American Medical Women's Association

Position Paper on Health Care for All

I. AMWA advocates comprehensive health care reform to make health care accessible and affordable for all inhabitants of the United States.

II. AMWA advocates health care reform that:

a. Recognizes that increasingly million of people in the U.S, are uninsured or underinsured, lacking access to healthcare;
b. Recognizes that we must make affordable health care accessible to all;
c. Asserts that significant challenges and disparities must not be permitted to remain as barriers to equitable access to care;
d. Asserts that a serious approach to reform must begin immediately with leadership from health care professionals; and
e. Commits to active advocacy for and participation in helping to develop a comprehensive national health care plan in the U.S. that will ensure affordable health care for all.

Since 1915, the American Medical Women's Association (AMWA) has worked for improved delivery of health care and the expansion of health care for all Americans. In 1990, in recognition that lack of access to effective health care was a major impediment to improving health and reducing health disparities among residents in our nation, AMWA issued a resolution advocating major reform of the health care system in America.

Today, health care has become one of the leading problems in the U.S. This crisis adversely affects not only individual health but the economy and our quality of life as well. (1) Consequences of our failure to address health care at the system level include: high costs, inefficient care, inadequate continuity of care, and tremendous inequities in quality of care and access to care for millions of Americans. AMWA believes that for too long we have tolerated a health system that serves no one optimally and leaves millions of Americans nearly or completely without care. We can and must do better – and now.

AMWA advocates public health policy reform to make health care accessible for all U.S. inhabitants.

*Background*

The complex and fragmented system of multiple public and private payers in the U.S. excludes an increasing number of people. Based on the Current Population Survey (an annual survey conducted by the U.S. Census), there were 45.8 million uninsured persons in 2004. Millions more have marginal, inadequate or intermittent coverage. (3-5)

People covered by Medicare and Medicaid are publicly insured, but coverage may be inadequate in areas such as long-term care, access to specialists when needed, and medication expenses. Medicaid patients receive documented differences in health delivery resulting in lower quality care. Finding providers willing to accept increasingly inadequate reimbursement is challenging. In addition, underinsured persons face prohibitive co-payments, exclusions for pre-existing conditions, and limited benefits, especially in preventive and mental health services. (6) Prescription coverage adds another layer of inequity, with complicated formularies, medication substitution, and per-month fulfillment limitations resulting in denial of adequate care for millions of Americans.

*The Uninsured*

Many reasons exist for people to be uninsured:

- Many employers do not provide health insurance for any employees;
- Many employers limit or deny coverage for those who less than full-time;
- Many employers cover workers but not their dependents;
- Many workers cannot afford coverage for their spouse and children;
- People work on a contract basis may lack benefits;
- Coverage may cease or be delayed when workers change jobs;
- Insurance may terminate due to divorce or death of a spouse;
- Insurance may lapse due to inability to pay premiums.

Traditional employer-based health insurance is rapidly eroding as the health care mainstay in the U.S.(7 ) In addition, escalating co-payments for medical services and medication have become a fact of life in the U.S.(1,8) No other developed nation ties insurance to employment.

Women are particularly vulnerable to being uninsured or underinsured under the current system. They earn less than men, make up the majority of the part-time work force, and are more likely to be insured through their spouses or to be single parents. Furthermore, women are primary caregivers and decision-makers for our nation's children and dependent elderly. Consequently, lack of coverage for women often impacts coverage for entire families. Women's family roles must be recognized as potential barriers to access to care, and appropriate enabling services (such as child care and transportation) should be available.

*The Crisis*

Three goals were to be achieved by "market driven" managed care when it was embraced twenty years ago: (a) decreased costs, (b) improved access, and (c) improved quality of health care. The experiment has failed to achieve any of these goals. The proliferation of managed care plans has failed to solve the problems despite incremental changes designed and implemented to address them. There is widespread realization that costs continue to rise, while access decreases, and quality and continuity of care deteriorate. (1)

New problems have been created by payer efforts toward cost-containment:

- Restriction of patient choice of physician;
- Lack of continuity of care due to financially driven plan changes;
- Interference with physician autonomy over clinical management of patients;
- Limiting physician time with patients;
- Lack of patient record confidentiality;
- Lack of parity for mental health care;
- Discharging patients before they are ready to be at home;
- Non-clinical oversight of clinical decisions;
- Burdensome paperwork with multiple forms, contracts and payers.

These problems must be resolved or removed in order for physicians to do what they do best: provide quality care to patients.

Despite efforts to improve reimbursement for primary care services, the system remains tilted toward reimbursing procedures and highly specialized services, while neglecting basic primary care, preventive care, and early disease detection. Furthermore, lack of parity in reimbursement for mental health services and chemical dependency treatment remains a significant barrier to care. In addition, under the current system, delivery of care for the uninsured is financially illogical. Although office-based primary care is often unavailable to the uninsured, under current federal law there is unrestricted access to emergency departments--where the cost is higher and inappropriate for routine care--wasting resources and creating financial hardships for the patient and hospital. Furthermore, no federal payments accompany hospital-provided indigent care in the emergency department, but hospitals face fines if they fail to comply with the Emergency Medical Treatment and Labor Act. (9)

Uninsured or underinsured people often refuse to go for needed emergency care because of the financial consequences. Uninsured patients who absorb their own medical costs are ineligible for the managed care negotiated rates and are often charged double or triple what insurance companies pay for the same services. This unfair cost shifting is another reason why many uninsured are not getting the care they need. (5) In fact, medical bills are now the primary cause of personal bankruptcy in the U.S. (10-11)

The movement toward system wide electronic health records (EHR), an area in which the current system is fostering positive change, would be substantially enhanced by health care reform that includes all U.S. residents. More reliable data will also improve analysis of data, the range of measurable outcomes, and contribute to quality of health care delivery. EHR will help to optimize care by increasing use of evidence-based medicine. Universal EHR would facilitate prompt diagnosis and treatment, more accurate and timely billing and reimbursement, and improve cost comparisons.

*Coverage*
Availability of health care should not be linked to employment, age or marital status. The U.S. is the only developed nation that does not insure all of its inhabitants. All other developed nations have comprehensive health care insurance covering everyone from birth to death, so that necessary health care is affordable andavailable to all. (12,5) While it has long been contended by many that the U.S. cannot afford to provide health care for all residents, there is considerable experience here and in other developed countries to contradict that assumption.13-14

According to World Health Organization health indices and Organization for Economic Co-operation and Development economic data for developed countries, America spends 1.5 times more per capita on health care as the next highest spending developed nation, and twice as much per capita as the average of developed nations, yet thirteen developed nations have longer life expectancies and better health outcomes.(15-16)

These facts suggest that both health disparities and system inefficiencies in the U.S. closely correlate with the costs of care and lack of care for the millions of Americans unable to access timely health care because they are uninsured or underinsured.(12,5) Furthermore, our own experience with Medicare and the Veterans Health Administration and the experience of many other developed nations indicate that a single risk pool system would reduce costs through a combination of efficiencies of administration, standardization of forms and procedures, and earlier intervention into serious medical conditions made more costly by the inaccessibility of care. (17-18) The Centers for Medicare and Medicaid Services (CMS) report an overhead rate of approximately two percent, compared

with private insurance companies where overhead and profits add up to 15-20 percent.(18)

It is time for physicians who have a commitment to making health care accessible to all those living in the U.S. to become involved in helping to design a comprehensive and universal health care plan for all that is fair, equitable and affordable. (5) The billions of dollars saved by putting everyone into a single risk pool, efficiency of administration via standard forms and procedures, and elimination of serious medical problems due to care denial, would be sufficient to provide comprehensive health care to all. There would even be sufficient funds to help with the cost of professional training and to support research.(1,19) This crisis is an opportunity for AMWA to take a leadership role in defining what would be optimal and proposing how it could be funded and administered simply and effectively.

References:


1. Bartlett DL, Steele JB. Critical Condition: How Health Care in America Became Big Business and Bad Medicine. NY, Doubleday, 2004;1-27.

2. DeNavas WC, Proctor B, Lee, C H, Income, Poverty and Health Insurance Coverage in the United States: 2004. U.S. Census Bureau, Current Population Reports U.S. Government Printing Office: Washington, DC, 2005;15:60-229. [web post http://www.census.gov/prod/2005pubs/p.60-229.pdf].

3. Rhoades JA. The Long-Term Uninsured in America, 2002 to 2003: Estimates for the U.S. Population under Age 65. Statistical Brief # 104. Medical Expenditure Panel Survey, AHRQ. 2005.

4. Insuring America's Health. Principles and Recommendations. Report of the Institute of Medicine Board on Health Care Services: Consequences of Uninsurance, Jan. 2004.

5. LeBow B. Health Care Meltdown, Confronting the Myths and Fixing Our Failing System. Alan C. Hood & Co. 2003:15-32.

6. Medical Debt and Access to Health Care, Kaiser Commission Report on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation. September.2005.

7. Crimmel BL. Trends in Employer-Sponsored Health Insurance Plans That Required No Employee Contribution to the Premium Cost, 1998–2003. Statistical Brief # 108. Medical Expenditure Panel Survey, AHRQ. Jan, 2006.

8. Gouging the Medically Uninsured: A Tale of Two Bills. Health Affairs, Sept./Oct. 2005; 24.

9. 42 USC 1395dd (EMTALA statute); 42 CFR 489.24; 42 CFR 489.20 (EMTALA regulations).68 Fed. Reg. 53,221-53264 (2003): the new final EMTALA regulations on EMTALA. CMS. Fed Reg. 2003; Sept. 9 Fed Reg Online GPO: http://www.access.gpo.gov/su_docs/fedreg/a030909c.html under "Separate parts in this issue."

10. Himmelstein, DU, Warren, E, Thorne, D, Woolhandler, S, MarketWatch: Illness and Injury as Contributors to Bankruptcy. Health Affairs (Millwood). 2005: Feb 2; [Epub ahead of print.]

11. Doty MM, Edwards JN, Holmgren AL. Seeing Red: Americans Driven into Debt by Medical Bills.Results from a National Survey. Issue Brief (Commonwealth Fund). 2005; 837:1-12.

12. Mueller R. As Sick As It Gets: The Shocking Reality of America's Healthcare, Olin Frederick. 2001;1-38.

13. Hussey P, Anderson GF. A comparison of single- and multi-payer health insurance systems and options for reform. Health Policy. 2003 Dec. 66(3):215-28. World Health Organization (WHO) Health Indices 2002 and 2004.

14. Himmelstein, DU, Woolhandler, S, Wolfe SM. Administrative waste in the U.S. health care system in 2003: the cost to the nation, the states, and the District of Columbia, with state-specific estimates of potential savings. Int J Health Serv. 2004;34(1):79-86.

15. Basic Indicators for All WHO Members States (2003). World Health Report 2005, Stat Annex. WHO. 2005;78-82.

16. Organization for Economic Cooperation and Development (OECD) Economic Surveys, Health Data 2004.