To what extent do President Obama’s proposed health system reforms address the fundamental causes of unequal access in the US health care system?

According to the WHO it is ‘important for a society to organize its health resources equitably, so that access to those resources are(sic) open to everybody’ (Whitehead and Dahlgren, 2007: 3). Most of the influential definitions of equity in health care appear to identify equal access as an integral element of this concept (Braveman, 2006: 170-171, Whitehead and Dahlgren, 2007: 4-5). The notion of equal access implies that health care in a given society is to be distributed according to need and that everyone is equally entitled to make use of the available services (Whitehead, 1991: 8). Since World War II almost all high income countries have embraced the ‘normative proposition that the pursuit of universal coverage is desirable’ and have undertaken efforts to make health care physically and financially accessible for all citizens (Mills and Ransom, 2006: 522, Kutzin, 2000: 1-2). The United States is exceptional in this respect. Despite being one of the world’s richest countries the proposals aimed at establishing universal coverage have never been adopted as legislation (Hacker, 2009: 6). In contrast to all other developed countries the US health care system relies heavily on voluntary health insurance as the main source of financing and this arrangement seemingly fails to generate equality with regards to the consumption of health care. In present day America there are 46.3 million people with no health insurance whatsoever (U.S. Census Bureau, 2009), 24 percent of the population are underinsured (Consumers’ Union, 2007) and there are great disparities among different health insurance plans held by the insured. Access to health care varies enormously across and even within these groups. This paper aims to identify the fundamental causes of unequal access to health care in the US and to assess the extent to which President Obama’s reforms address them. It will be suggested that most of the fundamental causes of unequal access stem from America’s distinctive conception of equity. It will be maintained that the emphasis that this conception places on choice and affordability rather than equality makes it unique and that the implications of this philosophy trickle down through the entire health care structure. It will be argued that President Obama’s proposed reforms do not address these fundamental causes and instead concentrate solely on mitigating the worst effects the secondary causes of unequal access. These are identified as causes associated with the current mode of financing and the consequences that they have for effective pooling of funds. It will be proposed that rather than making access to health care equal the Obama reforms aim at widening it.
In the eyes of the WHO equity in health implies that none should be disadvantaged from achieving their full health ‘potential because of their social position or other socially determined circumstance’ (Whitehead and Dahlgren, 2007: 4). Everyone should therefore be able to enjoy equal access to the available health services. Even though most of the developed world seems to identify with the value judgment expressed by this conception one should not forget that this definition is by no means universal. It is considerably biased in favour of the egalitarian approach to health care provision, which sees ‘access to health services as a right of citizenship that should not depend on individual income or wealth’ (Mills and Ransom, 2006: 525). Egalitarian commentators argue that health care should not be treated as a luxury good and that ‘resources for the essentials of life (such as health)’ should be distributed according to need (Braveman, 2006: 183). The US system; however, seems to be based on a more libertarian set of values. American political culture is said to be ‘sceptical of egalitarian government’ (Hacker, 2009: 4) and characterised by ‘rugged individualism’ (Nolte et al, 2005: 16). It has also been suggested that ‘Americans are more supportive of choice’ than Europeans and that freedom to choose could potentially represent ‘the paramount American value relevant to health care’ (Daschle in Brett, 2009: 440, Brett, 2009: 440). From this perspective, the US political culture seems to favour choice rather than equality with respect to conceptualising equity. It is undeniable that if the US system’s ability to generate equitable access to health care is to be assessed using the egalitarian normative framework severe inadequacies are likely to be uncovered. However, it could be plausibly argued that since ‘[t]he definition of fairness may vary considerably for different systems’ the performance of a system can only be assessed in terms of goals it aims to achieve (Murray and Frenk, 2000: 719). Since egalitarian equity of access does not represent one of the system’s goals it may appear slightly biased to use it as a measure against which the system’s performance should be evaluated. Nevertheless, in order to assess the extent to which the proposed reforms address the causes of unequal access in the US this analysis needs to be undertaken.

The definition of equity that a health system chooses to adopt has far reaching consequences for the entire health care set-up. The implications of the libertarian equity seem to permeate the entire US health care system as they have a key role in determining the mode of its financing, which in turn plays a crucial role in determining the equity of access (Nolte et al, 2005: 22). Given its overreaching normative influence this essay considers the uniquely American conception of equity to be the most fundamental cause of unequal access. It is clear that tackling of this
cause would require a major transformation in social and political values as well as a major break with the country’s tradition. It therefore appears unrealistic to expect the Obama reforms to address this issue directly. Nevertheless, it interesting to observe President Obama’s reluctance to introduce the concept of equality more widely into his speeches and the wording of the proposed reforms. In his 45 minute speech to the Congress on 9 September 2009, which he used to outline his vision of the health care reforms for the first time, President Obama did not use the words equal, unequal, equality or inequality one single time (The White House, 2009a). None of these words feature in the description of ‘The Obama Plan’ as published by the White House either (2009b). On the other hand, both of these pieces are riddled with references to ‘affordable choices’ (The White House 2009a, 2009b). This leads one to believe that the proposed reforms are unlikely to break with the received conception of equity and that equality in access is perhaps not their explicit goal. As equal access does not seem to represent one of the reforms’ aims, once again, it appears debatable to what extent this measure should be used in their evaluation.

It can be argued that the financing mechanism of the current system is the most obvious direct cause of inequalities in access to health care services in the US. This system is predominantly financed by individuals’ or employers’ payments to private health insurance providers. To be sure, the government also provides public insurance. Most notably, public insurance is offered to the elderly and the poor in form of the Medicare and Medicaid programmes respectively. Nevertheless, the tax funded public health insurance programmes cover only ‘just over 27 percent of Americans’ and privately paid premiums continue to represent the most significant source of funding (Hacker, 2009: 5). It has been pointed out that ‘[p]rivate health insurance premiums are a perfect example of a horizontally inequitable source’ of funding as there is likely to be a significant ‘variation in contribution levels among those with similar ability to pay’ (Mills and Ranson, 2006: 536, 519). In a universal health care system the funds raised would be pooled in order to ensure that ‘financial resources in the pool are no longer tied to a particular contributor and contributors share financial risk’ (Murray and Frenk, 2000: 724). The process of pooling does not take place on a comparable scale in a privately funded system, where the levels of consumption remain closely tied to the levels of original contribution. In the US system the price of insurance premium is determined by ‘individual’s actuarially determined likelihood of illness’ (Mills and Ranson, 2006: 536). This process is commonly referred to as risk rating and can be applied to groups as well as individuals (employer based contributions). Factors such as age, sex and disease
history may be used to determine the price of individuals’ premiums and consequently the level of their access to health care. As a result of the risk rating process numerous pools come into existence. This arrangement offers limited opportunities for cross-subsidisation between the high and low risk contributors. Access to health care in the US system is strongly associated with individuals’ risk rating and their ability to pay, which translates into substantial inequalities in access to the health services available. If the system’s underlying political ideology is considered to represent the fundamental cause of unequal access, then its financing mechanism should be viewed as the most significant secondary cause.

To what extent do the proposed reforms address the financing-related causes of unequal access? As he introduced his health care reforms President Obama has made it clear that he wishes ‘to build on what works and fix what doesn't, rather than try to build an entirely new system from scratch’ (The White House, 2009a). It seems justified to assume that an establishment of a new financing mechanism, which would be both horizontally and vertically equitable, would require nothing less than starting from scratch. From this perspective, the secondary causes of unequal access also remain unaddressed. Nevertheless it should be noted that the Obama reforms go some way in mitigating some of the worst effects of the lack of effective risk pooling. Specifically, the proposed legislation sets out to end ‘discrimination against people with pre-existing conditions’ by making it ‘against the law for insurance companies to deny coverage for health reasons or risks’ (The White House, 2009c, 2009b). The reforms also aim at limiting ‘discrimination based on gender and age’ (The White House, 2009b). Even though these reforms are likely to alleviate some of the worst of its implications, risk rating can be expected to remain firmly in place. Individuals will be unlikely to encounter an outright refusal from the insurance providers; however, the premiums they will be required to pay will still be determined by their personal characteristics. The access to health care services can be expected to widen but not to become equal.

The tax-funded health systems seem better equipped to achieve horizontally equitable access than privately funded systems ‘insofar as taxes on individuals are generally not related to characteristics other than income (Mills and Ranson, 2006: 533). The problem of risk rating is bypassed as the contributions of the rich and healthy are pooled with those of the poor and sick. The resources can then be equitably redistributed and access to health services can be granted on the basis of need. Low risk individuals in a tax-funded system are under legal obligation to participate and
contribute financial sums that are likely to be disproportionate to their likelihood of developing health problems. The US system is reliant on voluntary health insurance and none is forced to participate in this arrangement. Consequently, low risk individuals may wish to opt out of the scheme. This type of adverse selection has a negative impact on effective pooling of resources and indirectly translates into higher premiums for the high risk individuals and their restricted access to health care. President Obama recognizes the existence of this behaviour and refers to it as ‘irresponsible’ (The White House, 2009a). Under the reform plan it will become mandatory for individuals to ‘carry basic health insurance’ (The White House, 2009a). If they fail to comply they will face a penalty, the extent of which varies in the House and Senate versions of the reform bill (Cohen et al, 2009). Even though the personal mandate will not make access to health care equal, it will spread the financial risk over wider proportion of the population and the insurance premiums should be expected to become more affordable.

It has been pointed out that ‘even with perfectly operating private markets for health services and health insurance, there will always be individuals too poor to afford to access them’ (Mills and Ranson, 2006: 524). Since the US health insurance market appears to be failing in meeting some of the basic assumptions of perfect competition (e.g. absence of information asymmetries and monopolistic practices), the number of people who cannot afford access to health care is likely to be even higher (Sloman, 2003; The White House, 2009a). The Obama reforms aim to correct some of the market imperfections and make access to health care more affordable by setting up a ‘new insurance marketplace – the Exchange – that allows people without insurance and small businesses to compare plans and buy insurance at competitive prices’ (The White House, 2009b). President Obama would also like to further encourage competition in the Exchange by introducing a ‘public option’ health insurance provider to compete alongside the private insurers (The White House, 2009a). At the moment both the House and Senate versions of the reform bill include some version of the ‘public option’; however, it should be noted that the debates over the Senate bill are still ongoing and its final form might differ substantially from the one introduced on 18 November (Cohen et al, 2009). Regardless of whether the ‘public option’ makes it onto the final bill it is hoped that competition generated by the Exchange will drive prices of premiums down and make health care more widely accessible. Those who will still be unable to afford insurance will be provided with ‘tax credits, the size of which will be based on …need’ (The White House, 2009a). If successful, the reforms will ensure some type of coverage for all legal residents in the US. Even
though every one will have access to health insurance the breadth and quality of health insurance will continue to vary over different plans and, consequently, so will individuals’ access to health care services.

This paper has addressed the issue of equal access predominantly in economic terms. It should, however, be recognized that unequal access can also be approached from different analytical perspectives. Whitehead and Dahlgren point out that access to health care can also be considered in terms of culture and geography (Whitehead and Dahlgren, 2007: 8-9). With respect to cultural access, the attention of US commentators has typically ‘focused on racial/ethnic differences in health and health care’ (Braveman, 2006: 179). For example, Fiscella et al (2002: 58) observed that there seem to be ‘significant associations of race and language fluency with health care use’ in the US. It seems reasonable to expect that some of these inequalities could be explained by the fact that minority ethnic groups ‘are disproportionately represented in the lower socioeconomics ranks’; however, it appears to be the case that the majority of ‘racial and ethnic disparities remain even after adjustment for socioeconomic differences’ (Nelson et al, 2002: 6, 5). This leads one to believe that all of the causes of unequal access cannot be explained simply in economic terms. Nevertheless it also seems clear that the causes of culturally unequal access are rooted in wider social interactions and are not unique to health care. As such the Obama health care reform plan appears to make no direct effort to address them. With regards to geographical access, the idea that ‘the availability of good medical care tends to vary inversely with the need for it in the population served’ is not a new one (Tudor Hart, 1971: 405) and needs to be considered in relation to the US health care system. President Obama realises that certain states are disadvantaged by the monopolistic practices of their local insurance providers (The White House, 2009a). The reforms tackle this problem by setting up the Exchange and by attempting to correct some of the market imperfections (The White House, 2009b). It is clear; however, that the issue of unequal geographical access to health care could gain in significance if the states were allowed to opt out from providing the ‘public option’, which is something that was proposed by the first version of the Senate reform bill (BBC, 2009). It could be argued that, if passed as legislation, the opt-out clause could contribute to generating rather than reducing inequalities in geographical access to health care.

It was the aim of this paper to identify the main causes of unequal access in the US health care system and to examine the extent to which President Obama’s proposed reforms address them. A doubt was raised over the appropriateness of this analysis as
equal access is neither the main goal of the US health care system nor President Obama’s proposed reforms. Using equal access as the measure by which to evaluate the Obama reforms might therefore appear slightly biased to some observers. The uniquely American conception of equity and the libertarian ideology that it stems from have been identified as the main causes of unequal access in the US health care system. The Obama reforms appear not to address them; however, it may seem unrealistic to expect them to. The system’s mode of financing and its implications have been identified as the most important secondary causes of unequal access. It has been suggested that even though the reforms do not aim to drastically transform the present day financing mechanism they do go some way in addressing some of its worst consequences. It seems to be the case that the Obama reforms aim at widening access to health care rather than making it equal. Even though this paper has chiefly focused on examining unequal access from the economic perspective it has been acknowledged that this issue also has cultural and geographical dimensions. The geographical dimension may be expected to gain in significance if the opt-out clause proposed by the Senate passes into legislation and the states will be allowed not to provide the ‘public option’.
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