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Abstract

Lack of health care insurance, once thought to be a problem of the poor, and has now begun to affect a new population- the middle class. The major factors contributing to this are increased deductibles and co-payments, cost shifting and the introduction of managed care networks. The idea of a universal health plan has been introduced several times over the last few decades. With the introduction of Medicare and Medicaid came the promise of a more inclusive health care plan for all Americans. However, Medicare and Medicaid remain largely unchanged from what they were when they were first introduced in 1965. The U. S. was built on the foundation of 'unalienable rights'. Why then is the number of uninsured and uninsured rising and projected to continue rising? This article seeks to explore these questions.

Keywords:

Health care; Universal Healthcare; Healthcare Access; National Health; Health Costs

Universal Healthcare in America

Introduction

One in six Americans doesn't have health insurance. Studies have shown that health insurance and poverty are the strongest determinants of access to health services (Guendelman, et. al, 1986). The uninsured are less likely to obtain medical attention when they have a perceived "need for care". This is best illustrated in the case of George and Tina. George and Tina were siblings who had been diagnosed with diabetes in childhood. However, their disease went untreated because their family rarely had health insurance. When they became teenagers they worked for employers who didn't offer health insurance. Because of this, they went without insulin, syringes, and glucometer sticks. George's blood sugar levels averaged around 200 mg/dl and he went blind at the age of 20. His condition left him depressed and housebound and he was unable to see or work. When he was finally able to collect Medicaid at age 20, it was too late. George died at the age of 21 of multiple organ failure because of uncontrolled diabetes. His sister Tina's baby lived for five months and never left the hospital. The child died from complications of gestational diabetes. One year later Tina had a heart attack due to complications of diabetes. She died at the age of 25 despite bypass surgery. George and Tina's story places a grim spotlight on the plight of many uninsured Americans today (Bell, 2000).

History of Health Care in the U. S.

A strong economy and an alliance between insurance providers characterized the period between 1945 and 1970. The largest health insurance provider was Blue Cross and Blue Shield. Blue Cross was formed by the American Hospital Association. Blue Shield was primarily controlled by state medical societies affiliated with the American Medical Association. As a result, physicians had a strong influence on the insurance industry. Thus, physicians and hospital staff created most of the early reimbursement policies. Because there was no system of checks and balances, health care costs increased dramatically. However, the economy was healthy and there were resources available for health insurance. By the end of World War II, the U. S. was an economic superpower. There was no public outcry at rising health care costs because employers paid the bills. Employers didn't protest because profits were high and health insurance was tax deductible (www.amsa.org/hp/crises.cfm).

By the 1970s the U. S. had fallen from economic dominance and Americans began to become more aware of rising health care costs. Inflation and underemployment prevailed. Americas share of world industrial production dropped from 60% in 1950 to 30% in 1980 (www.amsa.org/hp/crises.cfm). Although businesses were concerned about health care costs, the concern was not enough to cause substantial change in health care policy.

With the 1980s came marked increases in health insurance premiums and a further declining economy. Costs of health care plans jumped from 18.7% to 20.4% by 1989. From 1976 to 1988, the percentage of the payroll used for health care premiums doubled from 5% to 9.7% (www.amsa.org/hp/crises.cfm). Companies began to raise premiums as a way to offset the increasing cost of health care.

The 1990s brought in managed care and trends leading toward the complete domination of health care by managed care organizations. These managed care organizations (MCOs) and health maintenance organizations (HMOs) experienced enormous growth. A few MCOs controlled almost all of the patient population. The way it happened is very simple. Managed care organizations contracted with specific hospitals. Those hospitals fortunate enough to obtain the contracts disbursed the majority of patient care. Hospitals without contracts found themselves without patients. Physicians found themselves either joining these organizations or going out of business.

MCOs also exercised the right to take contracts away from hospitals that spent too much money and in doing so kept costs at a minimum. During the process of suppressing costs, conflicts began to arise between the insurers and the physicians about how much money should be allocated and consequently which tests and how many tests should be performed. These conflicts caused physicians to base treatment decisions on both financial and clinical reasoning (www.amsa.org/hp/crises.cfm).

Rising Health Care Costs

The economic status of the U. S. is directly proportional to health care delivery (Lee and Estes, 2001). Between 1945 and 1970 the economy was booming and health care costs increased unchecked and with very little protest. However, as the economy changed, businesses began to look for ways to become more cost effective and save more money. The attention then turned to rising health care costs. Rises in health care costs can be broken down into four groups: (1) population growth; (2) general inflation; (3) medical price inflation above general inflation; and (4) increases in the number and intensity of services. (Lee and Estes, 2001). In order to control costs, many employers participate in managed care plans that limit employee choice and reduce or eliminate employee benefits.

Managed care is one of the most important tools used to control rising costs. These plans exercise strict controls on the use of medical services, as well as financial incentives for physicians and hospitals. These incentives are designed to reduce both services and costs (Lee and Estes, 2001). Between 1984 and 1993 the number of employees enrolled in health maintenance organizations increased from 5% to 50%. In 1998 almost 85% of employees with health insurance coverage were in some form of managed care plan (Lee and Estes, 2001). Traditionally, providers used a fee-for-service system to charge insurers by the number of services or tests performed. Insurers paid providers a flat rate for each type of service provided or test performed. However, if the employee was excessively sick or the physician ran too many tests,

insurers were at risk. To alleviate the financial burden, insurers began to use managed care organizations, shift the costs to employees and increase deductibles and co-insurance payments. MCOs control costs by paying physicians a set amount of money to take care of patients. If the costs exceed the budget, hospitals and physicians then incur the risk.

Another strategy utilized by employers to reduce health care costs is cost shifting. In the mid-1980s large corporations that provided comprehensive insurance usually paid the entire cost. Over the last decade, cost shifting has become common practice. By 1990, employee health care coverage declined to 30% in the case of preferred provider networks as a direct result of cost shifting (Lee and Estes, 2001). Cost shifting can be done in a number of ways. Employers can cap employees total benefit contribution. This forces employees to trade off health insurance against pension and other fringe benefits. The number of employers providing full cost coverage for employee retirement declined from 27% in 1990 to 8% in 1995 (Lee and Estes, 2001). Another tactic is to require employees to pay premium costs and increase deductibles. Some employers cover employees only. Others cap services such as prescription drugs and emergency outpatient psychiatric benefits.

Medicare and Medicaid

In 1939 Senator Robert Wagner introduced the National Health Act of 1939. A major component of the Act was to include a national compulsory health insurance for almost all employees and their dependents. Costs were to be covered by employer and employee contributions. However, no final action was taken on the bill and it died in Committee (www.medicare.com/about/history/ssachr.asp). In his 1944 State of the Union Address, President Roosevelt outlined an economic bill of rights that included the "right to adequate medical care and the opportunity to achieve and enjoy good health" (www.medicare.com/about/history/ssachr.asp). However, he made no specific recommendations.

In 1945, President Truman proposed a comprehensive medical insurance plan for all people through the Social Security System and introduced a revised Wagner- Murray-Dingell Bill. This bill called for national health insurance that would be subsidized by a federal payroll tax. President Truman also called for a committee to be formed to determine the Nations immediate and long-term health needs. He called this committee the Commission on the Health Needs of the Nation. In 1960, the Social Security Amendments of 1960 were enacted. This law provided increased federal grants to states for medical care programs for the elderly. It also contained as part of its package the Kerr-Mills component, which offered assistance for elderly people who were not on public assistance but could not pay for medical services. After a decade of debate, President Johnson signed the Social Security Amendments of 1965, which provided insurance for the elderly (www.medicare.com/about/history/ssachr.asp).

While Medicare and Medicaid were both introduced on the same bill, the two programs are entirely different. Medicare was implemented after years of planning and debate. Medicaid occurred as an afterthought. Medicare is a universalistic program. This means that all elderly are beneficiaries and are automatically entitled to benefits once they reach the age of 65. Medicaid only represents about 67% of poor people in America. The few who do receive benefits must meet state set eligibility rules and must be able to successfully complete the enrollment process. The federal government controls Medicare. Its eligibility requirements benefit package, policies concerning payments to providers and decisions about how payment for services will be administered are determined in Washington, D.C. Medicaid runs on general revenues supplied by both federal and state governments. (Brown and Sparer, 2003).

Universal Health Care as a Solution

The U. S. is the only industrialized country that does not have a universal health care plan. Canada, Germany, and the United Kingdom each have universal health care plans. When compared to these countries, the U. S. receives poor patient satisfaction ratings. A recent World Health Organization (WHO) Survey placed the U. S. 37th overall in health system performance. This is surprising since the U. S. spends 13.7% of its gross domestic product on health, which is more than any of the other 191 WHO nations (Landers, 2000). In order to measure each country's overall performance, 3 criteria were used: (1) provision of good health; (2) responsiveness to expectations of the population; and (3) ability of each individual to fairly contribute toward their care (www.ama-assn.org/sci-pubs/amnews/pick_00).

The problem is that while we have the very best in health care, not all citizens are covered. In 1999, President Clinton unveiled his proposal to strengthen and modernize Medicare. His proposal was designed to: (1) make Medicare more competitive and efficient; (2) modernize and reform Medicare's benefit package; and (3) make a long term financing commitment to Medicare designed to extend the Medicare Trust fund until 2027 (www.seniorhealth.about.com/library/news).

Clintons health care plan proposed to utilize market oriented purchasing and quality improvement tools in order to control costs and improve health care. The initiative also provided for a Competitive Defined Benefit (CDB) which would enable true price competition among Medicare managed care plans. Clintons plan also proposed to establish a voluntary Medicare "Part D" drug benefit that would be affordable and available to all beneficiaries (www.seniorhealth.about.com/library/news).

These were just a few of the benefits proposed in the 1999 initiative package. In short, Clintons plan proposed to reduce Medicare spending by 72 billion dollars over 10 years. It added an optional prescription drug benefit. In addition, it extended the life of the Medicare trust fund for a quarter of a century until 2027. Although it presented solutions to the problems of rising health care costs, insurance premiums and accessibility to health insurance, Clintons plan called for changes that were too much too fast for the

comfort of conservatives. As a result, the plan was doomed to fail before it was introduced.

Though many reasons have been offered to explain why the U. S. does not have a universal health care plan. The simplest explanation seems to be that the political environment in the U. S. is not ready for a universal health care plan. Other countries view health care as right rather than a privilege to be enjoyed by those who can afford it. Unfortunately, there is no indication that the sentiment has yet registered in the U. S. For now the closest the U. S. has gotten to a universal health care plan are incrementally based programs such as Medicare and Medicaid. Critics cite demographic and technological trends as proof that these programs are highly uncontrollable in terms of the federal budget and reducing the deficit. Still others complain that Medicare is an "out of control entitlement that consumes too much of the federal government budget and obstructs deficit reduction" (Marmor, TR 2000). To these critics, Medicare and Medicaid are always on the verge of bankruptcy. However, in 1989 by changing its methods for paying hospitals and physicians, Medicare produced higher savings than the private sector. This is important because Medicare covers an older and sicker subset of the population that requires more specialized and technologically intensive services. In addition, it is interesting to note that these "universal" programs have weathered the same storms as private for profit programs and in some instances have fared far better. Between 1970 and 1988 private health insurance increased per capita spending 11% annually. Medicare's growth rate was 10.2% (Sparer and Brown, 2003).

Because of cost cutting, cost shifting and increased deductibles and co-payments, employees are facing increases in health care costs. Today rising health care costs is one of the greatest threats facing our society. In the past, the lack of insurance has primarily affected the poor. However this issue is now becoming a major concern to the middle class. It was important enough to become one of the major issues debated during the 1992 presidential election.

The U. S. has a history of providing funding for health care in increments. Programs exist for Native Americans, migratory workers, other categorically defined poor people, veterans of military service, the permanently disabled, people with end stage renal disease, and all elderly people. Programs designed for these groups now compose approximately 42% of the nation's total annual spending for health care. (Davies et al., 1990). Because this issue has become an increasingly important problem, many governmental laws and policies have been established and introduced which attempt to distribute access to health care more equally and cost effectively. Over the last century, numerous attempts have been made to introduce a universal health insurance program. The Social Security Amendments of 1965, introduced during Johnsons Administration, were believed to be the beginning a universalistic health policy which would include all Americans. This proved to be false hope. Medicare and Medicaid have changed very little since their inception in 1965.

Conclusion

Lack of insurance has been associated with lower use of the health care system (Mayberry, et al., 2002). The primary source of care for the uninsured is the emergency room. It is also the most expensive. The emergency room can't help those with chronic diseases. More often than not, the uninsured are unable to return for follow-up treatment. The uninsured are also less likely to receive preventive care, are diagnosed at more advanced disease stages, and once diagnosed, tend to receive less therapeutic care. (Bell, 2000). This is not just a problem that affects the poor. Seventy-five percent of the uninsured have full-time jobs or live in a family where one person works full-time. When parents are uninsured, their children are uninsured. An uninsured child is 30% less likely to receive treatment when injured. (Kaiser Report, 2000).

Physicians often compromise their best medical judgment when dealing with patients who don't have insurance. Examples include giving medical advice over the phone as opposed to office visits to avoid billing for office visits and changing medications to offer free samples of whatever medications are available that day. Some physicians report instances in which patients ration medicine that they are prescribed so that the medication will last longer. Some physicians even exaggerate patient symptoms so that the patient can be admitted into the hospital. Others simply don't bill patients that they know can't pay (Bell, 2000).

The values and beliefs that prevail in society influence systems responsible for financing and delivering health care. Policy decisions are made based on those values and beliefs. In creating health care laws and policies there are often debates concerning distributive justice versus "crises rationing" (Lee and Estes, 2001). Those in favor of distributive justice feel that each individual should receive health care according to his or her needs. Those who support the theory of "crises rationing" argue that there are limited resources and those resources should be rationed out in ways that will provide the most benefit to the most people. In 1932, the Committee on the Costs of Medical Care wrote, "the quality of medical care is an index of a civilization". (Committee on the Cost of Medical Care, 1932). In creating policies concerning health care, we must reexamine both our values and policies and evaluate all of the issues and decide what measures can be taken to benefit the most people. Today, all of the industrialized nations except the United States have developed a system to ensure that all of their citizens are adequately covered. It is ironic that the U. S. deprives its citizens of universal health care coverage yet it is still regarded as a model of democracy and a champion of human rights. A survey was conducted in 1990 to measure the level of public satisfaction against ten other industrialized nations. The U. S. placed last while Canada ranked first. West Germany placed third and the United Kingdom placed eighth (www.ama-assn.org/sci-pubs/amnews/pick_00). This is incredible since the U. S. spends a far greater percentage of its gross domestic product on health care than any other country. Senator Bill Bradley put it best during his 1999 bid for Presidency when he said, "It is not right that kings and dictators can come to America and get the best

medical care in the world while Americans two blocks away can't afford health care.
Health care is not a luxury." (www.cnn.com/ALLPOLITICS)

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