



Health Policy Reports

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Health Policy Reports

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HEALTH INSURANCE: DOES IT AFFECT HEALTH?

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In the previous Health Policy Report, I briefly considered some of the factors leading to lower health services utilization and lower health status among African Americans. In this report, I will consider health care issues of another group of Americans – the uninsured. This group has received widespread attention in the media and in public policy discussions in the past several years for several reasons. The rising number of uninsured, particularly those who are employed and who are otherwise members of the middle class, has heightened public concern for the problem, while the rising public cost of caring for those without other means has strained the budgets of governments as well as public and private health care delivery systems. In this report, I shall briefly address three questions: [1] who are the ‘uninsured’?, [2] does the absence of insurance reduce access to health care?, and [3] does inadequate insurance affect health outcomes?

Who Are “The Uninsured”?

During the first half of 1996 [the most recent year with complete data], 17% of Americans, corresponding to 44,756,000 citizens, had no form of health insurance (1). For those under 65 years of age, 19.2% had no insurance for the full six month period. Of the entire uninsured population, 17% were under 12 years old [corresponding to an uninsured rate of 14.5%, despite expanding public programs to cover children], 55.8% were white, and 41.1% were employed. Highest rates of uninsured status are among those with ages between 19-24 years [37.8%], the employed [17.8% vs 16.4% of the unemployed, with 20% of those with access to job-based coverage turning it down primarily because of unacceptably high cost],

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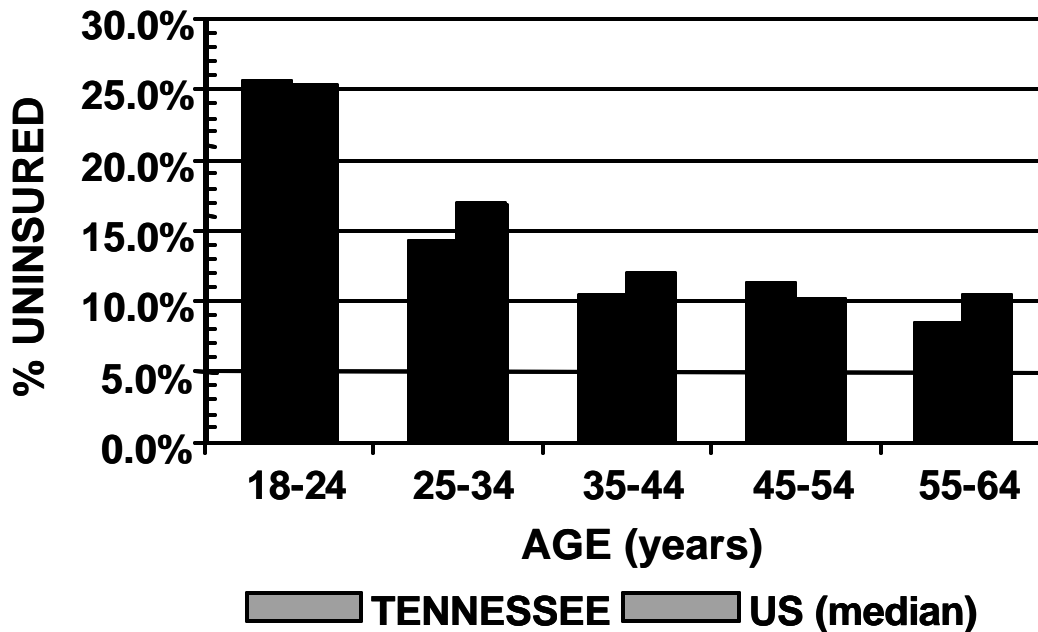


Figure 1: Percent of the Tennessee and populations without health insurance during 1995-1996, stratified by age. US data represent median values for the 50 states. Data from (3).

Hispanics [33.5% for all Hispanics and 37.2% of Hispanic males] and African Americans [22.9% vs 13.1% of whites]. Ironically, persons with self-reported fair or poor health have higher rates of uninsured status than do those in better states of health. Thus, the answer to the question “who are the uninsured?” is “everyone”.

Data on the percent of Tennesseans without health insurance in 1995-1996 (2,3) are presented in Figure 1. For the population between the ages of 18 and 64 years, 87.5% reported having insurance for the entire period, 6.2% reported lapses of coverage for less than 12 months, and 6.3% reported lapses of 12 months or longer. National averages for these three values were 86.5%, 4.2% and 9.3%, respectively.

Total lack of insurance is, however, only aspect of the problem. An additional large segment of the population is “underinsured”, that is, they have some form of health insurance but coverage is not adequate to provide for real or likely health care expenses. Estimates of the size of this group vary with the precise definitions used. One recent analysis (4) indicated that, in 1994, 29 million people under the age of 65 years with private health insurance [18.5% of the population with private insurance] were underinsured, defined as risking out-of-pocket expenses of 10% or greater of annual family income in the event of a catastrophic illness. Thus, the proportion of the US population at risk for the consequences of inadequate insurance coverage, either as uninsured or underinsured, exceeds one-third of those under 65 years of age.

Does Lack of Adequate Insurance Reduce Access to Health Care?

It is often considered that absence of insurance has little impact on the real access to health care. Those without insurance have ready access to public health care systems that, in some cases, include the “best” university-staffed tertiary care facilities. If so, the problem of lack of health insurance is a finance one, not a real health care issue. Is this true?

Numerous research reports have demonstrated that services consumed by the uninsured are not, in fact, equivalent in quantity or appropriateness to those received by others with insurance. Studies from the RAND Institute confirm that adults lacking health insurance for a full year

have approximately 60% as many outpatient visits [2.7 vs 4.4 visits per year] and 70% of inpatient days of care [0.43 vs 0.64 days per year] as do insured persons (5). The gaps, ironically, were greater for patients in poor health; for example, adults in excellent or good health had 76% of the inpatient days of insured persons, whereas those in poor health had only 61% of the days of care of insured persons in poor health. In another study (6), 22% of patients without insurance reported not receiving needed care [vs 12% of the overall population], 58% had no regular doctor [vs 39% of the general population], and 24% had no regular source of care [vs 12% in the overall population]. Uninsured children are more likely than insured ones to not obtain needed medical or other health care [22.2% vs 6.1%](7), and as many as 40% of serious injuries to uninsured children are not cared for by physicians (8). Patients with insurance are 70% more likely to have appropriate cancer screening tests such as mammography, Pap smear, etc., than are those without insurance (9).

Within the health care system, treatment patterns are different for uninsured patients. Wenneker et al (10) demonstrated that among patients with cardiovascular disease admitted to Massachusetts hospitals, privately insured patients were 80% more likely to undergo cardiac catheterization and 40% more likely to have coronary artery surgery than were clinically equivalent uninsured persons. Similarly, injured patients without insurance are less likely to have surgical procedures or physical therapy than are insured ones (11). Perhaps most interestingly, Mort et al (12) reported that physicians are more likely to recommend services, especially “discretionary” ones, for patients with insurance than for uninsured patients with identical diseases. Thus, a significant “access gap” – the difference between the current use of health resources by the uninsured or underinsured and the amount of care they would be expected to utilize if fully insured – does exist for primary, tertiary and emergent care.

In contrast, uninsured persons consume inappropriately high resources in some segments of the health care delivery system. The unnecessary use of emergency rooms, with attendant high costs, for nonurgent care by the uninsured is well recognized; one study suggested that this adds \$5 to \$7 billion in excess health care costs per year (13). In addition, preventable hospitalizations, that is, hospitalizations for conditions such as diabetes mellitus and asthma for which effective outpatient care should prevent the need for hospitalization – are considerably more common in geographic areas with high proportions of uninsured people (14).

Does Lack of Adequate Insurance Reduce Health?

The final — and pivotal — question is whether or not health insurance restrictions result in reduced measures of health. Limited access to health care services suggests but does not prove that actual health status is impacted. Data do demonstrate that, in virtually every condition that has been studied, patients without insurance have poorer health outcomes than do those with insurance. Uninsured women, for example, present with more advanced stages of breast cancer and have significantly lower survival rates than do those with insurance (15). The adjusted risk of death was 49% higher for the uninsured than for those with private insurance during the first 89 months after diagnosis. The likelihood of a ruptured appendix among those admitted to a hospital with appendicitis is 49% higher among adults without insurance than in those with insurance (16).

Studies have also documented the most important impact of lack of insurance – a reduction in life expectancy. Franks et al (17) reported results from following a group of 4694 adults without insurance from 1971 to 1987. By the end of follow-up in 1987, 9.6% of the insured died whereas 18.4% of the uninsured died. The hazard ratio, estimating the increased risk of death among those without insurance after adjusting for many other variables including education, income, smoking status, etc., was 1.25. That is, those without insurance had a 25% greater risk of death than did insured patients with equivalent clinical and demographic characteristics. The

significantly higher probability of death for the uninsured was found among all sociodemographic groups, that is, among those with higher or lower incomes, those with and without other risk factors for early death, etc. Thus, not having insurance does, indeed, affect health.

So?

This brief summary of available information demonstrates that the lack of health insurance has a major impact on health. Access to basic and relatively inexpensive health services is limited, and health care outcomes from common and benign as well as high risk conditions are lower. On the bottom line, life expectancy is reduced.

These findings do not, however, lead directly and simply to the conclusion that expanding insurance coverage will reverse these negative impacts. Reasons other than absence of insurance may prevent effective use of health care resources. For example, Piper et al (18) studied the impact of the 1985 expansion of Medicaid eligibility in Tennessee for married women during pregnancy. Although the number of pregnant women enrolled in Medicaid increased by 32%, the rates of prenatal care during the first trimester, very low birth weight babies born and neonatal mortality did not improve.

It is also important to appreciate that having health insurance, even of an adequate amount, does not assure appropriate access to and use of health care resources. Himmelstein and Woolhandler (19) demonstrated that, of all patients reporting the inability to obtain needed health care services, only one-fourth had no insurance and 46% had private insurance coverage; of women aged 50 to 69 years who had never had a mammogram, 89% had insurance.

The failure of insurance coverage to assure access to appropriate health services in these and in other studies may reflect many structural and social factors. Some of the barriers to care for those with insurance include practical constraints on enrolling in insurance plans [for example, limited dissemination of eligibility criteria, office hours, etc.]; high out of pocket expenses for copayments, deductibles or uncovered expenses; limited awareness of the need for certain health services; limited sick leave; limited availability of physicians who will provide services for patients with certain insurance types such as Medicaid; limited geographic access to care services because of inadequate public transportation; conflicting demands for, for example, child care; and dysfunctional family and social support systems. Dutton (20) summarized this issue as: "if costs are the problem, better health insurance is the remedy; if inappropriate health attitudes are the problem, health educational programs are the remedy; if inadequacies in the health systems are the problem, structural improvements in these systems are the remedy."

What is demonstrated by the sample of studies reviewed here is that health insurance, while not the single answer to all health delivery problems, does matter. Without it, a large proportion of our population are denied an opportunity for health and, most importantly, life.

And what is particularly disturbing is that we may expect this problem to grow despite greater public awareness and more analyses of the issues. The continuously rising cost of health insurance has led to a fall in the number of employees accepting employer-sponsored health insurance (21), while increasing demands of managed care for efficiency, shrinking profit margins and the increasing role of for-profit health care delivery systems have reduced the ability of physicians and health systems to provide care to those without insurance. Unless specific action is taken at the public policy level, we are likely to see more widespread and more significant impacts on the health of the public.

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