Commentaries: PCPC5

ACCESSING, STREAMLINING, AND DELIVERING HEALTHCARE FOR ALL

Summary article based on a presentation by David U. Himmelstein, MD at the Fifth Annual Primary Care and Prevention Conference, September 21–23, 2005; Atlanta, Georgia.

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INTRODUCTION

Health care in the United States is troubled and, according to a *Washington Post* article in 2003, 62% of Americans would prefer a national health insurance system. As healthcare costs rise almost 10% per year, 46 million Americans have no health insurance. The numbers of people with chronic conditions who lack insurance are staggering: 727,000 have diabetes; 2,160,000 have elevated cholesterol; and 2,430,000 have hypertension (high blood pressure).[1]

Medical bills are a major problem, even for people who have insurance coverage. Among individuals with medical problems, 44% of the uninsured said they were unable to pay their medical bills; 16% who had insurance coverage said they could not afford the prescriptions they received; and 15% of those with insurance said a bill collector had contacted them.

CAUSES OF BANKRUPTCY AND DEATH

Illnesses and medical costs are major causes of bankruptcy. According to Dr. Himmelstein, almost half of all bankruptcies involve a medical reason or a large medical debt. Three-fourths of the people who declare bankruptcy for medical reasons had been insured when they became ill.

People at the end of life should not have to endure financial suffering. Yet, 39% of terminally ill persons reported moderate-to-severe medical cost-related problems. Twenty-one percent said the family had to contribute more than 10% of its household income for the patient's out-of-pocket medical costs.[2]

This financial and medical catastrophe building in America is further manifested by the fact that more than 18,000 adults die annually because they are uninsured.[3] This number of deaths would be equivalent to the death rate that would be seen if a hurricane Katrina occurred every month. Unfortunately, the deaths go unnoticed because there has yet to be an uproar in this country about deaths among the uninsured.

BURDEN ON THE UNDER-SERVED AND ELDERLY

The burden falls most heavily on under-served and elderly populations. Data from the National Center for Health

Statistics show that, of the excess deaths among African Americans compared to deaths among Whites, about 30% are due to heart disease and 20% are due to cancer, conditions in which early intervention and primary care could prevent many of these needless deaths. For elderly citizens, choosing a healthcare provider or HMO can be daunting; many are ill-equipped to do comparison-shopping. Only 11% of seniors know enough about HMOs and other insurance plans to make fully informed choices, according to an AARP survey in 1998.[4]

An ineffective health system built on an archaic financial foundation keeps under-served populations away from the help they need. Yet, problems in affording care are not solely responsible for disparities in health. For instance, the lack of minority health professionals contributes to inadequate health services for minority populations. Although enrollment of African Americans in US medical schools rose until the 1990s, it has declined in recent years.

Equitable health care policies needed

Many studies have found that health care in the United States is not doled out equitably.[5] The nation has a surplus of medical resources that some people receive while millions of others are denied care. For example, many patients undergo unnecessary procedures such as hysterectomies. The Commonwealth Fund found that 25% of hysterectomies are questionable and 16% are inappropriate. Thirty percent of heart bypass surgeries are questionable, while 14% should clearly not have been performed.[6]

While many receive unneeded care, others find themselves ejected from hospitals prematurely. The controversial Milliman and Robertson insurance guidelines for the length of hospitalization of children for various medical conditions, for example, stipulate a one-day stay in the hospital for diabetic comas, two days for osteomyelitis, and three days for bacterial meningitis. A Milliman and Robertson spokesperson was quoted in the *Wall Street Journal* (July 1, 1998) as saying that the guidelines were not based on any randomized clinical trials or other controlled studies, nor were patient outcomes studied for the development of the guidelines.

The managed care approach

For years, America has been experimenting with the managed care approach to health services. Findings from the RAND Health Insurance Experiment have shown that high-risk HMO patients, compared with high-risk fee-for-services patients, had a higher risk of dying.[7] Despite this, and similar evidence, health care in America continues the HMO experiment.

Two-thirds of HMOs are operated for profit. These investor-owned HMOs provide lower quality care, but are dominating our system. Not-for-profit HMOs outperformed the for-profit HMOs in virtually every quality measure, such as mammograms, pap smears and diabetic eye exams, as well as in overall patient satisfaction.[8] Some researchers believe that the HMO approach is to recruit healthy patients: the healthy go in; the sick go out. In one study, before joining a Medicare HMO, individuals had incurred costs that amounted to 66% of fee-for-service Medicare. After leaving an HMO, the percentage rose to 180%.[9]

Private insurance spending and for-profit hospitals

Although private insurance spending has grown much more rapidly than Medicare spending over the past three decades, government leaders insist on privatizing Medicare. The total growth was 1,514% for Medicare and 2,498% for private insurers. (K. Levit, Centers for Medicare and Medicaid Services, Personal Communication, Nov. 13, 2003).

For-profit hospitals have higher death rates than not-for-profit hospitals, yet for-profit hospitals continue to grow,[10] despite actually costing more than comparable non-profit hospitals. For-profit dialysis centers also experience more deaths and their patients receive fewer transplants.[11] For-profit hospital fraud also contributes to overall higher costs at the for-profit hospitals. Take, for example, the Tenet Healthcare Corporation, which has repeatedly been charged with criminal activity.

Others in the US healthcare system are making a profit from disease treatment and management. The pharmaceutical industry, for one, has higher profits than other Fortune 500 companies. In fact, drug companies have consistently ranked first in earnings among all industry groups each year. Total drug company profits amounted to $37.4 billion in 2002.[12]

Canadian healthcare system

Despite skyrocketing health costs, death rates in America remain higher than in most industrialized nation. The United States has higher rates of infant and maternal death than Canada where, the infant mortality rate among the poorest 20 percent of families is lower than the average rate in the United States.

The Canadian healthcare system, which is similar to Medicare but is operated by the provinces, requires the provincial plans to meet four minimum standards:

- Universal coverage that does not impede, either directly or indirectly, whether by charges or otherwise, reasonable access.
- Portability of benefits from province to province.

- Coverage for all medically necessary services.
- Publicly administered, non-profit program.

Canadians spend 50% less for health care than Americans, yet get remarkable results. With less insurance overhead and less complicated billing services, funds, which in the United States are used to pay for billing staff, are diverted to actual health care in Canada.

REQUIRED: A NEW NATIONAL HEALTH SYSTEM

A *Washington Post*/ABC News poll in 2003 revealed that 62% of Americans would prefer national health insurance run by the government and financed by taxpayers. Only 32% said they would prefer the current system, and 6% had no opinion.[1]

Patching up the nation's healthcare system with stop-gap measures is not a viable option. Only national health insurance can fix the problem.

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