Commentary: How does ‘insurance’ improve equity in health?

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In a meta-analysis of eight studies on overall mortality in women with breast cancer, Kevin Gorey1 makes a powerful case that better equity in survival in Canada than in the USA is a direct result of universal financial coverage for health services in the former country. The combined studies made it possible to examine age-adjusted survival rates in different age groups (under and over the age of 65 years), with different geographic units of analysis, in different types of place of residence, and with different specifications for socio-economic characteristics. All in all, 78 different comparisons were made in seven domains [two socio-economic status (SES) group comparisons in each of the two countries and one comparison in each of three socio-economic strata of the two countries]. The main findings were as follows.

(1) SES is not strongly related to overall survival in almost all of the Canadian contexts.
(2) SES is strongly and consistently related to poorer survival in all US contexts.
(3) There is an SES gradient (‘dose response’) in the US contexts.
(4) Survival is shorter in women of lower SES in the USA, suggesting either later diagnosis (more serious disease) or less adequate treatment.
(5) The cross-country difference in survival is present in low-income areas, but not in high- or middle-income areas.

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(6) The Canadian advantage in survival for low-income area is larger among the women aged <65 years than in older women, although with geographic area variability.

(7) The Canadian advantage for lower-income areas is larger for later-stage diagnosis (node positive breast cancer) than for earlier stage diagnosis. That is, there is almost certainly a medical care effect, hypothesized to be a result of differences in universality of insurance in the two countries.

Gorey’s analysis is not the first to examine US–Canadian differences in health outcomes. After reviewing studies concerning the outcomes for a wide variety of types of health problems, Guyatt et al.\(^2\) concluded that there were inconsistent differences between Canada and the USA, but the review did not address socio-economic differences and did not distinguish differences in incidence from those in case fatality associated with health system characteristics such as insurance, access to care, or use of preventive or therapeutic interventions. Other studies have explored the relationship between insurance and health outcomes within the USA. Provision of financing for medical care in the mid-1960s in the USA (primarily through the US Medicaid Program), improved health for 16 health problems in childhood, through reductions in frequency of occurrence, detection and management in the premorbidity stage, and through prevention of complications or sequela.\(^3\) Much more recently, McWilliams and colleagues\(^5,6\) showed that recent progress in the control of blood pressure, blood glucose and cholesterol levels has not reduced racial, ethnic or socio-economic differences in the US population EXCEPT in individuals aged >65 years, whose costs have been partly covered by the Medicare program since 1965.

Theoretically, it is possible that insurance might improve health indirectly, by making more income available for individual and families to pay for health-producing material goods instead of costly medical care. It is more likely, however, that the effect is more direct: through making health services more available to the people who would otherwise find it difficult to purchase them. To work in this way, however, the health services would have to be effective in reducing inequities in access to and receipt of them. Few health systems are fully capable of doing this. Eddy van Doorslaer and colleagues\(^5,6\) have demonstrated that equity in access to and use of primary care in most industrialized countries (but not the USA) has been achieved, although few countries have reached it for specialty care services.

A wide variety of types of studies (international comparisons, within-country comparisons, clinical studies in different types of facilities, population-based studies) robustly support the conclusion that people with a good source of primary care have better outcomes, including lower total mortality rates, heart disease mortality rates and infant (especially post-neonatal) mortality rates, even when the effects of income inequality are taken into account. They also experience earlier detection of cancers such as colorectal cancer, breast cancer, uterine/cervical cancer and melanoma. Almost uniformly, reductions in racial and ethnic disparities result from better exposure to primary care that achieves high levels of first-contact care (to avoid unnecessary and potentially dangerous secondary care interventions), person-focused care over time (not just within encounters and for specific diagnoses), provision of a broad range of services within primary care settings and coordination of care when people must go elsewhere for problems that are too uncommon for primary care practitioners to maintain competence in providing them. These benefits derive specifically from six characteristics of primary care: better and more equitable access to health services (especially for deprived populations); better technical quality of care overall; more adequate and appropriate preventive care (including screening for breast cancer); earlier and more appropriate management of health problems arising in people and populations (including reductions in hospitalizations for conditions that are treatable in community settings); better coordinated care; and the accumulated contributions of each of these essential features of primary care. Only when quality is assessed by disease-oriented criteria (rather than generic outcomes), do specialists show superiority in their particular area of practice and, even then, the findings are not robust.\(^7,8\)

As the health system in Canada is more primary care oriented than that in the USA, it is likely that the benefits of universal financial coverage are a result of better access to and use of better primary care services in that country. In the USA, the contribution of Medicare to improved equity in the over-65 population is a result of better access to and use of primary care services among the elderly.\(^9\) Given the choice of providing insurance or providing primary care services directly, the former is more important in providing access for acute care needs whereas the latter is more advantageous for achieving high-quality care over time.\(^9-13\) The advantages of better primary care for survival in breast cancer almost certainly can be attributed to more person-focused care, better access to more appropriate specialist care, interventions tailored to the needs of particular individuals and better coordination of care (with fewer adverse events) during and after therapeutic interventions.

Insurance is necessary but not sufficient. If the medical care that insurance facilitates is inadequately oriented towards primary care, neither health outcomes nor equity in their distribution will be achieved.

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References


