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The Health Insurance Crisis

by

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Introduction

Although health insurance gained popularity less than 50 years ago, the spiraling costs of obtaining the present standard of medical care in this country have made insurance a necessity if overwhelming debt in the event of illness is to be avoided. Such debt can indeed be enormous, given the large and increasing costs of hospitalization, physicians' fees and prescribed treatments. Despite the specter of these costs, the number of uninsured people in America has increased 40% since 1980 [1 - 3]. According to the U.S. Census Bureau, thirty-seven million Americans, or 17% of those under 65, have no insurance of any kind. Although this is a heterogeneous group, the majority are less than 24 years old. Two-thirds are working adults and their dependents, and one-third are children. While most are poor, a sizeable percentage belong to the middle and even upper classes. This development has resulted in avoidance of needed medical care, tremendous financial losses to hospitals forced to absorb increasing charitable obligations and lower quality of care received by poor Americans. The problem has reached such proportions that in many circles it is being described as a "crisis."

This Bulletin will provide a brief history of the problem of health care financing in the United States, describe the present extent of the problem with specific attention to the Rochester area and review a number of proposed solutions, including the Canadian system of health care financing.

An Historical Perspective of Health Care Financing

Early in this century, provisions for welfare in America were left entirely to states and localities. There were wide regional variations in how the poor were supported, dependent on such factors as wealth and attitudes held about the lower socioeconomic classes. Some viewed the poor as "parasites to be deplored, suffering from social disease and degeneracy" [4]. Others viewed them simply as unfortunates, handicapped by age, sickness or tragedy.

Even into the 1900s, assistance to the poor often took the form of workhouses or poor farms. This type of relief dated back to colonial times and had roots in the Elizabethan Poor Law of England. The thinking underlying this form of assistance was that minimal help should be provided to those in straitened circumstances lest they should corrupt both themselves and, ultimately, other members of society. More progressive states supported public or private "charitable" hospitals or homes to lodge and care for the poor. Most communities also made some use of cash handouts.

Over time, social opinion recognized identifiable groups of persons who could not be labelled social deviates or paupers by choice, and a number of special assistance programs slowly grew up during the early 20th century geared to provide help to "deserving" people: impoverished old people, underfed children and other handicapped and unemployable individuals who couldn't be blamed for their condition nor envied for being recipients of relief.

However, by 1933, with the country in an economic depression, the proportion of the population receiving welfare relief in some states reached 40%. Existing programs broke down under the burden, and the federal government stepped in to assume some responsibility. The federal legislation empowering the bulk of this social welfare intervention was passed in 1935 as the Social Security Act. The general purpose of this Act was to provide for those made dependent through no fault of their own, and more generally, to eliminate destitution as a factor that could lead to social unrest and disturbances in the general economic system. There was hope that with social security for the "deserving" poor and unemployment insurance for others, public assistance would never be needed again and poverty would disappear.

The social safeguards such as unemployment insurance and workmen's compensation gained state and federal support and became mandatory in the workplace but, unlike in Europe, health insurance never caught on in this country as a government-sponsored benefit. At first the American Medical Association (AMA) supported compulsory health insurance, noting in a 1916 report that the new British system had "unquestionably improved the condition of the working classes which have come under the law" [5]. However, since it was independent of the working situation, it was less appealing than workmen's compensation to worker and employer alike. Employers wanted to hold down costs, and workers were wary of payroll deductions for services they might not need. Private medical practitioners began to express opposition to a system that would inevitably lead to some controls over the way they practiced medicine, if only in the form of additional paperwork and some supervision of fees. During World War II, health insurance got labeled as "German" and hence un-American. Furthermore, after 1920 the AMA developed a powerful lobby against health insurance that still stands strong today. Thus when the Social Security Act passed, health insurance was not part of the package. Federal interests

in medical care remained limited to support of the armed forces and containment of public epidemics. States and localities filled the void of health care for the poor with public hospitals or by partially supporting care provided by private hospitals on a charitable basis. It was a piecemeal, patchwork system of providing medical care for the poor , but it has continued to this day.

For the working population, private health insurance schemes grew to fill the void caused by the failure to implement public insurance or offer a viable alternative. These policies offered a chance to spread the risk of large medical bills among the population. Hospitals actually provided the initiative for policies to cover the cost of hospitalization. They provided much of the support for the Blue Cross policies that were created in the midst of the depression, when hospitals had no assured source of revenues. As the influence of modern medicine grew, so did the cost of health care, and the popularity of health insurance increased. Employers could subsidize the cost of policies to attract employees and write off the expense as a tax deduction. The number of individuals covered by such policies grew dramatically after World War II. This tax deduction, however, represents a loss of federal revenues that in 1982 equalled $28 billion [6].

For the poor, the government passed stop-gap measures such as the Hill-Burton Act of 1946, which provided construction funds for hospitals and other related facilities in return for care to those unable to pay. Cost-sharing grants to the states became another means for the federal government to assist providers of health care to the poor. Social Security Act amendments in 1960 and 1965 legislated federal grants to subsidize states which provided direct payments to providers of medical care to the needy. The Medicaid program, which began in 1965, aimed to provide medical care to families with dependent children, the aged and the handicapped who met certain income criteria. Additionally, states had the option of providing medical care to any individual who was eligible for the state's welfare program or lacked the resources to pay for needed medical care. Along with the Medicaid legislation passed Medicare, the first program of compulsory health insurance ever established, created for individuals on Social Security. However, in neither program was there explicit recognition of access to affordable health services as a basic American right. Both programs were vulnerable to later cutbacks in entitlements, funding and eligibility. When problems began with administrative complexity, financial concerns and even charges of fraud, reordering took place which is still in place today.

The Present Problem of the Uninsured

The reasons for the dramatic rise in the number of uninsured in recent decades are found in changes in the workplace, government and society at large [7]. Our country has seen a rapid

growth in the types of businesses that can least afford insurance: small businesses and retail and service industries which pay low wages. Smaller businesses find it more difficult to deduct health insurance premiums. Part-time workers, now more common, are generally not covered by health insurance policies, and erosion of the power of unions in the workplace has meant cutbacks in employee benefits like health insurance.

Under President Ronald Reagan, the federal government's reductions in Medicaid spending was achieved at a cost of lost eligibility for many poor Americans. Fewer than 50% of those with incomes less than federal poverty standards are now eligible for Medicaid. While federal spending for Medicaid was $23 billion (in addition to $19 billion in state money) last year, nearly 50% of these funds went to only 5% of the recipients. These were primarily facilities offering long-term institutional care, such as nursing homes. Children, who comprised 40% of Medicaid recipients, received only 18% of payments. In addition, vast differences between state Medicaid programs exist. For example, while $1600 was spent last year on an average Medicaid recipient in New York State, his counterpart in Mississippi received only $100. Overall, most payouts went for institutional care and hospital services with little appropriated for ambulatory services such as preventive care.

Competition among health insurance companies to provide the lowest cost premiums has led to a switch across the country from "community rating" to "experience rating" to set premiums. That is, client companies will pay a premium to cover their employees that reflects the cost per health care incurred by their employees rather than by the residents of the community as a whole. While this usually means a reduction in premiums for large companies, smaller companies' premiums often rise. If individuals purchase insurance on their own, they are faced with high and ever-increasing policy costs. Thus little insurance is purchased outside of the workplace.

Hospitals are also being impacted by these changes. Because businesses and insurance companies are no longer tolerating the practice of recovering the cost of providing charitable care by charging higher hospital rates, hospitals are cutting back on service to the poor to avoid ever-increasing bad debt and costs of charitable care.

Rochester has long enjoyed a "community rating" which makes health insurance affordable to many people [8], and thus has fared remarkably well under these pressures [9]. Approximately 10% of this area's residents are uninsured, fewer than any other metropolitan area in New York State and among the lowest rates in the country. We owe our favorable standing to a combination of factors that includes a low level of unemployment, a preponderance of large, well-established companies which offer health insurance as an employment benefit, the "community rating" of insurance premiums offered by insurance companies and a relatively

good State Medicaid program. However, Medicaid cutbacks, pressure from area companies to change to "experience rating" by insurance companies and the ever present threat of loss of large company-based employment are potential clouds on Rochester's health insurance horizon.

Some of the consequences of doing without health insurance have been studied. For example, in a Massachusetts study of individuals cut off of Medicaid, 61% did without care entirely while only 27% were able to continue to receive care as charity. Of those needing emergency care, 72% were treated, 20% sought but were denied care, and 8% did not seek care. Other studies indicate that uninsured people are less likely to have their children vaccinated and to seek needed psychiatric care. It is evident that those excluded from Medicaid and private insurance receive less medical care. While Medicaid and Medicare have been associated with a myriad of problems, there has been a clear rise in life expectancy since they were initiated in 1965 [10]. There had been little change in longevity in the years immediately prior to this legislation. By 1980, age-adjusted death rates had decreased by 20% and black infant death rates had dropped 45% in 13 years. Moreover, it has been estimated that for every dollar spent for prenatal care, over three dollars in expenditures for neonatal treatment are saved. In the past 20 years, there has been a striking reduction in the rates of death from disease where medical care can be lifesaving, such as in childbirth, pulmonary infections and diabetes mellitus. In addition, many studies have demonstrated the efficacy of psychiatric care, including a 1983 report showing that when one member of a family received psychotherapy, the entire family's use of all types of in-patient services declined over 22% [11].

Thus, health insurance facilitates access to medical care that is clearly efficacious. However, skyrocketing costs of health care in this country have led to efforts at containment, and the consequence has been diminished access. It is indeed paradoxical that the U.S. spends $500 billion per year on health care — nearly 11% of its gross national product, and more than any other country in the world — yet our health is far from the best. Americans still lag well behind other industrialized countries in many indices of health, such as longevity and neonatal mortality [12].

Proposals for Increasing Access to Health Care

According to a recent Gallup poll, Americans feel strongly about health care for the poor. Three of five Americans believe that government should pay for the poor's health care, and seven of ten Americans would be willing to pay higher taxes to fund such care. Such broad support in concert with challenges to the present system from academic, medical and

government circles have generated much controversy and a number of proposals for change [13,14].

Proposals to change the present system identify the workplace, providers of care and government policies as targets for reform. Some believe that the present system is completely unworkable and must be dismantled, since patchwork reforms have proven to be failures in the past. Most proposals would require new regulations on the health care "marketplace," thus arousing antipathy from the medical profession. Examples are the following:

- Employers might be obliged or given financial incentives to provide some minimal level of health insurance to each employee, regardless of full- or part-time status, and this could be extended, like unemployment benefits, for a specific length of time after employment ceased. However, the cost to employers could be onerous and lead to cuts in wages and even greater unemployment.
- Hospitals, clinics and individual providers could be funded directly for care of the indigent. Such funds could be raised through special taxes exacted from hospital billings or other sources.
- Government tax law could be amended to allow tax credits for health insurance premiums or direct medical expenses to individuals.
- Medicaid eligibility could be expanded.
- Risk pools could be created for individuals deemed uninsurable for health reasons and funded through a portion of insurance company premiums.

All of these proposals lack effective means for controlling costs and maintaining quality of services, however, and despite greater competition between hospitals, insurance companies and even physicians, costs continue to grow at rates well beyond inflation. The private sector has proven unable to regulate itself, and the government has increasingly stepped in to try and hold expenditures down, at least in Medicaid and Medicare programs.

The Canadian Health Care System

In contrast, the Canadian health care system has for years demonstrated a capacity to deliver high-quality medical care for considerably less than the cost of care in the U.S. and several other industrialized nations [15]. Every Canadian citizen is covered, and the system enjoys a very high rate of satisfaction. Each individual pays an insurance premium according to financial ability. Those lacking financial resources are eligible for full or partial assistance; for example, nearly 30% of Ontario's residents get premium-free care. Benefits include physician services at home, in doctors' offices and in institutions. Also provided is home care and long-term care at nursing homes and hospitals. Physicians collect only according to a

government fee schedule. No private or semi-private hospital accommodations are allowed, but individuals can purchase extra coverage through commercial health insurers.

This health plan has succeeded in controlling costs through rationing of high-technology medical equipment and services and negotiation of binding physician fee schedules and hospital budgets. Since the provincial government is the only buyer of services, administrative costs are minimized. Because physicians are only paid for time spent with a patient, a physician must increase the number of hours worked in to increase his or her income. Despite the controls limiting physician billings, however, Canadian physicians still earn wages comparable to their U.S. counterparts.

Each province regionalizes services. For example, while the city of Boston, Massachusetts has 13 linear accelerators and 6 teaching hospitals, the province of Ontario can effectively limit the number of such machines and other hospital services, such as cardiac surgery units, to only those absolutely necessary. Canada also has more tightly restricted physician numbers and has powerful incentives to distribute physicians to underserved areas.

The Canadian system is not immune to economic pressures, however. Although less than 9% of its gross national product is spent on health care by Canada, it, too, is feeling the pressure of higher health care costs as it strives to balance its budget. In addition, the system is under increasing criticism because citizens are caused delays in receiving surgery, diagnostic testing and even hospitalization because of waiting lists for care. In addition, physician criticism of the Canadian system has been strong [16].

Summary

There has been a dramatic rise in the uninsured population in recent years despite escalating health care expenditures. Our present system of health care financing has been overwhelmed by intractable problems unforeseen by its designers. Without decisive action, erosion of our standard of health can be anticipated. Without more effective means of controlling costs, however, even our standard of living may fall as we spend a greater proportion of our incomes seeking equal quality of care for all American citizens. Although the problem has engendered much discussion, no clear solutions have yet emerged.

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