Insurance and the U.S. Health Care System

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Nearly 15 percent of children in the United States are inadequately insured because they lack health insurance for all or part of the year. In this issue of the Journal, Olson and colleagues describe the potent effect of inadequate insurance coverage on several aspects of access to services. They also examine several other effects of inadequate insurance coverage. Olson et al. characterized insurance coverage as full-year, part-year, or none and as private or public. The manifestations of compromised access to services were delays in seeking care, unmet medical care needs, unfilled prescriptions, no visits to doctors’ offices, the lack of usual places for care, and no well-child visits.

Hispanic children were by far the most likely to be inadequately insured. Inadequate insurance coverage was associated with all manifestations of compromised access to services. Another notable finding was that public insurance was associated with better receipt of well-child care and physicians’ services than was private insurance for children in poor health.

Although having health insurance coverage is related to the use of health care services and enables people to have a consistent source of care, we cannot be sure that having insurance guarantees the receipt of high-quality care, particularly for children who are at a disadvantage because of their social class or race or ethnic group. Such children are likely to receive their care in hospital outpatient clinics and emergency rooms — facilities that generally are not designed to provide strong primary care.

In considering the possible confounding effects of family income, race or ethnic group, family structure, parental employment, geographic region, and citizenship on the health care coverage of children, the authors examined each while holding constant the influence of the others. Some of the findings in these analyses were unexpected and require closer examination.

When the level of insurance coverage and other possible confounders were controlled, children who were citizens of the United States were more likely than children who were not citizens to have delayed care, unmet medical care needs, or unfilled prescriptions but less likely to lack usual places for care, to have no well-child visits, or to have no visits to doctors’ offices. Hispanic children were less likely than non-Hispanic blacks, whites, or others to have delayed care and no well-child visits but more likely to lack usual places for care and to have no visits to doctors’ offices. Non-Hispanic black children were not disadvantaged in any of these ways except for being more likely to have no visits to doctors’ offices. These aspects of access would be expected to be the same in their associations with sociodemographic characteristics, but they are not. Are there other characteristics of the health care system that act as powerful mediators in different areas, for providers of different types, and across populations with distinct characteristics?

Only two characteristics were consistently and independently related to all manifestations of compromised access to services. These were being uninsured (especially all year) and being poor. Family structure and parental employment had no relationship with any of the manifestations of compromised access. Race or ethnic group, citizenship status, and geographic region had inconsistent relationships with the manifestations of compromised access, which suggests that there may be unexamined interactions or perhaps even important characteristics of the health care system (other than insurance) that were not included in the analysis.

Two merging areas of focus in the medical care literature suggest possible explanations for these inconsistencies. Researchers at Dartmouth Medical School have demonstrated large variations in the use and costs of services among geographic areas that are unrelated to a better quality of care or better outcomes. Although the research is based on Medicare populations, there is no reason to expect anything different for children, according to similarities between adults and children in studies of hospitalizations.

The second area of focus concerns the benefits of good primary care, defined as high levels of first-contact accessibility, patient-focused care over time, a comprehensive package of services, and coordination of services when services have to be provided elsewhere. Studies have shown the beneficial effect of primary care on a myriad of health outcomes, both in adults and in children. Rates of low birth...
weight among infants; infant mortality; total mortality; and mortality from heart disease, cancer, and stroke are lower and outcomes such as life expectancy and receipt of preventive care are better in areas with higher ratios of primary care physicians to population, in populations that receive their ongoing care in a primary care facility or from a primary care practitioner, or in populations whose primary care is of high quality as measured by objective criteria.\textsuperscript{10,11}

Beyond the association between insurance and access, the findings of Olson et al. provide no clues about how having health insurance coverage might improve the health of children. Only one variable in the study concerns an aspect of care specifically related to health status: receiving well-child care. The “usual places for care” variable was treated as an outcome, although it is a known link in the chain of insurance, appropriate care, and improved health outcomes. It is likely that access to different types of “usual places for care” would have notable effects on the appropriateness of care and health outcomes. Unfortunately, the type of usual place for care was not considered in the analysis, which combined all types of places in one category.

On ethical grounds alone, it is unconscionable that the United States is the only industrialized country to lack universal financial coverage for health services. But the United States is an outlier in other ways that influence health, most particularly in the absence of a strong focus on primary care services.\textsuperscript{12} Given the wide confidence intervals for many of the characteristics and persisting disparities when the presence of insurance is accounted for, it may be that insurance coverage alone (and especially private insurance) will not be enough to reverse the consistent disadvantages that low-income children have. Expansions of private insurance coverage may even magnify current problems, such as the multiplicity of insurance policies and benefit structures, the administrative expenses that increase the costs of the U.S. health care system,\textsuperscript{13} and the receipt of care from sources that are unable to minimize excessive, unnecessary, and inappropriate specialty services. Without strong efforts to avoid exacerbating administrative waste and the receipt of care from inappropriate services, we cannot be sure that expansions of insurance coverage alone will live up to expectations for improving health.

Olson and colleagues have provided the basis for thinking more logically about the role that health policy must play in improving the health of children in the United States — which has been declining relative to the health of children in other industrialized nations.\textsuperscript{14} Insurance coverage is only one means to the end of providing effective and equitable health care services. We know that appropriate health care services improve health and reduce disparities in health across population groups. The country needs universal financial coverage for health care services, but it also needs a delivery system that ensures a source of good primary care and minimizes inappropriate services. Our efforts to influence health policy should focus not only on improving access but also on determining what insurance coverage should accomplish in improving and paying for health care services.

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