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Marking 33 Years of Universal Health Coverage

Unknown to most Americans, the United States provides universal health coverage to its more than 305 million citizens and legal residents. Such coverage began 33 years ago, growing out of the 1946 Hill Burton Program that helped finance the construction of many hospitals throughout the country. According to the Federal Health Resources and Services Administration Web site:

> *In 1975, Congress enacted an amendment to the Hill-Burton Program, Title XVI of the Public Health Service Act, which established Federal grants, loan guarantees, and interest subsidies for health facilities. Facilities assisted under Title XVI were required to provide uncompensated services in perpetuity.*

Therefore, if hospitals are required by federal law to treat sick people irrespective of their ability to pay for care—it is tied to hospitals accepting federal grants, loans, etc.—then universal health coverage exists: Everyone has access to care irrespective of their health insurance coverage. Unfortunately, this "universal care" is probably the worst framework for deployment of universal coverage.

Expensive 37th Ranking

Under our current system, uninsured patients obtain care when it is more acute and expensive to treat. Care is provided in the emergency room where it is many times more costly than comparable care delivered in a clinic or physician's office. Finally, continuity of care rarely exists, leading to failed follow-up and little opportunity to provide preventive services.

Although much faith is placed on information technology to help control the rapidly increasing cost of care, IT is simply a tool and not a solution to problems of cost, quality, and access.

According to the World Health Organization's *The World Health Report 2000 — Health Systems: Improving Performance:*

> *The U.S. health system spends a higher portion of its gross domestic product than any other country but ranks 37 out of 191 countries according to its performance,… The United Kingdom, which spends just six percent of GDP on health services, ranks 18th.*

Therefore, our sub-standard universal healthcare coverage built on Title XVI plus our investment of more than $2 trillion—equal to more than 16% of GDP—delivers a level of quality and access to healthcare that trails most of the world's industrialized countries. In addition, this high cost of care weighs heavily on businesses trying to compete in a global marketplace.

Although much faith is placed on information technology to help control the rapidly increasing cost of care, IT is simply a tool and not a solution to problems of cost, quality, and access. Policy changes drafted from an overarching strategic healthcare vision are required first before healthcare IT can be utilized to solve problems.

Public and Private Universal Coverage

This past May, Schoen et al. of the Commonwealth Fund published an article in *Health Affairs* making the case for a more robust universal healthcare coverage. The article titled "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance" introduces a path and presents arguments supporting a comprehensive universal healthcare plan. The plan considers the underpinnings of competitive free markets as well as the concerns of public health advocates who seek untying access to care from the ability to pay. The plan builds upon the existing mix of public and private coverage by expanding group coverage through private and public sponsored insurance.

The authors suggest a national insurance "connector" that offers small businesses and individuals a choice of a Medicare-like public option and private plans. Under the plan, individual coverage is mandatory, employer contributions are required, and tax credits are offered to assure affordability.

Table 1: Building Blocks Framework

Element	Description
Insurance connector: Choice of Medicare and private plans	Establish Medicare-like option for those under age 65 along with a choice of private plans for businesses with fewer than 100 workers, the self-employed, and everyone without large-employer insurance or Medicare. Mandate of standard benefits.
Employer play-or-pay	Employer mandate of coverage for employees or a 7% payroll tax up to $1.25 per hour.
Medicare expansion	Enhanced benefits package offered to seniors at a premium amount.
Medicaid/SCHIP expansion	All legal residents below 150% of poverty would be eligible for SCHIP-type acute care services.
Premium assistance	Refundable tax credits based upon adjusted gross income thresholds.
Mandatory participation and automatic enrollment	Mandatory with evidence of insurance supplied at time of tax filing.
Insurance market rules	To avoid adverse selection, federal standards would require states to establish community or community modified rating and guaranteed issue of insurance.

The principles of the "Building Blocks" framework are to:

1. Provide access and affordability, with a national minimum standard of benefits, and financial protection relative to income.
2. Offer choice of physicians and health plans.
3. Lower administrative costs.
4. Share responsibility for financing among government, business, households, and other stakeholders.
5. Pool health risk broadly, with market rules to limit competition based on health risk in private or public markets.

Table 1 explains the elements of the "Building Blocks" framework. The authors expect a net increase in healthcare spending of $15 billion on a base of over $2.4 trillion in projected national spending for 2008. They suggest that their plan allows for the maximum amount of coverage with a minimum of disruption.

Albert Einstein once defined insanity as "doing the same thing over and over again and expecting different results." As our healthcare system remains on the same path, functioning the same way, is it surprising that costs continue to rise, while quality and access do not improve?

Good Thing, Bad Thing

The universal coverage plan proposed by the leaders of the Commonwealth Fund offer something to be pleased about and something to be concerned about for people on all parts of the political spectrum. For those on the right, the plan makes use of private markets and choice—a good thing—but expands government and public spending—a bad thing. For those on the left, the plan expands coverage to the uninsured and eases the financial burden on middle-income families—a good thing—but continues to allow a tiered system of inequality of coverage based upon an individual's ability to pay—a bad thing. Perhaps the fact that there is a bit of good and bad for everyone shows the strength of the plan and the inherent compromises it anticipated as necessary to build acceptance by a heterogeneous public.

Although health IT offers great promise as a tool to improve quality, safety, and access to care, its impact is driven by the marketplace and healthcare policies under which it is deployed. Fixing the problems of access and financing of care through a broadly accepted universal coverage program presents an opportunity for our healthcare system to effectively leverage health IT. With healthcare as one of the top five issues in this presidential election year, I encourage you, a healthcare leader in your work setting and community, to spend some time studying the Commonwealth Fund universal coverage proposal. Whether you agree or disagree with its content, it will provide a framework to develop your own vision for universal coverage that is different from the current inadequate services provided courtesy of Title XVI of the Public Health Service Act. PSQH

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Further Reading

Chaiken, B.P. (2006). Can we deliver quality care without universal coverage? ***Patient Safety & Quality Healthcare. 3***(2), 10-11.

References

http://www.hrsa.gov/hillburton/compliance-recovery.htm

http://www.who.int/whr/2000/media_centre/press_release/en/index.html

Schoen, C., Davis, K., Collins, S. R. (2008). Building blocks for reform: Achieving universal coverage with private and public group health insurance. *Health Affairs, 27*(3), 646-657.