

National Health Insurance

Falling Expectations and the Safety Net

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In October 2003, a *Washington Post/ABC* poll found that 62% of Americans favor “a universal health insurance program, in which everyone is covered under a program like Medicare that’s run by the government and financed by taxpayers.”¹ A similar proportion of doctors agree (at least in Massachusetts),² and 12,000 physicians have endorsed a proposal for national health insurance (NHI).³

Yet, over the past 3 decades, discourse on health reform in the United States has swung sharply away from NHI. In 1971, Senator Edward Kennedy and Congresswoman Martha Griffiths introduced a single-payer NHI bill⁴ that attracted considerable support. President Nixon countered with a proposal to achieve universal coverage through an employer mandate approach.⁵ Today, Kennedy is pushing for Nixon’s plan. The leading Democratic presidential contenders in 2004 moved even further to the right; all except Kucinich and Sharpton proposed to cover only a fraction of the uninsured, generally by some combination of an expanded Medicaid program and increased tax subsidies for purchasers of private insurance.

The academic health policy community has been blown by these political winds. Where once NHI was a central issue for academic research (The Rand Health Insurance Experiment was initiated as a test of NHI), today it rarely surfaces in the health services literature. A quick Medline search for English-language articles in which the titles include the words “national health insurance” confirms this shift. Between 1971 and 1980, an average of 40 articles appeared each year, virtually all addressing the U.S. situation. Over the past decade, the number dwindled to 8 per year, most (besides the ones we authored) describing experience in Taiwan or elsewhere.

The gap between what patients (and doctors) want and what the policy community offers mirrors the widening chasm between the possibilities and actual performance of our healthcare system. Despite skyrocketing health spending and a proliferation of dazzling gadgets and miracle drugs, patients’ satisfaction has been falling.¹ Life expectancy and other measures of health status in the United States lag further and further behind those in other wealthy nations.⁶ In 1980 (when we were medical residents), the United States spent 8.7% of Gross Domestic Product on health care, slightly less than Sweden and Denmark, about the same as Germany and a bit more than Canada.⁶ In 2002, health care consumed 14.9% of GDP in the United States, almost 50% more than in any other nation.

As residents, we were outraged by the blatant injustice of America’s healthcare system; urgently ill patients “dumped” from private hospital emergency departments⁷;

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vast public subsidies handed to private hospitals that did the dumping;⁸ and medical resources wasted on useless paperwork.⁹

Last week, we met with residents and young colleagues who told us of the continuing abuse suffered by the uninsured: a patient with a heart attack sent by taxi from a private hospital emergency department to our public facility; fractures that were diagnosed but not treated at private hospitals; people examined at a university hospital emergency department (as required by the Federal antidumping law) who were judged stable and therefore refused treatment, then subsequently sent a \$300 bill for their examination; and a diabetic woman refused admission for treatment of osteomyelitis who was found dead at home after she failed to appear for her scheduled outpatient visit.

For us (and many patients), it is cold comfort to be reassured by Marquis et al. in this issue that the safety net for the poor did not fray even further during the mid-1990s.¹⁰ Should we cheer the fact that over 700 community health centers survived? Our city of 100,000, which has upgraded access to primary care through a network of 6 neighborhood health centers, provides a glimpse of what might be an adequate number; an equivalent population-to-clinic ratio nationally implies the need for over 17,000 clinics.

Moreover, even Marquis et al.'s conclusion that things did not get worse could be overly optimistic. Their analysis examined trends in the use of "safety net" resources per low-income person, not per uninsured person. During the period they studied, the number of poor and near-poor persons fell by 10%, whereas the number of uninsured rose by 13% (Himmelstein DU, Woolhandler S. Unpublished analysis of the March Current Population Survey for 1994 and 1999). Hence, an analysis of safety net resources using the number of uninsured people rather than the number of low-income people as the denominator would likely find a downward trend.

Other aspects of Marquis' analysis are also problematic. She classifies academic medical centers as safety net providers. It is quite plausible that academic centers, and even some community health centers and public hospitals, intensified their marketing to the affluent and tightened restrictions on care for the uninsured during the period studied. Hence, sustained levels of care at "safety net" institutions could well reflect the expansion of care for those with coverage rather than the maintenance of care for the uninsured. Finally, the authors curiously dismiss their positive findings that HMO penetration and for-profit ownership are associated with some small, but significant, decrements in the use of services. Their measure of competition appears so flawed that the analysis of the effect of competition is uninterpretable; they apparently treat multiple hospitals owned by a single firm as competitors. Hence, their analysis ignores the dramatic decrease in hospital competition in Boston (and many other cities) as a

large number of hospitals congealed into a handful of networks.

The news about prenatal care in California presented by Hessol et al. in this issue is somewhat better.¹¹ In California, like in the rest of the nation,¹² the rate of grossly inadequate prenatal care shrank during the mid-1990s thanks, in part, to expanded Medicaid coverage for poor pregnant women. Moreover, even controlling for insurance coverage, rates of grossly inadequate prenatal care fell. We would speculate that this broad effect—over and above improvements in insurance coverage—resulted from a community-wide spotlight on the importance of prenatal care, with broadening access to this service contributing to a wider cultural change.

Unfortunately, progress on prenatal care since 1998 has, according to national estimates, slowed to a crawl.¹⁰ Moreover, although the rate of grossly inadequate prenatal care, which the authors focus on, fell, they found scarcely any change in the proportion of women receiving fully adequate care. This is not surprising, because the coverage expansion mostly excluded women until a pregnancy was proven. For many women, this gap probably prevented early (and pre-conceptual) care.

Thus, the California story is both encouraging (coverage expansions really do work to increase the use of essential services) and cautionary (narrowly targeted programs that provide coverage under limited circumstances are not equivalent to a straightforward system that guarantees universal access to comprehensive care).

Moreover, the California data reinforces a message from earlier studies: Medicaid coverage is better than nothing, but far inferior to private insurance.^{13,14} In essence, we are learning that in health care, like in education, separate means unequal. Segregating the poor, and many minorities, in a public insurance program that pays lower rates than most private coverage assures a lower standard of care.

Segregation is also implicit in the reliance on a narrow group of "safety net" providers to assume primary responsibility for the care of the poor. We are proud to have spent our entire careers working as clinicians in city hospitals. However, we are painfully aware of the limitations of such institutions. So long as different facilities are designated for rich and poor, the health gap in our society cannot be bridged.

Shortly before his death, Martin Luther King, Jr., told a meeting of the Medical Committee for Human Rights: "Of all the forms of injustice, injustice in health care is the most shocking and inhumane." However, like many other researchers, we have experienced a kind of tachyphylaxis; we have become desensitized to the inhumanity of the healthcare system. The 44 million uninsured and the more than 18,000 deaths each year that result¹⁵ no longer shock us. The \$300 billion wasted annually on needless administration¹⁶ and outrageous profits is written off as a necessary concession to the powerful private insurance and drug industries, even as

we accept that funds cannot be found to achieve universal coverage.

Too often the health services research community limits its discourse to narrow incrementalism: reforms that aspire to cover a few more, to slow the increase in the uninsured, to defend the meager resources allotted to the safety net. Although many colleagues privately endorse NHI, recognizing that the rational deployment of the \$1.6 trillion now spent annually on health care could secure high quality care for all Americans, too frequently we self-censor. By concluding in advance that rational reform is not politically conceivable, we accept and reinforce a political consensus that blocks change.

We are old enough to recall an age when legal segregation was the norm and ending it seemed a pipe dream. We vividly remember academicians' confident predictions that the Berlin wall would endure beyond our lifetimes.

It is time for the health services research community to spend more time exploring bold ideas, not just tinkering with old ones. The *JAMA* has urged clinicians to donate time to care for the uninsured.¹⁷ We ask research colleagues to tithe themselves in like manner, to devote a fraction, perhaps 10% of their professional time, to unfunded research and advocacy efforts on behalf of the poor and uninsured. We hope that some will find latitude in unfunded research that unleashes creativity too often squelched by the need to shape ideas to meet funding priorities, in short, the freedom to dream.

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