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Insuring the Uninsured
Time to End the Aura of Invisibility

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MOST PHYSICIANS HAVE THEIR STORIES. MINE DATES to one of my first nights on call as an intern in family medicine at San Francisco General Hospital in the summer of 1985. I was summoned to the emergency department to admit a young woman with a presumptive diagnosis of subacute bacterial endocarditis. For a new intern at that stage of unspoiled eagerness when the very act of wearing a pager instills a noble [illegible]se of professional duty, this type of call made me hasten to the emergency department in excited anticipation of encountering a patient with a classic but rare disease. Indeed, the patient had all the textbook characteristics of the infection: rheumatic fever in her youth, recent weeks of malaise and low-grade fevers, a holosystolic murmur, and blood cultures sent from clinic 2 days earlier growing chains of gram-positive cocci.

I explained to the patient the likely diagnosis and need for hospitalization. Her anxious expression intensified into one of panic. "Don't worry," I reassured her. "We have excellent antibiotics that can cure this disease. I am confident we can make you well."

"But I don't have insurance," she replied. "I can't pay the hospital bill. They'll take my house. I won't stay in the hospital."

I was dumbfounded. My medical school courses had taught me how to manage subacute bacterial endocarditis. But nothing in my medical education had prepared me to treat the terrible American disease of deficiency of health insurance.

This young woman was typical of many uninsured Americans. She worked full-time, but in one of those permanently "temporary" job classifications that made her ineligible for benefits from her employer. She had legally immigrated to the US many years earlier. Her husband was a self-employed truck driver. The patient and her husband earned a modest family income, and had saved enough money to have just purchased a small house in anticipation of having children. Suddenly, the tragedy of her serious illness was compounded by the terror of potential financial ruin and loss of her home.

Most physicians have similar stories. Stories of the anguished look in the eyes of a patient who does not know where the money will come from to pay for a pharmacy bill. Stories of the patient with advanced stage breast cancer who never followed through on obtaining the mammogram ordered years earlier because she did not have insurance. Stories that define in starkly human terms the problems of access to care and the egregious inequity of the US health system.

From the Aura of Inevitability to the Aura of Invisibility

In the years following my personal introduction to the plight of the uninsured, the medical profession and the nation visibly struggled to confront and remedy these systemic problems. In 1991, *JAMA* published the first of its theme issues devoted to the problems of the uninsured and underinsured. The following year, public support for health care reform helped to carry Bill Clinton into office as president. As the momentum for change grew, Americans no longer asked "Will we have universal health care?" but "What type of universal system will we have?" Then abruptly, in the summer of 1994, health care reform imploded. The Clinton health plan was dead on arrival in Congress. In California, voters rejected a ballot initiative sponsored by a grass-roots coalition that sought to establish a single-payer state health plan.

Exhaustive analyses of the failed universal health care proposals in the United States identified myriad reasons for their

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demise.[1,2] Special interests, in particular the insurance industry, poured tens of millions of dollars (of subscriber premiums) into media campaigns opposing universal insurance schemes involving a prominent role for government. Many people in the United States (at least many of those who vote) have a strong antigovernment, antitax ideology, an ideology so emboldened by the Reagan era as to seemingly stamp out the last vestiges of New Deal politics. People in the United States often find it difficult to agree on health policies, such as the choice of single payer vs employer mandates vs tax credits as the preferred type of universal insurance.

In editorials accompanying the initial *JAMA* theme issues on the uninsured and underinsured, Lundberg wrote of the "aura of inevitability" of imminent health care reform.[3-5] In the years after 1994, an aura of invisibility descended on this problem. Legislators suddenly distanced themselves from universal health care proposals, apparently fearing that embracing plans for sweeping reform would endanger their political life expectancy. The media quickly moved on to other health care issues. In the late 1980s and early 1990s, hardly a week went by without a major newspaper, magazine, or TV news show presenting a headline about the increasing numbers of uninsured or a human interest story about the suffering of the uninsured. By the mid-1990s, these stories were replaced by accounts of the struggles between insured people and their managed care plans—an important issue, to be sure, but one that crowded out news coverage of the persistent, fundamental inequities in the nation's health system.

Not surprisingly, the public became afflicted with growing apathy—or perhaps simply succumbed to false reassurance—about access to care for the uninsured and underinsured. Unlike the situation several years ago, a majority of Americans now believe that uninsured persons in the United States can obtain medical care when they need it.[6] In an April 2000 poll, only 15% of respondents indicated that health care is 1 of the 2 most important issues for government to address, down from 55% who thought so in an August 1994 poll.[7] For the first time in half a century, the Democratic Party in 1996 dropped its commitment to enacting universal insurance from its platform.[8]

Increasing Numbers of Uninsured and a Fraying Safety Net

Despite this aura of invisibility, the problem of the uninsured has worsened over the past decade. Forty-three million people in the United States were uninsured for the entire year in 1999, representing 15.5% of the total population.[9] The number of uninsured increased by nearly 10 million between 1990 and 1998 before declining in 1999 for the first time in more than a decade, from 44.3 million in 1998 to 42.6 million in 1998.[10] However, it is remarkable that the recent boom in the economy and enactment of incremental expansions of coverage such as the Children's Health Insurance Program have had such a relatively minor impact on the long-term trend of growing numbers of uninsured.[10,11] As the article by Ayanian et al[12] in this issue of THE JOURNAL demonstrates, uninsured patients continue to experience poor access to medical care. Compared with insured patients, those without insurance are 2 to 3 times more likely to report that they could not see a physician in the past year due to cost, and they did not receive appropriate preventive services. The data used in that study are new (1997 and 1998), but the conclusions are depressingly old. Virtually every study on this topic conducted in the past 15 years has shown that access to care and health outcomes are inferior for uninsured patients.

Not all uninsured patients in the United States completely forgo health care. Many receive services from an informal system of safety-net care that has developed to assist disadvantaged populations. This safety net consists both of organizations such as community health centers and public hospitals that have an explicit mission to care for uninsured and poor patients, and of practitioners and institutions that predominantly care for insured patients but are willing to reduce or waive their fees when caring for uninsured patients. The study by Forrest and Whelan[13] indicates that this latter component of the safety net—private, office-based physicians—provides more than three quarters of all ambulatory care delivered to uninsured and Medicaid patients. Other organizations fill crucial niches in the safety net. Community health centers play a strategic role in caring for urban minority and rural populations. The article by Broyles et al[14] in this issue reports the special effort of 1 hospital outpatient department in Texas to improve access to care for high-risk, low-income children.

The existing safety net is essential, but it will always be what its name implies: a fallback system to catch people who lack a secure footing in the health insurance system. Although the safety net protects some patients from the traumatic consequences of lacking health insurance, the safety net cannot fully compensate for the lack of universal health insurance. Moreover, the existing safety net is imperiled. A recent Institute of Medicine report concluded that health care trends in the United States "are beginning to place unparalleled strain on the health care safety net."[15] Physicians experiencing growing economic pressures from competitive managed care plans are decreasing the amount of charity care they provide.[16] Federal policies enacted in the 1997 Balanced Budget Act are reducing subsidies to safety-net hospitals for uncompensated care.[15]

Health Insurance, Quality of Care, and Health

Health insurance is vital for good access to care. But health insurance alone cannot ensure good access to quality care, nor good health itself. Eisenberg and Power[17] offer a useful framework for understanding the series of "voltage drops" that may occur between the "availability of insurance and the delivery of high-quality care." Other analysts have pointed out that even the best medical care does not seem to eradi-

cate disparities in health status associated with differences in socioeconomic status, and that greater attention needs to be paid to addressing more fundamental determinants of health and illness.[18]

Persons who are skeptical about the need for universal insurance may be tempted to interpret these observations as justification for abandoning the campaign for universal coverage. To the contrary, appreciating the more formidable health system challenges makes the lack of universal coverage in the United States all the more inexcusable. No national health system has mastered quality of care or eliminated social disparities in health. These are truly daunting challenges without easy blueprints for constructing solutions. All developed nations with the exception of the United States have achieved 1 simple thing: guaranteeing their residents universal health care. There is no shortage of functioning models around the world demonstrating the feasibility of universal coverage. The chasm separating the United States from universal coverage represents a deficit in national political will, rather than a lack of technically viable options.

Ending the Aura of Invisibility

The United States must end the aura of invisibility surrounding the problems of the uninsured and underinsured. For physicians and other health professionals, one simple way to begin is by telling their stories. The indecency of the nation's system of financing health care must once again become front-page news. In addition to issues devoted to access to care, medical journals should regularly publish case studies that put a human face on the ongoing problems of the uninsured and underinsured. Several physician organizations have Web sites that catalogue both individual stories and research literature about the uninsured (http://www.pnhp.org/; and http://www.acponline.org/uninsured/index.html).

Outrage is justified and necessary to end the aura of invisibility. It is outrageous that a rich nation with a large government budget surplus does not have universal health care coverage. It is unacceptable that in this presidential election year, neither of the nation's major political parties have thus far included a commitment to enacting universal health insurance in its platform.[19,20] The challenge for the nation, of course, will be to translate empathy and outrage into political action that can surmount the many obstacles to meaningful health care reform. It may well be that health care reform in the United States will be contingent on other changes occurring first: campaign finance reform, a serious economic downturn that injects a new bolus of middle-class Americans into the masses of the uninsured, or some other unpredictable change in the sociopolitical landscape.

Will universal coverage arrive in the United States? In the play "Twilight Los Angeles, 1992," by Anna Deavere Smith, a character discusses the future of race relations in the United States in the aftermath of the Rodney King riots.[21] The character points out that there is a difference between optimism and hope. Optimism, says the character, is based on a scientific judgment of what is likely to happen. Hope, on the other hand, is a matter of faith. About improvement in race relations, the character concludes that he is hopeful but not optimistic.

About prospects for universal health insurance coverage in the United States, I remain hopeful if not optimistic. I am not willing to believe that the United States cannot achieve a more just health care system.

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