The US health care system: On a road to nowhere?

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Abstract

THIS ARTICLE REVIEWS THE CURRENT STATE AND FUTURE PROSPECTS of the health care system in the United States. The 1990s were a decade of reform and change in US medical care, with the debate over the Clinton plan for universal insurance and, after its defeat, the spread of managed care. In particular, managed care had a profound impact on the delivery of medical services, transforming traditional insurance arrangements. However, after all of the changes, the United States appears to be no closer to solving the problems that have characterized its health care system for the past 3 decades. Over 40 million Americans lack health insurance, universal coverage is nowhere in sight, and medical care costs are rising again after a period of moderation. It is doubtful that incremental health reforms will significantly ameliorate these problems.

Review

Synthèse

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The health care system in the United States remains a "paradox of excess and deprivation."[1] The United States spends more on medical services than any other nation, and US physicians earn more than their counterparts in Canada, Europe and Japan. Americans with insurance have access to the latest in sophisticated medical technology and innovative medical procedures; rates of diffusion for many medical technologies, such as magnetic resonance imaging, are generally higher in the United States than in other industrialized democracies.[2] Indeed, the availability of these resources is so widespread that some analysts believe that well-insured Americans are receiving too many medical services. At the same time, millions of Americans receive too little medical care.[3] Over 40 million Americans do not have health insurance,[4] which makes the United States the only democratic country in the world with a substantial uninsured population.

The 1990s was a decade of reform and change in US health care. After the 1994 failure of then President Bill Clinton's effort to enact a government-sponsored system of universal health care insurance, the private market emerged as the engine of health reform. US medicine moved toward "managed care" arrangements, with rising enrolment in health maintenance organizations (HMOs) and the growth of for-profit health plans. Market-based health reform was viewed by proponents as a solution to health care cost inflation and an opportunity to enhance both quality of care and patient choice. However, by the end of the decade a widespread backlash against managed care had developed.

What is the state of the US health care system after a decade of turbulence? What has been the impact of managed care? And what is the outlook for health care reform? This article reviews the current status and future prospects of the US health care system. In particular, I focus on the persistent problem of the uninsured, efforts at cost control and the role of managed care.

Little progress for the uninsured

The US health care system is often erroneously labelled a private health care system. In fact, the United States has a mixed system of public and private insurance, though the word "system" connotes much more organization and logic than is actually at work. Most working-age Americans receive health insurance through their employers. Medicare, a federal government program similar in structure to Canada's single-payer medicare insurance, provides health insurance to all Ameri-

cans over 65 years of age as well as to persons with disabilities or end-stage renal disease. Medicaid, a jointly funded federal–state program, covers low-income Americans (it reaches about 40% of the poor), including seniors who "spend down" their incomes and assets to a level that qualifies them for Medicaid–funded nursing-home care. In between those covered by this hodgepodge of private and public plans, however, lies a substantial population without any health insurance at all (Table 1).[5]

In 2000, 14% of Americans lacked health insurance.[5] About 80% of the uninsured are either workers or live in families with workers. They typically have low-wage jobs or work in small businesses in which the employer does not offer health insurance or, if it is offered, they cannot afford to purchase it.[6] The uninsured are disproportionately of low income. In 2000, one-third of the poor were uninsured, and two-thirds of uninsured adults had incomes less than 200% of the federal poverty line, or US$26 580 (Can$39 498) for a family of 3.[6] Substantially more black (18.5%) and Hispanic (32%) than white (13%) Americans were uninsured in 2000.[5]

Many Americans mistakenly believe that the uninsured obtain adequate care from hospital emergency rooms and other charity sources. Studies have consistently found, however, that the uninsured receive significantly less medical care than the insured.[7] Nearly 25% of uninsured children and 40% of uninsured adults have no regular source of medical care.[6] The uninsured are much more likely to delay or forgo needed treatment, have their conditions diagnosed at a later stage and be admitted to hospital for avoidable conditions.[6] Moreover, inadequate insurance coverage carries with it financial as well as medical risks: the costs of medical treatment are a leading cause of bankruptcy in the United States.[8] Indeed, about half of all bankruptcies in the United States "involve a medical reason or large medical debt."[9]

The number of uninsured individuals actually declined from 1998 to 1999, from 44.3 to 42.6 million, and in 2000 fell again to 38.7 million (though this latter drop was mainly due to statistical adjustments in how the government counts the uninsured). Yet perhaps most striking is not the decrease but, rather, that it took so long to happen and that the overall trend in the past decade remained one of an expanding uninsured population. Since the early 1990s, the United States has enjoyed ideal conditions for an expansion of health insurance. The economy has gone through an unprecedented era of sustained growth, the rates of general inflation and unemployment have remained low, and the rate of health care inflation has moderated. Still, from 1990 to 1998 the number of uninsured people increased by nearly 10 million (Fig. 1).

That even these favourable circumstances did not generate any significant expansion of health insurance is disquieting. And future trends are no more encouraging. The US economy slowed in 2000, and the unemployment rate rose. This economic downturn generated new ranks of the uninsured: the recent decline in the uninsured rate has ended. Because most Americans receive health insurance through their employer, a recession would have a strong negative impact on access to insurance. For the foreseeable future, then, the number of uninsured Americans is likely to continue to grow.

Table 1: Sources of health insurance coverage in the United States, 2000

Type of coverage	Population covered, %*
Any private plan	72.4
Employer-based plan	64.1
Government plan	24.2
Medicare	13.4
Medicaid	10.4
Military plan	3.0
None	14.0

Note: Source of data is the US Census Bureau.[5]
*Total is not 100%, because some people have multiple sources of insurance.

The politics of health reform

National health insurance periodically emerged on the US political agenda during the 20th century and was often tantalizingly close to enactment. The most recent failure came in 1994, with the defeat of the Health Security Act, sponsored by President Bill Clinton (and drafted under the guidance of his wife, Hillary). Clinton proposed to achieve universal coverage in the United States by mandating that all employers provide private health insurance to their employees and by giving small businesses and unemployed Americans subsidies with which to purchase insurance.

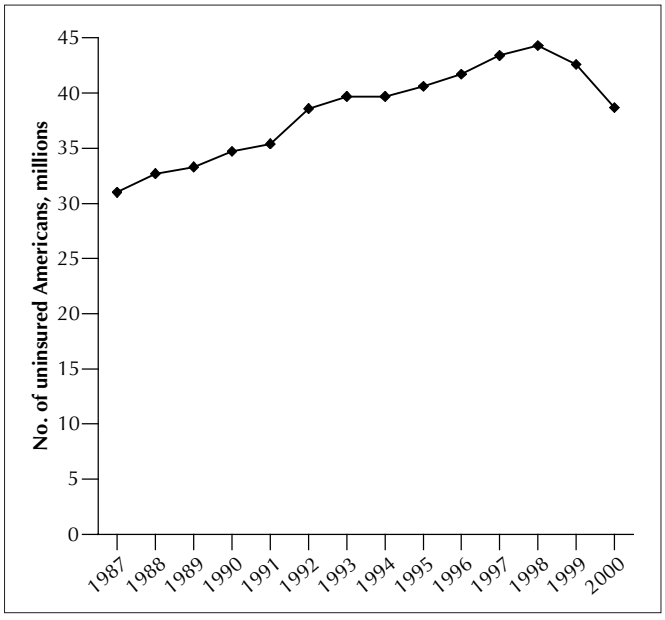

Fig. 1: Number of uninsured Americans, 1987–2000.

However, the Clinton plan triggered fierce opposition from the insurance industry (which disliked the proposed regulation of behaviours, such as experience rating, which has enabled them to charge higher premiums for sick patients), the business community (which criticized the employer mandate), ideologic conservatives (who saw the plan as an unwarranted nationalization of the health care system) and large segments of the public (who were anxious about the plan's emphasis on moving patients into HMOs). Confronted with this opposition and the lack of a liberal political majority in Congress, the act was defeated. The American Medical Association, which initially endorsed and then waffled on the idea of universal insurance coverage, did not play a prominent role in the 1993/94 debate, a sign of its deteriorating influence on US health politics.

One legacy of the Clinton plan's failure has been caution regarding health policy. Many politicians took the lesson of the plan's demise to be that comprehensive reform — transforming the US system into one of national health insurance, like Canadian medicare — is not politically feasible. Consequently, talk of attaining universal coverage has all but disappeared. Neither of the 2 major parties' presidential candidates in the 2000 election, Al Gore and George W. Bush, offered plans for universal insurance coverage. None of the plans currently under serious consideration in Congress attempts to cover all of the uninsured. And even one of the few organized advocates for the uninsured, the consumer group Families USA, has toned down its calls for universal coverage in favour of more modest policy goals.

What is remarkable about the absence of proposals for universal coverage in the period 1999–2001 is that the fiscal circumstances of the United States appeared to be conducive to their adoption. After 2 decades of budget deficits, the federal government in 2000 ran a sizeable budget surplus, projected at $5.6 trillion over the next decade.[10] It has long been assumed that the lack of affordability of a public program was a central barrier, particularly in an era of sizeable federal deficits in which large spending initiatives were politically constrained and tax increases taboo. Now, though, the affordability argument has been exposed as a fallacy. Despite the availability of a budget surplus that could be used to pay the costs of covering the uninsured, universal coverage did not emerge as a central political issue in 2000/01. Instead, political attention focused on improving the medical experiences of the already insured through regulation of managed care and expansion of Medicare to cover outpatient prescription drugs.

It is clear that the most relevant fact about US health politics is not that some 15% of the population are uninsured but that about 85% of the population are insured. Those who are insured are generally satisfied with their own medical care, even if they think poorly of the system as a whole; consequently, they are not a strong constituency for change. Indeed, any reform that threatens to alter the medical care arrangements of the insured is likely to provoke public opposition. The formidable constituency against reform is mobilized, wealthy and politically influential. Meanwhile, the uninsured are disproportionately low-income, unorganized and apparently politically expendable. As the Clinton plan exemplified, the political benefits to a president and legislators willing to take on a trillion-dollar health care industry that opposes reform are uncertain, but the costs are certain to be high. The result is that universal coverage remains an elusive reform in the United States, and the uninsured continue to live in an "aura of invisibility."[11]

Incremental reforms

Although there is currently little appetite for comprehensive reforms that would assure universal coverage, there is momentum for incremental measures that would reduce the ranks of the uninsured. Two main pathways to improved coverage have emerged. The first approach is to expand existing public insurance programs, including Medicaid, which provides insurance to about 40% of the poor, and the State Children's Health Insurance Program (SCHIP), which provides insurance to children living in families with incomes up to 200% of the federal poverty line. Proponents of this approach would change eligibility requirements for these programs, opening them up to more of the poor and near-poor (e.g., to parents of children enrolled in SCHIP). One of the more ambitious plans would extend Medicaid and SCHIP coverage, without premiums or cost-sharing, to all persons with incomes below 150% of the federal poverty line and subsidize enrolment for persons with incomes up to 300%.[12] It is estimated that this plan would extend eligibility for public insurance to over 25 million Americans who are currently uninsured. Most plans, however, would not expand coverage so broadly and would thus not reach most of the uninsured.

A second approach — one favoured by the Bush administration — is to adopt tax credits that would help the uninsured purchase private insurance. This approach appears to be especially attractive given the political appeal of tax cuts and the promise of expanded coverage with minimal government involvement. Most tax-credit proposals would target individuals, though some plans have instead focused on credits for employers. Credits could be refundable, so that even low-income persons who do not pay federal income tax would be eligible.

There are several problems, however, with tax-credit proposals in particular and incremental reforms more generally. The main problem with tax credits is the mismatch between the size of the credits that are being proposed and the cost of insurance. The average annual premium of a health insurance policy in the United States is now more than US$6000 (Can$8910) for a family and more than $3000 for an individual. President Bush's proposal would provide a tax credit of only $2000 to a family and $1000 to an individual. It is questionable how much difference these tax credits would make to the uninsured, many of whom have little disposable in-

come. This is especially true because insurance for individuals has much higher administrative costs than group insurance, and consequently higher premiums.

More fundamentally, neither tax credits nor expanded public insurance does anything to control medical care spending. The debate has changed markedly since the early 1990s, when concerns over rapidly rising costs and the economic competitiveness of US firms drove health reform. Politically, the absence of cost containment in the current proposals is hardly surprising. After all, health care costs equal the total incomes of the providers of medical care, a group comprising not merely physicians but also insurers, hospitals, nursing homes, pharmaceutical companies and all those selling medical services and products. Any attempt to restrain national health spending is viewed by providers as an assault on their livelihood, which triggers intense opposition. An understandable reading by US politicians of the Clinton reform debacle is that expanding coverage is difficult; simultaneously mandating spending controls would be political suicide.[13]

Yet there are signs that the moderate medical care inflation that made inattention to cost control comfortable is ending. Absent cost control, then, incremental reforms may become self-defeating, with high rates of medical care inflation leading to higher-than-expected program costs, which could make expansion of insurance coverage less affordable and politically problematic.

The rise of managed care

US medical care has long been the most expensive in the world.[14,15] The defeat of comprehensive health reform in 1994 did not obviate the pressures to control health spending; rather, it shifted the engine of control to the private sector. Employers looking to hold down their medical bills embraced managed care and, in a staggeringly short time, managed care became the norm. By 2000, 92% of persons with employer-sponsored insurance were enrolled in a managed care plan.[16] Managed care has also spread to public programs for the elderly, poor and disabled — Medicare and Medicaid — though enrolment in such plans is generally lower than for the employer-sponsored population.[17]

Managed care has come to refer to a wide range of health plans and practices that depart from the traditional US model of insurance. In the traditional model, insured patients chose their physician; physicians treated patients with absolute clinical autonomy; insurers generally paid physicians whatever they billed on a fee-for-service basis; and employers paid premiums for their workers to private insurers, footing the bill regardless of its cost. Managed care has altered all of these arrangements. As a consequence of not having national health insurance, cost control in the United States has focused more on setting limits on the individual medical encounter ("managing care") than on establishing budgetary limits for the entire health care sector.

The rise of managed care has brought about 4 major changes in US medical care. First is the substantial decline in traditional indemnity-insurance arrangements, which allowed unfettered access to physicians and unregulated delivery of medical care. The proportion of Americans with employer-sponsored indemnity coverage declined from 95% in 1978 to 14% by 1998.[18] This drop was accompanied by an increase in enrolment in a wide variety of managed-care insurance programs, including HMOs, Preferred Provider Organizations (PPOs) and Point of Service plans (POSs). Not only did HMOs grow in enrolment — from 36.5 million in 1990 to 58.2 million in 1995 — but they also changed substantially in form. In particular, there has been rapid growth in for-profit HMOs as well as network and individual-practice association models that contract with providers; in contrast, group or staff-model HMOs (such as Kaiser Permanente) own their facilities, and their physicians work exclusively for them.[19] Yet, while they continue to be regarded as the symbol of managed care, the growth of HMOs has stalled in recent years, and more Americans with job-provided insurance are now enrolled in PPOs (41%) than in HMOs (29%).[16]

Second, patients in managed care receive full coverage for services only if they choose a physician within the plan's network. In the case of HMOs, patients receive no coverage if they see an out-of-network provider. In some plans, patients must go through a gatekeeper, typically a primary care physician, to obtain a specialty referral. The corollary is that most insurers no longer contract with all physicians in a community. Rather, they contract with a limited number of doctors, negotiating price discounts in exchange for guaranteed patient volume and excluding high-cost providers.

Third, physicians' clinical decisions are now regularly subject to external review by insurance plans. Indeed, US physicians probably experience more intrusion into their clinical lives than physicians anywhere in the industrialized world, an ironic development given that the American Medical Association long opposed national health insurance as a threat to clinical autonomy.[20] Under utilization-review arrangements, physicians may have to seek permission from the patient's insurance company for admission to hospital, diagnostic tests or medical procedures. Utilization review and physician profiling may also occur after treatment, with the goal of identifying "inappropriate" or "excessive" care according to the insurer's standards. Proponents of managed care argue that these practices can not only control costs but also enhance quality of care — for instance, by assuring adherence to evidence-based medicine.

Fourth, insurers no longer give physicians a blank cheque; instead, they may dictate not only the price of reimbursement but also the form. This has led to the widespread adoption of predetermined fee schedules for physician payment by managed care plans, which seek discounts from "normal" fees. HMOs have also adopted capitated payment, often focusing on primary care providers. Under capitated payment, physicians receive a set amount for each patient enrolled in their practice, regardless of that patient's actual

use of services. The stated aim is to avoid the financial incentive for overtreatment inherent in fee-for-service payment. Another important change in payment arrangements is the introduction of bonuses and other incentives for physicians to meet targets in providing care. Frequently these incentives are aimed at ensuring that physicians hold down costs in a capitated environment; for instance, bonuses may be provided to physicians whose rate of admission to hospital for their patient pool is lower than the insurer's target. Along with capitation, these arrangements put the incomes of many physicians at substantial risk.[21]

The impact of managed care on costs and quality

Since the advent of managed care in the early 1990s, health care spending in the United States has slowed. From 1993 to 1998, the share of gross domestic product (GDP) devoted to national health expenditures declined from 13.7% to 13.5%, and premiums for employer-sponsored health insurance actually grew more slowly than the per capita GDP.[22] However, the United States continues to spend far more on medical care than any other nation: in 1998, it spent $4270 per capita, compared with $2400 in Germany, which spent the second-highest amount, and $2250 in Canada.[14,15]

There is substantial disagreement among analysts about the significance of the relative success of the United States in controlling health care spending during the mid-1990s. Some observers believe that this experience demonstrates managed care's effectiveness in controlling costs and the efficiencies inherent in strategies such as selective contracting, utilization review and capitation. Others attribute the slowdown to a one-time switch from indemnity insurance that cannot be duplicated or to temporary circumstances that cannot be sustained, such as marketing strategies that led insurers to underprice their products to expand market share. The long-term cost-containment potential of managed care consequently remains uncertain. However, health care spending in 1999 and 2000 rose at higher rates: insurance premiums increased by 8.3% in 2000 (Table 2),[23] and even larger increases were expected for 2001.[24] This suggests that the era of low medical care inflation is over and that managed care's ability to restrain spending has been exaggerated.

Evidence for the impact of managed care on the quality of care is mixed. Most studies have found little difference in quality of care between traditional insurers and managed care plans, though there is evidence of worse outcomes for chronically ill seniors in HMOs.[25] That quality of care in many cases did not deteriorate despite reduced volume and intensity of services suggests that the previous standard of "unmanaged" care incorporated significant amounts of unnecessary services. However, these findings also cast doubt on the premise that managed care is improving quality through practice guidelines, preventive care, primary care, disease management, integrated delivery systems and other strategies. Too often, these strategies exist more as marketing labels than as workable or proven innovations, though that has not stopped them from being aggressively promoted outside the United States, often to receptive audiences looking for new levers to control costs and improve quality and consumer service. Yet, so far, managed care plans have not consistently implemented these practices, and market competition has not resulted in significant quality improvements. Instead, plans have focused on managing costs, a decision reinforced by employers, who are much more likely to select insurance on the basis of price than on the basis of quality.[26]

The managed-care backlash

Regardless of the evidence, there is strong sentiment among both physicians and patients that managed care is harming quality of care. Consequently, there has been a push to enact patients' bills of rights and other laws that regulate the behaviour of managed care plans.[27] Virtually all of the 50 US states now have such laws on the books, and Congress is debating federal legislation that would permit patients to sue HMOs, guarantee access to specialists and establish procedures for appealing health plan decisions denying coverage or medical care. If adopted, this legislation will no doubt provide political benefits to its sponsors, who can assure the voting public that they are doing something about HMO abuses. Its impact on patients and quality of care is less certain. The legislation is sufficiently vague that it is difficult to know how strictly it will be implemented and how much it will change health plan behaviour. Moreover, the proposed law does not address issues such as financial bonuses for physicians and the incentives of capitation that significantly affect patient care.

Table 2: Changes in annual per capita spending on medical care and employer-based insurance in the United States, 1991–2001

	Annual change, %	
Year	Medical care spending	Employer-based insurance premiums*
1991	6.9	11.5
1992	6.6	10.9
1993	5.0	8.5
1994	2.1	4.8
1995	2.2	2.3
1996	2.0	0.8
1997	3.3	2.1
1998	5.3	3.7
1999	7.1	4.8
2000	7.2	8.3
2001	7.7	11.0

Note: Source of data is the Center for Health System Change, Washington.[23]
*For 1991/92, 1994 and 1997, the data are based on large firms only; for all other years the data are for all firms. The 2001 figures are projections.

Conclusion

After a decade of change, the United States appears to be no closer to solving the problems of cost control and access that have characterized its health care system for the past 3 decades. The question is, after the political system takes care of the already insured through managed-care protections and expanded Medicare benefits for the elderly, what will it do for the uninsured?

The September 11, 2001, bombings of the World Trade Center and the Pentagon have triggered a new period in US politics, dominated in the short term by President Bush's war on terrorism. In the aftermath of the terrorist strikes, "United we stand" became a national slogan of solidarity. Some health reformers hope that this communitarian spirit and the renewed faith of Americans in government will give national health insurance a new life. And enactment of incremental expansions of public insurance programs and tax credits for the uninsured is a real possibility. But it is not clear that health reform will move beyond these limited steps, which would leave the bulk of the uninsured population untouched. Absent a sustained economic downturn that makes the middle class anxious about their own coverage, prospects for universal coverage and comprehensive health care reform remain dim. The more things change in US health care policy, the more they seem to stay the same.

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