Morbidity and Mortality Weekly Report* 1998). Again, certain groups of Americans are at even greater risk of being inadequately covered. For example, nearly one of every three African Americans, Hispanics, or people between the ages of 55 and 64 does not have adequate health insurance (Short and Banthin 1995), the type of health insurance one would need, for example, to be an effective consumer of the best available cancer care.

Cancer Care

Cancer, a prevalent health outcome over the life course, can be thought of as a constellation of interrelated diseases, each with unique sets of component causes. Many relatively common types of cancer have good survival prognoses. Moreover, a diverse array of screening and clinical investigation tools, as well as increasingly effective surgical, radiographic, chemotherapeutic, and other treatments exist for most common cancer types. For these reasons, I believe that cancer care is a sentinel indicator of a health care system's quality.

In the United States, health insurance status is highly associated with cancer-screening participation and the stage of disease at the time of diagnosis (Ayanian, Kohler, Abe, et al. 1993; Catalano and Satariano 1998; Lannin, Mathews, Mitchell, et al. 1998; Parker, Gebretsadik, Sabogal, et al. 1998; Potosky, Breen, Graubard, et al. 1998; Eisen, Waterman, Skinner, et al. 1999; Lewis and Asch 1999), and also with access to the best available treatments (Greenberg, Chute, Stukel, et al. 1988; Hadley, Steinberg, and Feder 1991; Mitchell, Meehan, Kong, et al. 1997; McKinlay, Burns, Durante, et al. 1997; Bennett, Stinson, Yang, et al. 1999). Rate ratios generally range from 1.50 to 2.50, basically indicative of twofold greater access among those with more generous insurance payers. Getting early access to the best care is, not surprisingly, very highly related to one of this field's key outcomes: the length of time one lives after being diagnosed with cancer. Fortunate, generally well-insured people who are diagnosed while their cancer is still localized and have the full gamut of cancer therapies available to them are two to ten times more likely to survive than their less fortunate counterparts (median rate ratio is approximately 5.00) (Goodwin, Samet, and Hunt

1996; Franzini, Williams, Franklin, et al. 1997; Kallakury, Sheehan, Ambros, et al. 1997; Lyman, Kuderer, Lyman, et al. 1997; Merrill, Henson, and Ries 1998; Preston, Bauer, Connelly, et al. 1999). In the realm of public health and social epidemiology, these effects are huge. Meta-analyses of these mathematical models suggest that 20 percent of American cancer survival variability can be accounted for by divergent uninsured and underinsured statuses.

My own international health services research with colleagues, ranging from published studies (see Gorey et al. 1997; 1998a; 1998b) and articles under review to work in preparation, has revealed consistent Canadian cancer survival advantages, implicating the more egalitarian access to preventive, investigative, and therapeutic services available in the single-payer Canadian health care system, compared with the insurance-driven, multipayer system that prevails in the United States. Originally, residents of relatively poor neighborhoods in Toronto, Ontario, were observed to survive cancer for longer periods than people of similar economic status in Detroit, Michigan. These differences were consistently large (20 percent to 50 percent differentials for the most common cancers that often have a good prognosis: breast, prostate, and colon) across most common types of cancer, and they have since been replicated in U.S. metropolitan areas with more socioeconomic resources (Hartford, Connecticut; Honolulu, Hawaii; San Francisco, California; and Seattle, Washington), as well as in smaller cities (Winnipeg, Manitoba, and Des Moines, Iowa). In another finding that is also consistent with the health insurance hypothesis, Canadian cancer survival advantages tend to be larger among younger cohorts not yet eligible for Medicare coverage in the United States. Finally, when socioeconomic deciles were explored, neighborhoods that could be categorically defined as working class or lower middle class demonstrated similar Canadian survival advantages. Such neighborhoods tend to include significant enclaves of the near poor, the working poor, and better-off working people who, for a number of social structural and economic reasons, remain uninsured or underinsured. All our work thus far suggests that approximately a million years of life are needlessly lost to cancer each year in the United States, and that one significant probable cause of this human and social waste is America's extremely inequitable distribution of health care resources.

Although conventional wisdom contends that the best health care in the world is available in the United States, research evidence, specifically

that related to cancer care, suggests this may indeed be the case—with one big caveat: if you can pay for it. The problem is that one of every five Americans cannot afford to purchase needed services from providers operating in a health care system that is arguably, once effectively accessed, among the world's best. Such a shamefully inequitable system ought not to be emulated elsewhere.

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