The Mirage of Available Health Care for the Uninsured

Since the failure to enact national health insurance in 1994, the issue of universal health care coverage has quietly slipped out of the limelight of American politics and public opinion. In 1994, 55% of Americans ranked health care as among the nation's 2 most pressing concerns; in 1999, all but 9% felt other issues were more important.¹ During this same period, the number of uninsured increased by roughly 1 million per year²; in 1999, approximately 1 in 7 Americans lacked health insurance during the entire year.³ The situation is even worse for minority Americans, particularly Latinos, one third of whom are uninsured.⁴ The magnitude of this problem can hardly be overstated. There is ample evidence that the uninsured forego needed medical care more frequently, receive less preventive care, are more often diagnosed with advanced malignancies, require hospitalization more frequently for preventable complications of illness, and experience higher in-hospital and overall mortality than those with insurance coverage.⁵ Despite these alarming statistics, current national debate regarding health care centers around efforts to enforce and expand coverage for those with insurance—through a Patients' Bill of Rights and a prescription drug benefit for Medicare beneficiaries—rather than around providing basic coverage to the uninsured.

The United States is the only industrialized nation in the world that does not guarantee universal access to basic health care services. Reasons that Americans seem able to tolerate having so many uninsured include perceptions that being uninsured is only a temporary inconvenience for most people and that those without insurance either do not need coverage or choose not to purchase it.⁶ Perhaps the most striking reason is that most Americans do not perceive lack of insurance coverage as a significant barrier to obtaining health care. In 1993, 43% of Americans believed that the uninsured were able to get the care they needed; in 1999, 57% believed this to be the case, and nearly a quarter believed that the uninsured were able to obtain the same quality of health care as the average insured person.¹

A study in this month's *Journal* illustrates how access to care for the uninsured may appear on the surface to be adequate, when in fact it is not.⁷ O'Toole et al. surveyed primary care physicians in the Pittsburgh metropolitan area with the intent of understanding physicians' office policies toward the uninsured.⁷ Nearly 90% of physicians reported that they accepted new patients without health insurance. However, less than 40% provided free or reduced-fee care for uninsured patients, and most required full payment at the time of service. Nearly all physicians charged more than \$25 per visit, and for half of them, fees exceeded \$50. Prior studies suggest that among health maintenance organization enrollees, \$5 copay-

ments provide enough disincentive to reduce office visits by about 10%.^{8,9} For the uninsured, over half of whom live below 200% of the federal poverty level,² full payment for an office visit is often likely to be prohibitive.

Furthermore, the authors' survey protocol may have caused them to underestimate the true prevalence of financial barriers to obtaining primary care. The author conducting the survey introduced himself as a representative of the county health department and explicitly stated the survey's purpose.⁷ This knowledge may have biased some respondents toward giving "favorable" answers. In addition, a third of eligible physicians did not complete the survey. Nonrespondents may have had unfavorable policies toward the uninsured that they did not care to disclose to the health department.

In interpreting the findings of this study, it is important to note that the provision of care for the uninsured varies widely from one community to the next.¹⁰ The providers, settings, and accessibility of care for the uninsured depend on the local demand for care, the market environment, state Medicaid policies, financing mechanisms for traditional safety-net providers, and local attitudes and politics.¹⁰ Hence, physicians' policies regarding the uninsured in Pittsburgh may not accurately reflect policies in Cleveland. However, financial barriers limiting access to physicians' offices appear to be a nationwide problem. Data from a national survey indicate that approximately 40% of uninsured persons are unable to see a physician when they need to because of cost, compared to 7% of those with insurance.¹¹ These findings were similar across different regions of the country.

O'Toole et al. also report findings that suggest that access to physicians for the uninsured may worsen as the health care marketplace becomes more competitive.⁷ Specifically, physician practices owned by hospitals or health systems and those that were part of larger group practices were less likely than small practices owned by on-site physicians to accept uninsured patients, to offer free or reduced-fee care, or to offer the option of a payment plan. A recent national survey revealed similar findings: the amount of charity care provided by physicians was lower among large and non-physician-owned practices.¹² These findings bode poorly for the fate of uninsured patients in coming years. The competitive forces that prompted many physicians to consolidate or sell their practices during the 1990s are likely to endure, as medical costs continue to rise.¹³ When practice ownership and management change hands, so does decision making about care for the uninsured. Responsibility for setting policies toward the uninsured moves from physicians, who often see providing charity care as part of their altruistic mission, to managers,

whose primary goal is typically to ensure the financial health of their organizations.

Even if physicians choose to provide care for the uninsured, the rising cost of medical care and the pressures of a competitive marketplace may limit their ability to do so. Cross-subsidizing the care of the uninsured from coffers filled by patients with insurance has become less practicable as insurance companies have reduced their reimbursement rates. The financial pressures of managed care further restrict physicians' ability to provide free care. Physicians practicing in areas of high managed care penetration provide significantly less charity care than those in areas of lower penetration.¹² In California, where managed care penetration is high, physicians whose panels include more than 3 uninsured persons per 100 patients are less likely than other physicians to have managed care contracts, suggesting that managed care organizations selectively avoid working with physicians engaged in the unprofitable business of caring for the uninsured.¹⁴

These adverse effects of price competition on access to care for the uninsured were certainly foreseeable.⁶ When we as a nation chose to rely on market forces as the primary mechanism for controlling costs and improving quality in health care, we tacitly accepted that responsibility for the "common good," including care for the uninsured, would no longer be collectively borne.¹⁵ The problem is that we did not develop a coherent plan for who would bear that responsibility. The implicit assumption, perhaps, was that providers who receive special funding or concessions from the government to serve as a "safety net"—predominantly academic medical centers, public hospitals, and community health centers—would take up the slack. However, these providers do not have the capacity or resources to care for all of the nation's uninsured. Moreover, competition from mainstream providers for publicly insured patients has left safety-net providers with fewer paying and more non-paying patients, eroding their financial base. While expanding and increasing support for traditional safety-net providers may improve access for the uninsured, over 80% of primary care visits for uninsured patients occur in physicians' offices.¹⁶ Thus, significant progress is unlikely without efforts to improve access to mainstream physicians.

What can we as primary care physicians do to improve access for uninsured patients? First, we can participate in setting policies within our practices and health care organizations regarding the provision of charity care. Although financial pressures may not allow us to provide open access for all uninsured patients, we can advocate for reasonable policies that do not amount to closing the door on those who are unable to pay for the full cost of a visit. Second, we can ensure that available options to make services more affordable, including sliding-scale fees and payment plans, are well publicized. Third, we can support and participate in initiatives that aim to improve access to

primary care for the uninsured, such as local charity care programs and state-subsidized insurance pools for the working poor. Where these programs impose expectations or burdens that we consider to be unfair, we can advocate for reforming them rather than leaving all the responsibility of caring for the uninsured to a safety net that is wearing thin. Finally, we can support efforts at both state and national levels that move us closer to universal health care coverage. We have thrown the political weight of our profession behind efforts to enact patients' rights legislation, which promises to limit the denial of services to our patients with insurance coverage. We should do at least the same for our patients without it.

Despite popular belief, access to care for uninsured Americans is becoming progressively more limited. To the extent that our office policies toward the uninsured create an illusion of adequate access, we as physicians are partly responsible for continued complacency toward the problem of the uninsured. Unless we care and advocate for our uninsured patients, the myth that the uninsured have adequate access to health care may never become a reality.

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