NATIONAL CENTER FOR POLICY ANALYSIS

Equality of Access to Medical Care: The Untold Story of the Changing Nature of the American Health Care System

Americans today enjoy the finest and most extensive health care of any nation in the world. They have the greatest access to medical services, and rank among the healthiest of all societies.

A recent Surgeon General's report underscores our excellent health status. It concludes: "The health of the American people has never been better." Between 1950 and 1980, the age-adjusted mortality rate for the U. S. declined by almost one-third. Between 1965 and 1981, the infant mortality rate was cut in half.

This achievement is partly the result of changing lifestyles and changing attitudes toward health. But it is also the result of two important developments in the health care marketplace. First, the rapid spread of private health insurance since World War II; and second, the growth of government-funded health insurance programs--Medicare (for the elderly) and Medicaid (for low-income families). Today, more than 94 percent of the American people are covered by some kind of health insurance, either private or public.

This report, one of several in a series of health policy analyses of the National Center for Policy Analysis, examines the implications of widespread health insurance coverage for low-income families, for black Americans and for the elderly.

ACCESS TO HEALTH CARE: LOW-INCOME FAMILIES

Data from the National Health Interview Survey, conducted periodically by the National Center for Health Statistics, reveal that throughout the decade of the 1970's:

- On the average, people with family incomes of less than $7,000 visited the doctor more often than any other income group.
- In addition, they spent more days in the hospital than any other income group--about twice as many days, for example, as families with incomes of $25,000 or more.

On the average, as family income rises, the use of medical services falls. The following tables illustrate this pattern:

Table I

Physicians Visits Per Capita by Income Group

Family Income	Visits, 1974	Visits, 1979
Less than $7,000	5.3	5.4
$7,000 - $9,999	4.9	5.0
$10,000 - $14,999	5.1	4.6
$15,000 - $24,999	4.8	4.6
$25,000 or more	5.2	4.7

Source: Data from National Health Interview Survey National Center for Health Statistics, 1974, 1979. Department of Health and Human Services, Washington, D. C.

Table II

Use of Hospital Facilities (Per 1000 Population) by Income Group

Family Income	Admissions 1974	Admissions 1979	Days of Care 1974	Days of Care 1979
Less than $7,000	160.9	163.0	1,717.3	1,490.0
$7,000 - $9,999	141.8	139.2	1,218.7	1,280.8
$10,000 - $14,999	137.3	127.4	1,130.1	1,101.4
$15,000 - $24,999	118.7	110.1	1,062.1	808.7
$25,000 or more	102.7	107.2	805.9	808.1

Source: National Health Interview Survey 1974, 1979

These tables show that in a system where the great majority of people have no financial barriers to health care, poor people will generally consume more health care than upper income groups. It is true that poor people tend to be sicker than more affluent people and, in addition, sickness is an important force in reducing individuals and families to poverty income levels. Even so, the magnitude of the difference is impressive: Throughout the 1970's, the poorest group of Americans tended to spend roughly twice as many days in a hospital per capita as the most affluent.

The poor who are covered by Medicaid have the best and most complete protection against medical expenses. They are largely buffered against the financial consequences of their health care choices. Thus, it should come as no surprise that family income is by and large inversely proportional to the amount of care families receive. Simply put, the poor who have assistance in purchasing their medical care tend to consume more health services than higher-income families, who must pay a much larger share out of their own pockets.

One factor that must be taken into account when discussing this pattern is that the poor see a doctor more often in hospital emergency rooms or outpatient clinics. Some of these facilities have a very impersonal atmosphere, and their personnel do not always show the respect for a patient's dignity that one expects when visiting a conventional physician in his private office.

But the other side of the coin is the fact that the staffs of hospital emergency rooms in inner-city neighborhoods tend to be expert--from long and repeated experience--in caring for the needs of victims of the violence which is endemic in many inner-city areas. A patient wounded by a bullet or knife slash is much more likely to be cared for properly in, say, the emergency room of New York's Harlem Hospital or Chicago's Cook County Hospital, than if that patient went to a suburban family physician or internist who may never see a bullet or knife wound for an entire year.

The following table shows the pattern of emergency room use for families at different income levels:

Table III

Physician Visits Per Capita: Hospital Emergency Rooms

Income	Visits	Percentage of Total Physician Visits
Less than $7,000	1.13	21.0%
$7,000 - $9,999	.79	15.4%
$10,000 - $14,999	.61	13.5%
$15,000 - $24,999	.52	11.2%
$25,000 or more	.43	9.1%

Source: National Health Interview Survey, 1979

ACCESS TO HEALTH CARE: BLACK AMERICANS

Just as there appear to be no institutionalized financial barriers to health care for low-income families generally, there appear also to be no serious financial barriers for most black Americans. In fact, black families are now consuming a significantly higher amount of health care than their white counterparts.

- In 1972, blacks spent 32 percent more days in hospitals than their white counterparts.
- By 1979, blacks were spending 50 percent more days in hospitals than their white counterparts.

Table IV

Hospital Stays: Days of Care Per Capita

	1972	1979
White	1.06	.96
Black	1.41	1.43

Source: National Health Interview Survey, 1972, 1979

Like low-income Americans, black families also visit hospital emergency rooms more often than white families. In fact, black families on the average make over twice as many visits to hospital emergency rooms each year as white families do.

Table V

Hospital Emergency Rooms: Physician Visits Per Capita, 1979

	Visits	% of Total Physician Visits
White	.5	11.7%
Black	1.1	24.5%

Source: National Health Interview Survey, 1979

ACCESS TO HEALTH CARE: THE ELDERLY

A major problem for all developed countries is the problem of creating access to health care for the elderly, who have more health problems than any other age group. In other countries, with comprehensive national health insurance schemes, the elderly are frequently discriminated against through the rationing of health care resources. In the United States, by contrast, the historical barrier for the elderly has been a financial one.

Data from the 1970's, however, reveal that partly because of Medicaid and Medicare, the average elderly patient today is consuming considerably more medical resources than younger patients are.

Elderly patients today, for example, see physicians over 50 percent more often than middle-aged patients do. They also spend four times as many days in the hospital as patients of middle age.

Table VI

Per Capita Use of Health Care Facilities by Age, 1979

	Physician Visits	Days of Care
Under 17 years	4.1	.35
17-44 years	4.5	.74
45-64 years	5.2	1.56
65 years or older	6.3	2.91

Source: National Health Interview Survey, 1979

RHETORIC VS. THE FACTS

What these data reveal is that the traditional rhetoric--that numerous Americans are being denied health care--is a gross distortion of reality. Why such rhetoric persists even now, 15 years after the passage of Medicare and Medicaid, is hard to understand except as an example of the durability of false stereotypes.

The fact that low-income Americans get more medical care on the average than higher-income Americans does not deny that there may be, and in fact probably are, some cases of low-income individuals who do not receive needed medical care. When unearthed and exploited, these cases rouse understandable public sympathy and strengthen the old stereotypes.

But on the whole, the numbers point to a very real and positive development--the problem of access to health care has largely been solved. We now need to turn our attention to the problem of improving the efficiency of health care delivery.

THE PROBLEM OF EFFICIENCY

Although there appear to be no serious problems in obtaining access to health care for most low-income families, there are serious problems in the way in which government programs designed to benefit the poor are administered.

For example, it is apparently not uncommon for unwed teenage mothers in the inner cities to carry their pregnancies to term without ever seeing a physician. This practice results in a high infant mortality rate and frequently leads to other serious health problems, both for the mother and the child. On the other hand, physicians throughout the country report countless examples of abuse of the Medicaid program--patients with minor health problems who make too many visits to physicians and spend unnecessary days in the hospital. [1]

A truly efficient health care program for the poor would be one in which the bulk of medical resources are allocated to those patients with the greatest health needs. To accomplish this goal, we must encourage those programs which target individuals with the greatest health risks--especially programs which have been shown to be cost effective. At the same time, methods must be adopted to discourage trivial visits to physicians and to discourage wasteful over-consumption of hospital resources. Small, nominal charges to Medicaid patients for basic medical services would undoubtedly go a long way toward achieving this goal.

1. Information supplied by Charles Ord, Executive Director of the American Association of Physicians and Surgeons.

In the current Medicaid program patients face a price of zero, and physicians and hospitals are reimbursed on the basis of cost. The result is that both the providers of medical care and the patients themselves have an incentive to overconsume medical resources.

SPIRALING COSTS OF GOVERNMENT HEALTH PROGRAMS

- Since the passage of Medicare and Medicaid, total expenditures on health have increased over 600 percent.
- Government spending on health has increased tenfold--twice the rate of private spending.
- Hospital expenditures under Medicare in 1980 were 4.3 times greater than the original estimate made when Medicare was enacted in 1965.

Table VII

Rising Expenditures on Health Care by Sector, 1965 & 1980

Year	Total Health Expenditures	Gov't. Health Expenditures (Billions of Dollars)	Private Health Expenditures
1965	41.7	10.8	30.9
1980	247.2	104.2	143.0

Source: Health Care Financing Review, September 1981, pp 18 & 19.

Since the enactment of the Medicaid and Medicare program, total expenditures on health care have increased sixfold. Government spending alone has jumped about tenfold. In addition, government, which provided only about one- quarter of all health dollars in 1965, now puts up more than 40 percent of the total. And because of Medicaid and Medicare, government spending on health care is increasing at twice the rate of private spending.

In response to this disturbing trend, Congress recently took a first step to controlling costs by passing legislation to reimburse hospitals at a fixed rate for the services they provide Medicare patients.

This new system, known as prospective payment, for the first time sets a limit on the amount of money the hospitals are paid under the Medicare program.[1] While this change is an important move in the direction of controlling costs, it must be viewed as only the first of many reforms needed to reign in the enormous outlays of government-funded health care.

SUMMARY

The American people, in particular low-income, black and elderly Americans, have greater access to health care than any time in history, thanks largely to government-sponsored health insurance. Yet, it is doubtful the backers of Medicaid and Medicare ever envisioned the kind of skyrocketing inflation now taking place. Having solved the basic problem of access to health care, we must now turn our attention to ways of increasing the efficiency of these programs and holding down their spiraling costs.

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1. Under the old system based on a retrospective system of reimbursement, the hospitals were paid for services rendered after the fact; hence, the more they spent the more the federal government had to pay them. Under this system, there was little incentive to be conscious of costs.