Chapter Two

The Economics of Women's Health

Chapter Objectives

On completion of this chapter, the student should be able to discuss:

1. The third-party payer system.
2. The fee-for-service model versus managed care.
3. Factors to consider when choosing an insurance plan.
4. Types of public health insurance, including Medicare and Medicaid.
5. The significant risks associated with being uninsured.
6. Ways that women as healthcare consumers affect demand within the healthcare system.
7. Healthcare reform and the arguments for and against a universal health system.
8. The financial burden of aging and how it disproportionately affects women.
9. Long-term care and its associated costs.

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Introduction

In the United States, the economics of health care—how it is financed, what the individual's responsibility for payment is, which services should be paid for, and which social factors influence the availability of care—are the key issues behind most health-care-related decision making and policy. Participants in the health-care system, including physicians, patients, hospitals, health insurers, health education firms, and pharmaceutical, medical device, and diagnostic companies, all work to shape the direction of health care. Although most individuals believe that all people have a right to health care, significant debate has arisen regarding the best pathway to achieving that goal.

Increasingly, health care is becoming a consumer- or patient-oriented industry. As in other markets, goods and services are being developed to court consumers and drive demand for specific services. At the center of the health-care paradigm, the patient is becoming a vital health-care decision maker and is increasingly being targeted by information on diseases and available treatments. Patients are showing a growing willingness to shop around for different providers, an increasing demand for wide access to services, and a growing eagerness to pursue litigation in cases of perceived substandard care.

Understanding the effects of women's growing economic power on women's health and the persistent limitations that marginalized women face in accessing quality women's health care is critical. A discussion of the way in which the health-care system is funded identifies how the system functions and leads to an examination of the factors that create inequities in women's health care. Other important issues include the economics of aging and the effects of an aging population on women's health, public policy that influences the economics of health care, and the roles that women as caregivers have in the delivery of health care.

Paying for Health Care

Health care functions within the parameters of a market setting, offering goods and services that carry costs to health-care consumers and patients. Unlike in other markets, like real estate or retail, all individuals are health-care consumers at one stage or another of their lives. People do not have control over the degree to which they need to interact with the health-care system in the same way that they do when deciding whether to purchase a TV. If a woman has heart disease and needs to go to a cardiologist, she has very little choice except to purchase the services needed or go without care. In addition, a patient must trust her physician to tell her which goods and services she needs instead of making that decision on her own. The necessity of health care, and an individual's inability to have full information to make purchasing choices, make health care a unique market from an economic perspective.

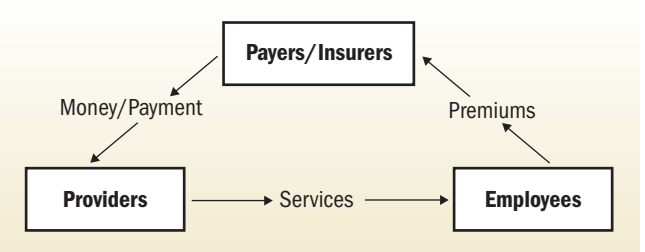

Figure 2.1

The third-party payer system.

In the United States, the health-care system is based on a **third-party payer system** in which most individuals do not pay directly for the delivery of care (**Figure 2.1**). Instead, many have health insurance, which, in return for a monthly or yearly payment called a premium, provides coverage for health-related goods and services. Before third-party payers became a mainstay of the U.S. system, patients would pay out-of-pocket for health care, either to their doctor or to hospitals. Medical care was purchased and delivered much like most other commodities. Private health in-

■ Before World War II, few Americans had health insurance.

surance was introduced in the early 1930s as a method to minimize the risk associated with hospital care costs. At that time, if an individual became sick or was injured on the job, the financial repercussions of paying for medical care could be significant. In response, health insurance was developed and based on an **indemnity** or **fee-for-service** system. Through this system, hospitals were reimbursed by health insurers based on a list of charges for services rendered. As the third-party payer system matured, it grew to include fee-for-service payments to physicians and other outpatient providers of health care (**Table 2.1**).

Today, most people (71%) are covered by private health insurance either provided by their employer or purchased individually. Much of private health insurance is now structured within a managed care plan. **Managed care** was introduced as a method to control costs by changing how the delivery of care is coordinated and how health care is reimbursed. In contrast to a fee-for-service model, managed care requires patients to go to specific providers, have access to care only when certain criteria are met, and, in some cases, the payer pays physicians a lump sum for all care delivered as opposed to a fee for each service rendered.

Table 2.1 **UN Conference in Beijing: Twelve Critical Areas of Concern for Women's Health**

1900s:	▪ American Medical Association (AMA) becomes a powerful national force. ▪ In 1901, AMA reorganizes as the national organization of state and local associations. Membership increases from about 8,000 physicians in 1900 to 70,000 in 1910—half the physicians in the country. This period is the beginning of "organized medicine." ▪ Doctors are no longer expected to provide free services to all hospital patients. ▪ The United States lags behind European countries in finding value in insuring against the costs of sickness. ▪ Railroads are the leading industry to develop extensive employee medical programs.
1910s	▪ U.S. hospitals are now modern scientific institutions, valuing antiseptics and cleanliness, and using medications for the relief of pain. ▪ American Association for Labor Legislation (AALL) organizes first national conference on "social insurance." ▪ Progressive reformers argue for health insurance and seem to be gaining support. ▪ Opposition from physicians and other interest groups, plus the entry of the United States into the war in 1917, undermine the reform effort.
1920s	▪ Consistent with the general mood of political complacency, there is no strong effort to change health insurance. ▪ Reformers now emphasize the cost of medical care instead of wages lost to sickness. The relatively higher cost of medical care is a new and dramatic development, especially for the middle class. ▪ The cultural influence of the medical profession grows—physicians' incomes are higher and prestige is established. ▪ General Motors signs a contract with Metropolitan Life to insure 180,000 workers. ▪ Penicillin is discovered. It will be 20 years before this antibiotic is used to combat infection and disease.
1930s	▪ The Depression changes priorities, with greater emphasis being placed on unemployment insurance and "old age" benefits. ▪ The Social Security Act is passed, omitting health insurance. ▪ There is a push for health insurance within the Roosevelt Administration, but politics begins to be influenced by internal government conflicts over priorities. ▪ Against the advice of insurance professionals, Blue Cross begins offering private coverage for hospital care in dozens of states.
1940s	▪ Prepaid group health care begins; it is seen as radical. ▪ During World War II, wage and price controls are placed on U.S. employers. To compete for workers, companies begin to offer health benefits, giving rise to the employer-based system in place today. ▪ President Roosevelt asks Congress for an "economic bill of rights," including the right to adequate medical care. ▪ President Truman offers a national health program plan, proposing a single system that would include all of U.S. society. ▪ Truman's plan is denounced by the American Medical Association (AMA), and is called a Communist plot by a House subcommittee.
1950s	▪ At the start of the decade, national health-care expenditures are 4.5% of the gross national product. ▪ Attention turns to the Korean War and away from health reform; the United States will have a system of private insurance for those who can afford it and welfare services for the poor. ▪ Federal responsibility for the sick poor is firmly established. ▪ Many legislative proposals are made for different approaches to hospital insurance, but none succeeds. ▪ Many more medications are available now to treat a range of diseases, including infections, glaucoma, and arthritis, and new vaccines become available that prevent dreaded childhood diseases, including polio. The first successful organ transplant is performed.

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1960s
- In the 1950s, the price of hospital care doubled. In the early 1960s, those outside the workplace, and especially the elderly, have difficulty affording insurance.
- More than 700 insurance companies sell health insurance.
- Concern about a "doctor shortage" and the need for more "health manpower" leads to federal measures to expand education in the health professions.
- Major medical insurance endorses high-cost medicine.
- President Lyndon Johnson signs Medicare and Medicaid into law.
- "Compulsory health insurance" advocates are no longer optimistic.
- The number of doctors reporting themselves to be full-time specialists grows from 55% in 1960 to 69% by 1969.

1970s
- President Richard Nixon renames prepaid group health-care plans as health maintenance organizations (HMOs), with legislation that provides federal endorsement, certification, and assistance to them.
- Health-care costs are escalating rapidly, partly due to unexpectedly high Medicare expenditures, rapid inflation in the economy, expansion of hospital expenses and profits, and changes in medical care, including greater use of technology, medications, and conservative approaches to treatment. U.S. medicine is now seen as in crisis.
- President Nixon's plan for national health insurance is rejected by liberals and labor unions, but his "War on Cancer" centralizes research at NIH.
- The number of women entering the medical profession rises dramatically. In 1970, 9% of medical students are women; by the end of the decade, the proportion exceeds 25%.

1980s
- Corporations begin to integrate the hospital system (previously a decentralized structure), enter many other health-care-related businesses, and consolidate control. Overall, there is a shift toward privatization and corporatization of health care.
- Under President Reagan, Medicare shifts to payment by diagnosis (DRG) instead of by treatment. Private plans quickly follow suit.
- Growing complaints are voiced by insurance companies that the traditional fee-for-service method of payment to doctors is being exploited.
- "Capitation" payments to doctors become more common.

1990s
- Health-care costs rise at double the rate of inflation.
- Expansion of managed care helps to moderate increases in health-care costs.
- Federal health-care reform legislation fails again to pass in the U.S. Congress.
- By the end of the decade 44 million Americans, 16% of the nation, have no health insurance at all.
- The Human Genome Project to identify all of the more than 100,000 genes in human DNA gets under way.
- By June 1990, 139,765 people in the United States have HIV/AIDS, with a 60% mortality rate.

2000s
- Health-care costs are on the rise again.
- Medicare is viewed by some as unsustainable under the present structure and must be "rescued."
- Changing demographics of the workplace lead many to believe the employer-based system of insurance cannot last.
- The Human Genome Project was completed a full two years ahead of schedule, in 2003.
- Direct-to-consumer advertising for pharmaceuticals and medical devices is on the rise.
- Medicare expands to include a prescription drug benefit as of January 2006.
- Employers continue to cut down on health insurance benefits in an attempt to address persistent increases in costs.
- Medical savings accounts become common.
- President George W. Bush unsuccesfully tries to privatize Social Security.
- Congress passes a major expansion to State Children's Health Insurance Program (SCHIP), which will provide insurance for an additional 4 million low-income children, in 2009.

Source: Adapted from *Healthcare Crisis: Who's at Risk?* Healthcare Timeline, PBS. Produced by Issues TV, 2000. Reprinted with permission.

Managed care has been perceived both as a driver of positive change by keeping costs down and providing broad access to services and as a villain by placing limits on care. It is blamed for decreased access to care, shorter physician office visits, higher co-payments, and more restrictions on which doctors patients can see. Managed care is not a static concept; in fact, the types of products that are offered are continually evolving to meet the changing needs and demands of patients, employers, and providers.

The limitations on access that lead patients and physicians to vilify managed care ended up slowing the rate at which health-related expenditures grew in the United States in the 1990s (see **Figure 2.2**). This goal was accomplished by managed care organizations asking for more

Employment-based health benefit programs have existed in the United States for more than 100 years. In the 1870s, for example, railroad, mining, and other industries began to provide the services of company doctors to workers. In 1910, Montgomery Ward entered into one of the earliest group insurance contracts. Prior to World War II, few Americans had health insurance, and most policies covered only hospital room, board, and ancillary services. During World War II, the number of persons with employment-based health insurance coverage started to increase for several reasons. When wages were frozen by the National War Labor Board and a shortage of workers occurred, employers sought ways to get around the wage controls in order to attract scarce workers, and offering health insurance was one option. Health insurance was an attractive means to recruit and retain workers during a labor shortage for two reasons: unions supported employment-based health insurance, and workers' health benefits were not subject to income tax or Social Security payroll taxes, as were cash wages. Under the current tax code, health insurance premiums paid by employers are deductible for employers as a business expense, and are excluded, without limit, from workers' taxable income.[1]

stringent proof of medical necessity before services are paid for—for example, by requiring physicians to get prior authorizations from the payer before certain care is rendered. Another method for controlling costs has been to allow members to get care only from a specific network of physicians who have contracted with the payers to offer low-cost care, or to make patients pay higher co-payments if they see doctors who are not members of the network. By controlling the supply of health-care resources, however, managed care organizations have been able to provide patients with access to a wider range of services at a relatively reasonable cost, such as pharmaceuticals and rehabilitation services, than fee-for-service models are now able to offer. More recently, health care as a share of the gross domestic product (GDP) has begun to rise fairly rapidly.

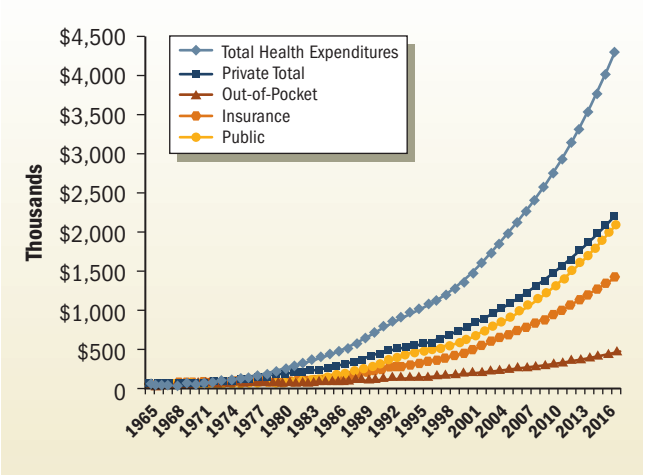


Figure 2.2

National health expenditures: 1965–2017 (projected).

Source: Centers for Medicare & Medicare Services, Office of the Actuary. National Health Expenditures data. Released January 2008.

It's Your Health

Drive-Through Deliveries

In the 1990s, HMOs and other managed care plans shortened average maternity stays for normal births. Such programs were dubbed "drive-through deliveries." Because women were being discharged from hospitals only 24 to 48 hours after giving birth, many lawmakers, alarmed that the practice would endanger newborns, adopted laws to require insurance coverage for at least 48 hours of care after delivery.

In a study conducted at Harvard Medical School, researchers found that newborns needed the same number of later emergency room visits and hospital readmissions, regardless of whether they had longer initial stays or shorter ones. In essence, the shorter stays were not adding risk to the newborns, even though the "common sense" of many women and legislators suggested that it would. The study looked at 20,366 normal deliveries in the 1990s. During the period studied, newborn visits to emergency rooms kept steady at an average of about 1% every three months. Hospital readmissions hovered around 1.5%. The same pattern held for a more vulnerable group of young, lower-income mothers with less education.

In an article on this subject published by the Associated Press (December 18, 2002), Larry Akey, a spokesman for the Health Insurance Association of America, said that short-stay programs were designed "not entirely as cost-saving measures, but an opportunity for the mother to get home" faster. The debate continues among women's advocacy groups, health insurers, and hospitals.

Managed care plans differ based on the level to which they control what services are provided to patients. Types of managed care plans include preferred provider organizations (PPOs), health maintenance organizations (HMOs), and point-of-service (POS) plans. **Table 2.2** describes the various types of managed care plans. Almost all health insurers today offer some form of managed care products or include elements of managed care products such as physician networks or tiered co-payments into their existing product lines.

In paying for health care, insurers decide which types of services they will cover (see **Figure 2.3**). Hospital care, outpatient care, physician office visits, diagnostic tests, preventive services, prescription drugs, mental health services, durable medical equipment like wheelchairs, and home health care are all elements of health care that most people would consider important; however, all of these are separate services that may or may not be covered under a given

Table 2.2 Table Title here

Health Maintenance Organization (HMO): An HMO is a managed care plan that offers a full range of services for a fixed prepaid fee, rather than charging patients for each service provided. Patients normally pay only a small co-payment for care. With some plans and for some services, patients also have to satisfy a deductible. Usually, patients don't have to file claims.

HMO plans typically fall into one of two categories:

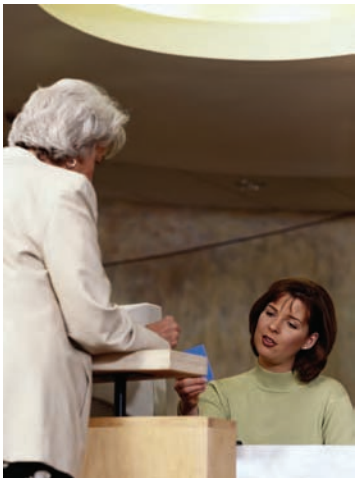
- **Staff Model:** A staff model HMO has salaried physicians who provide services only to plan members. They offer care at a hospital, clinic, or health center in the community.
- **Independent Practice Association (IPA):** An IPA maintains contracts with a number of physicians and/or physician group practices. These physicians see patients in their own offices.

Point-of-Service (POS) Plan: POS plans function much like IPAs. Patients select a primary care physician who coordinates all care within the participating provider network, including specialist referrals.

Preferred Provider Organization (PPO): A PPO plan functions much like a POS plan, but it eliminates the primary care physician. As with the POS plan, patients can use a health-care provider outside of the preferred provider network for an additional cost. Patients can usually see any participating provider—whether a primary care physician or a specialist—without a referral, at no additional cost.

High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA): An HDAR/HSA or HRA provides traditional medical coverage and a tax-free way to build savings for future medical expenses. It gives patients flexibility and discretion over how health-care benefits are used. The HDHP features higher annual deductibles than other plans (usually $1,000 to $2,000) and usually has some upper limit on out-of-pocket liability. HDHPs make consumers share the financial burden of health-care utilization. Most plans' coverage doesn't kick in until a large deductible is met, though many plans will pay for routine preventive care before the deductible is met.

■ A co-pay is the amount of money that a patient is responsible for paying to receive health-care services; co-pays are either a fixed amount of money or a percentage of the overall charge for a given service.



insurance plan. As patient demand evolves, many alternative therapies and preventive care services, such as massage, acupuncture, and chiropractic care, are beginning to be covered by health insurance.

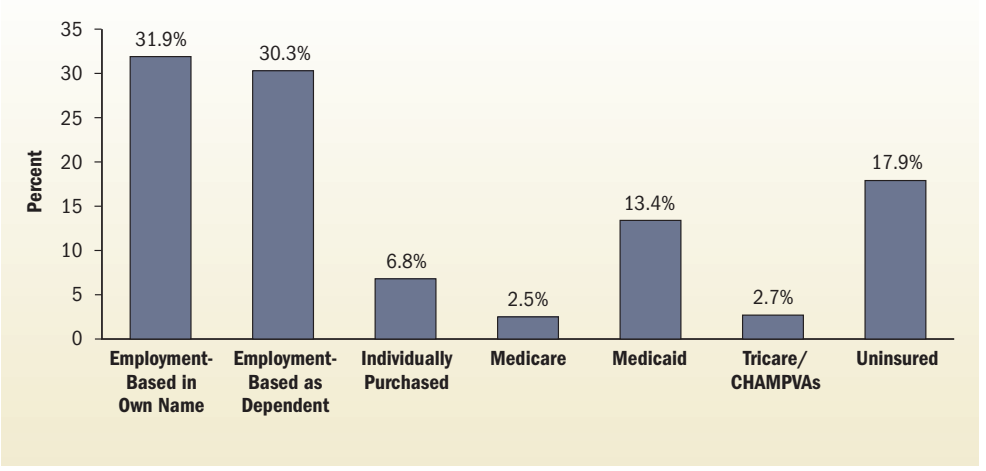
Choosing an Insurance Plan

When people choose between different insurance options, their choices are often influenced by which services are covered or what percentage of the total cost the insurer will pay. If a woman thinks that she is unlikely to use many services, as a 26-year-old woman without any existing medical conditions might, she may opt for a less expensive insurance program like an HMO that has more restricted coverage. Regardless of the insurance program selected, an individual is at significant financial risk if her insurance does not cover or only partially covers the services that she uses. The inability to pay for health care, beyond insurance premiums, leads many people to avoid going to the doctor when necessary or to cut short therapy if it becomes too expensive.

Figure 2.3

Health insurance coverage of nonelderly Americans by source of coverage, 2006.

Source: Employee Benefit Research Institute estimates from the March Current Population Survey, 2007 Supplement.



As a method to manage rising costs, patients are increasingly being required to pay out-of-pocket for a portion of their health care. A **co-payment** (or **co-pay**) is the amount of money a patient is responsible for paying to receive health-care services. Co-pays can be either a fixed amount of money, like a $10 or $20 co-pay for a routine office visit, or a percentage of the overall charge for a given service (referred to as a co-insurance), like the popular 80% covered/20% patient responsibility payment schemes.

With prescription drugs, many payers have introduced a tiered co-pay system, in which different levels of payment are required for different types of medications. Most tiered co-pays try to reward patients for purchasing lower-cost generic drugs, as opposed to more expensive brand-name drugs. **Generic drugs** are the chemical equivalents of brand-name drugs, but are far less expensive. Within a tiered co-pay system, for example, a patient may pay $5 for a generic antibiotic, $15 for a preferred brand-name drug, and $25 for the premium-cost brand-name drug. Women often are forced to make significant co-pays for birth control pills, with many prescriptions falling into the highest co-pay tier. As a result, a woman may have to pay $20 to $40 per month to control her fertility. Health insurers have lists of drugs for which they provide reimbursement called **formularies**, which describe to patients and doctors which drugs are covered, into which tier each drug falls, and how much each drug will cost the patient.

Out-of-pocket costs to women continue to be a significant barrier to appropriate care and compliance with taking medication. A report by the Kaiser Family Foundation found that one in five (21%) non-elderly women did not fill a prescription because of the cost, compared with 13% of men.[1] This issue was also a problem for 40% of uninsured women, 27% of women with Medicaid, and 15% of privately insured women.

Types of Health Insurance

Employer-sponsored health insurance, as well as health insurance purchased by individuals, is considered **private health insurance**. Most private health insurance in the United States is purchased and subsidized by employers. When an individual has a full-time job, health insurance is often a central benefit. Employer-sponsored health insurance can often be extended to cover the family of the insured individual.

Public health insurance is insurance provided by the government. The federal government is the largest health insurer in the United States through its Medicare, Medicaid, Veterans Administration, Department of Defense, and Bureau of Indian Affairs insurance programs (see **Figure 2.4**). Medicare is the result of a bill enacted by Congress in 1965 to provide health insurance at a reasonable cost to Americans aged 65 and older. Medicare is provided in several parts:

- Part A is provided to all enrollees and covers inpatient hospitalization.
- Part B is optional and covers outpatient services.
- Part D is optional and covers a portion of prescription drug costs.

Since 1965, the program has grown to cover disabled individuals and patients with end-stage renal disease. Most recently, it has grown to include a portion of prescription drug coverage. Medicare's prescription drug coverage is expected to have a significant impact on who pays for

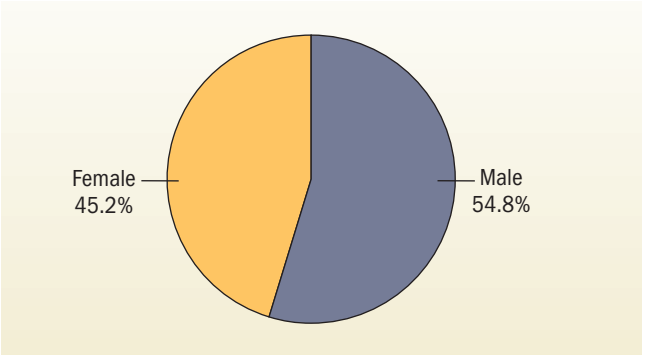


Figure 2.4

Uninsured nonelderly adult population by gender, 2006.

Source: Employee Benefit Research Institute estimates from the March Current Population Survey, 2007 Supplement.

Due to the aging population and the fact that women live longer than men, an increasing majority of Medicare beneficiaries are women.

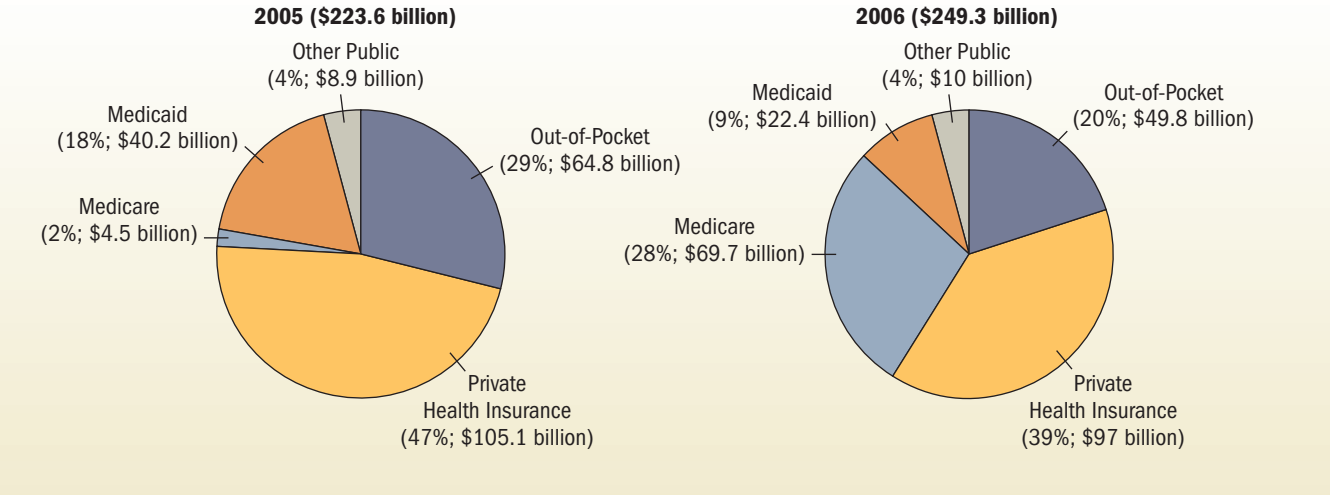


Figure 2.5

Projected prescription drug spending, by payer, 2005 and 2006.

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

prescription drugs in the United States (see **Figure 2.5**). Today, Medicare is the largest single insurer in the United States, covering more than 42 million people, 56% of whom are women. Due to the aging of the population and the fact that women live longer than men, an increasing majority of Medicare beneficiaries who are the oldest of the old are women (**Figure 2.6**).

Medicaid is a program jointly administered by federal and state governments that provides health insurance for low-income Americans. Whereas Medicare is a federally controlled health system, Medicaid is largely run at the state level. In some states, such as California and Tennessee, Medicaid has a state-specific name (MediCal, TennCare). The vast majority of Medicaid recipients are low-income women and their children; the children are covered through State Children's Health Insurance Programs (SCHIPs). Medicaid and the benefits it provides are fundamental to the provision of health care to economically disadvantaged women and children in the United States. In 2009, legislation passed by Congress, and signed by President Barack Obama, expanded SCHIP to provide coverage to an additional four million low-income children. Funded by an increased federal cigarette tax, the new SCHIP will insure a total of 11 million low-income children.

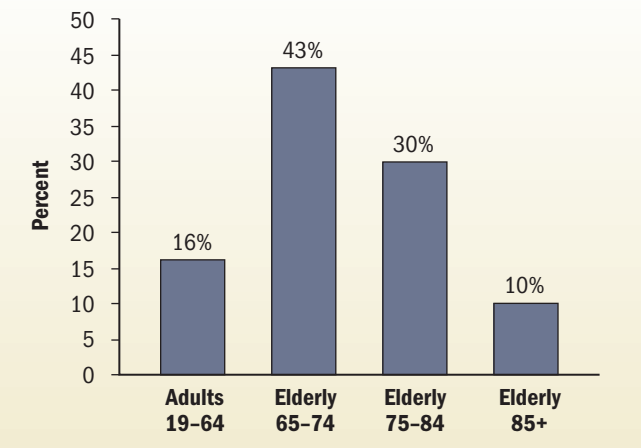


Figure 2.6

Medicare population by age.

Source: To come.

Currently, Medicaid covers nearly 52 million people. Individuals qualify based on income status, level of disability or need for long-term care, or by being a dependent of a Medicaid recipient. Medicaid is accepted as a payment method by all hospitals and most physicians, although some private physicians refuse Medicaid patients due to the lower reimbursement rates the system provides as compared to private insurance. All states cover the following basic services for Medicaid recipients:

- Inpatient and outpatient medical care
- Laboratory and X-ray services
- Chronic care facilities for persons older than 21 years
- Home health care for those eligible for nursing facility services

- Services provided by a physician or nurse practitioner
- Necessary transportation

States may provide optional services to eligible patients, including prescription drugs, case management, dental care, prosthetic devices, medical transportation, intermediate care facilities, optometry, and tuberculosis-related services. Federal law requires the delivery of services that are "medically necessary," but states exercise substantial independence in determining the amount and duration of services covered by establishing criteria for medical necessity and utilization control.

In addition to Medicare and Medicaid, the federal government provides health insurance to veterans through the Veterans Administration (VA), active-service military personnel through the Department of Defense (DOD), government workers through the government's own health insurance program, and Native Americans through the Indian Health Services. These programs are all separately administered and have differing organizational structures. For example, the VA is not only a payer for health care, but also a network of providers. Veterans covered within this system are eligible for care at VA hospitals and clinics. This approach is similar to how the DOD provides health insurance and health-care services to active-duty military personnel.

Uninsured Americans

In addition to those people with private insurance and those with public insurance, 45.7 million Americans were uninsured for all of 2007[2]—more than the populations of Texas, Florida, and Connecticut combined (**Figure 2.7**). A larger number of people are uninsured for a portion of the year. In one recent report, that figure almost doubles the number of people uninsured for the whole year. That means that close to one in three Americans were uninsured for all or part of the period studied. Of those, two-thirds were uninsured for six months or longer. [3]

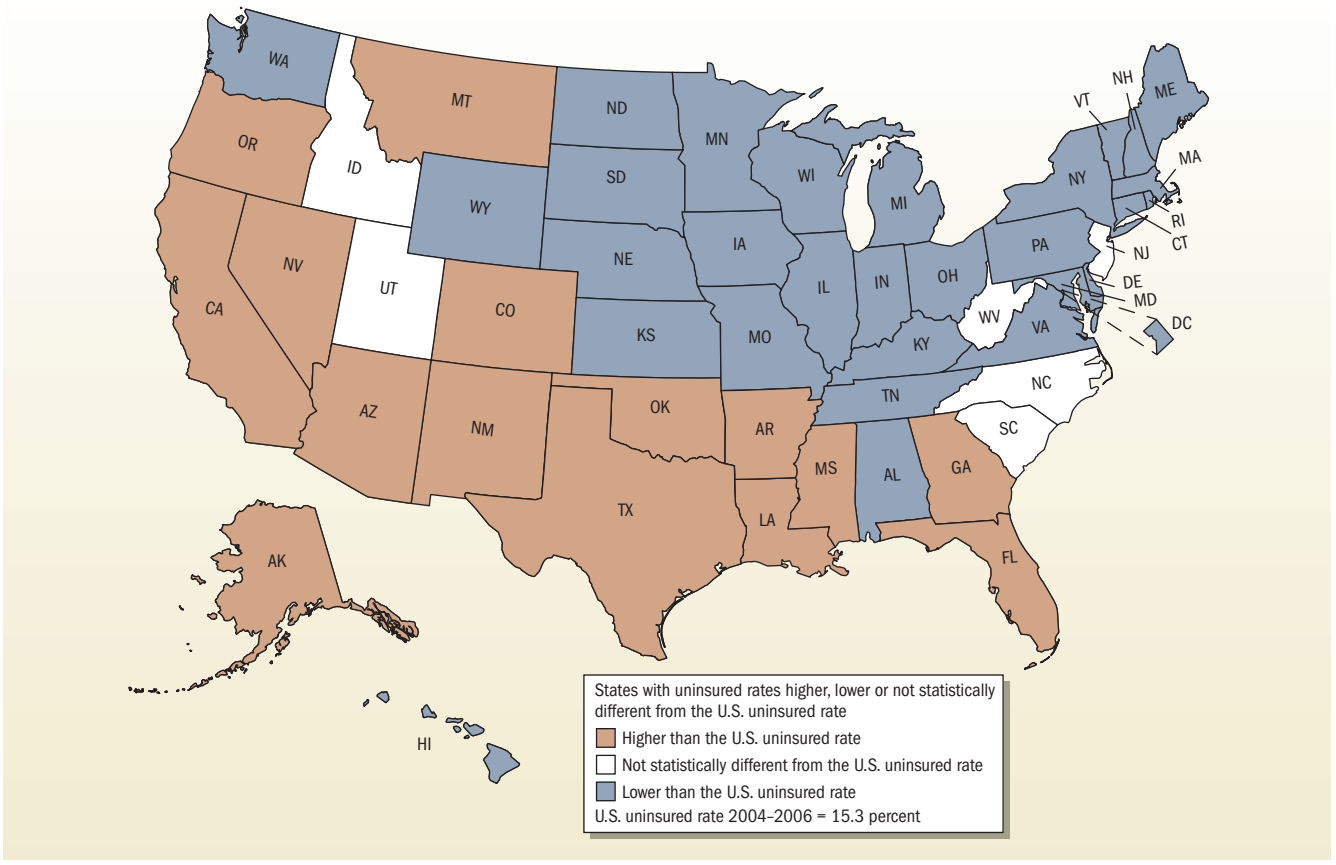


Figure 2.7

Uninsured rates by state, using three-year average: 2004[1]–2006.

Source: U.S. Census Bureau, Current Population Survey, 2005 to 2007 Annual Social Economic Supplements.

[1] The 2004 and 2005 data have been revised since originally published. See www.census.gov/hhes/www/hlthins/usernote/schedule.html.

The uninsured are men, women, and children, though today, men are more likely to be uninsured than women. Uninsured individuals are more likely to have poorer health, have significantly less access to care, and die prematurely than their counterparts with insurance. Nearly one in five families has at least one uninsured member. Most uninsured individuals are younger than age 30. In fact, 11.7% of children are uninsured.

People without health insurance are at significant financial risk if they get sick or have an accident that requires emergency medical care. Because the uninsured must pay out-of-pocket for medical services, such as doctors' office visits or prescription drugs, they often avoid preventive care or proper follow-up care due to cost concerns. In addition, the uninsured end up paying more for medical care because they are not eligible for the discounted pricing structures that health insurance companies negotiate with hospitals and doctors. As a result, the cost of care often strains family finances, jeopardizing families' physical, emotional, and economic health.[4] Long-term implications from being uninsured may include worsening of health status due to lack of appropriate care and not being accurately monitored by a physician, leading to suboptimal care.

Minorities, including African Americans and Hispanic Americans, have higher rates of uninsurance than white or Asian Americans (see **Figure 2.8**). Although lower-income people have the highest rates of being uninsured, the profile of who lacks health insurance is changing. Only 7.1% of people in the $75,000-plus income bracket are uninsured, compared to 35.7% of people with family income below $10,000. Unemployment has increased significantly due to a weakening U.S. economy and rising health-care costs for employers; as a result, many individuals who were formerly covered by their employers have suddenly lost their health insurance. A decline in coverage through employer-based health plans, rising out-of-pocket costs associated with these plans, and skyrocketing costs for insurance premiums are seen as major drivers of this trend.

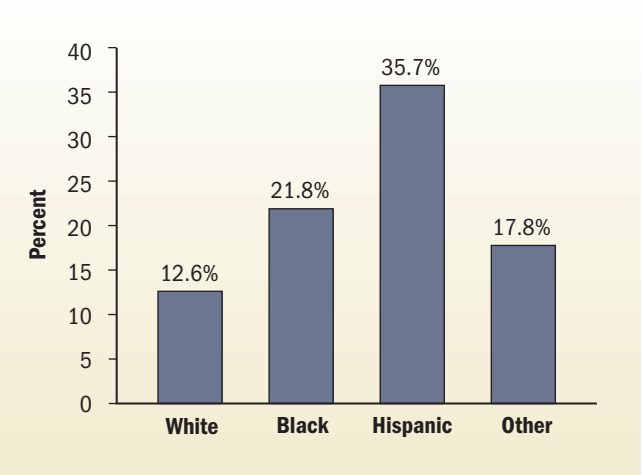


Figure 2.8

Percentage uninsured among the nonelderly population by race and ethnic origin, 2005.

Source: Employee Benefit Research Institute estimates from the March Current Population Survey, 2007 Supplement.

Lack of health insurance affects access to health services and contributes to poorer health, higher hospitalization rates, and more advanced disease states by the time health services are finally received. Although more than 1 in 10 children still lack health coverage, the expansion of Medicaid and the State Children's Health Insurance Program is helping. Nearly 20% of uninsured Americans—8.7 million individuals—are children. The likelihood that a child is uninsured fell from 13.9% in 1998 to 10.5% in 2004 (**Figure 2.9**). It has since increased to 11.7% in 2006. Federal health insurance coverage of children through the 2009 expansion of SCIP may eventually reduce this number, but these changes will likely take years for their full effects to be felt. Although children are more likely to be insured than non-elderly adults, health insurance is particularly important for children. Uninsured children are more likely than insured children to lack a usual source of health care, to go without needed care, and to experience worse health outcomes.[1]

Overall, the scope of the uninsured problem is vast and requires significant attention by the U.S. public if the goals related to equity in delivery of and access to health care are to be achieved.

Preventive Care and a Focus on Women's Health

Managed care plans have been successful at using evidence-based medicine and economic analysis to determine the value of new medical technologies, procedures, and drugs to the plan and its members. A positive outcome of this trend has been widespread support for many preventive services, such as mammograms, cervical cancer screening, and smoking cessation programs. The old saying that "an ounce of prevention is worth a pound of cure" has been proven true in most studies. (See Chapter 3 for more on primary, secondary, and tertiary prevention.) Payers have been shown that investing in preventive services and education leads both to members with fewer major medical problems, such as heart disease, and to the ability to diagnose diseases, such as breast cancer, at an earlier stage. Through their positive effects on health-care outcomes,

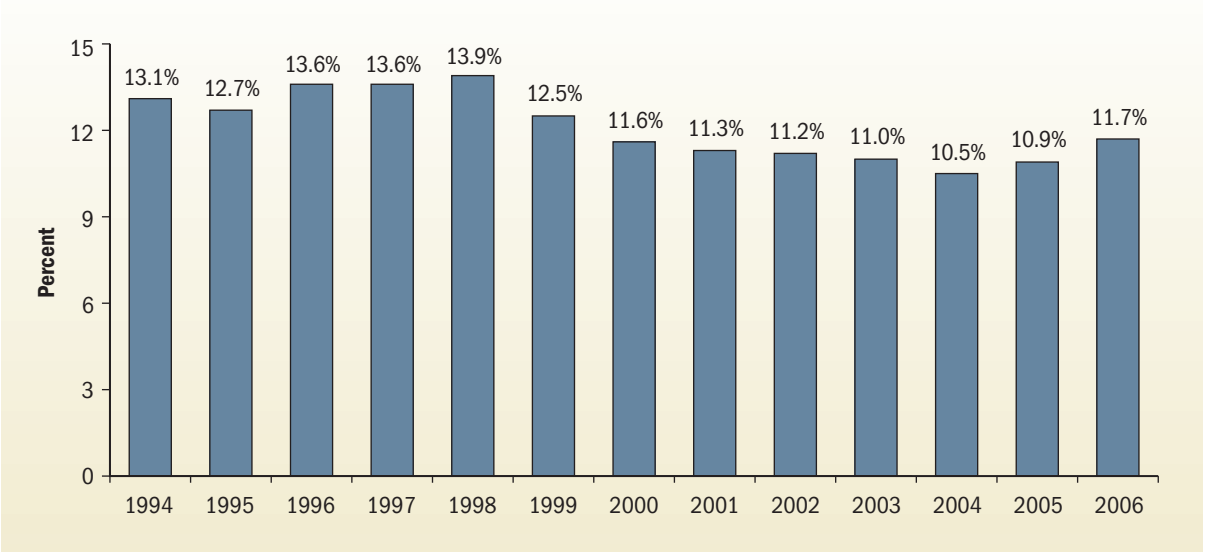


Figure 2.9

Percentage of children under age 18 without health insurance, 1994–2006.

Source: Employee Benefit Research Institute estimates from the March Current Population Survey, March 1995–2007 Supplement.

Note: 1994–2003 data are adjusted for Census correction announced in March 2007.

many preventive and educational services have shown their ability to decrease overall health-care costs.

Preventive services and health education are the cornerstones of women's health. As awareness and support of these and other women-specific health issues increase, many payers have established whole departments dedicated to women's health. These departments help to ensure that patients and physicians are educated about best practices and newly available treatments specifically for women; they also analyze the benefits of new technologies. Women's health departments within payer organizations have enjoyed success in prioritizing women's health issues—for example, by supporting prenatal check-ups and strict monitoring regimens for pregnant women, promoting women's cardiac health, and ensuring universal coverage of gynecological exams.

Women as Health-Care Consumers

Women have been recognized as the primary decision makers relating to health care and as a growing economic force to be courted. In one large survey, women were reported to make 90% of health-related decisions for their families.[5] As a group, women have seen their economic power and ability to affect the overall demand within the health-care system increase significantly. They have increased their participation in the workforce, in government, and in decision-making positions over the last 40 years. In the United States, women earn more than $1 trillion annually, and according to a study by the Commonwealth Institute, more than 68% of women say they manage the bills in their household, compared to 55% of men. Women's growing economic power has made them increasingly important in the eyes of pharmaceutical, medical device, and diagnostics manufacturers. More and more, research and development dollars are being poured into discovering both necessary and voluntary treatments for women. In addition, women are taking a more active role in their own health care, by learning more about their health status, by taking part in preventive health care, and by articulating their needs to providers, payers, manufacturers, and legislatures. Together, these factors work to raise awareness of women's health issues and force the health-care industry to make women's health a priority.

Although women's overall economic position has been improving, many women still find themselves in economically disadvantaged circumstances. Whether due to being unemployed or underemployed, not having adequate childcare support, lacking education, being in poor health, lacking access to resources, or just not having adequate support, they do not have the decision-making freedom that other women with greater access to resources enjoy. Today, lower-income women are disproportionately affected

by poor health. Those women with the least resources thus carry the largest burden of health-care costs, disability, and responsibility in caring for others. Women with health problems often have the most difficult time obtaining care because of coverage restrictions, high costs, and logistical barriers, such as transportation. For many women, coverage and access to care are unstable. Health coverage, involvement with health plans, and relationships with doctors are often short lived, resulting in spotty and fragmented care. A survey by the Kaiser Family Foundation found that one quarter (24%) of non-elderly women delayed or went without care in the past year because they could not afford it, compared with 16% of men.[6]

Health-Care Reform

In many countries, such as Canada and the United Kingdom, the government provides health insurance to all citizens through a system of **universal health insurance**. Universal health-care systems are aimed at allowing all citizens access to a minimum level of care that is deemed acceptable. Individuals are then allowed to purchase supplementary insurance to pay for items not covered under the national health systems. Proponents of these types of systems argue that health care is a right, not a privilege, and should therefore be available to all citizens. Their opponents counter that universal health care is an overly costly approach and prefer that the private sector manage and fund health care through a free-market approach. In the early 1990s, President Bill Clinton led a major drive for establishing universal health insurance in the United States. Although those efforts ultimately failed, health-care reform has remained a major political topic. (See **It's Your Health** for more information.) President Barack Obama has promised to make health-care reform one of the top priorities of his administration,.

In the future, health care is likely to be significantly affected by the research and development of new technologies. Major advances in women's health issues are likely to arise from research into genetic engineering, stem cell research, microscopic surgical techniques, and molecular diagnostics. How the system will pay for these advancements and make them accessible to the majority of people remains a challenge.

To ensure the ongoing improvement of our health-care system in general, and in women's health issues in particular, health-care reform must take into account the disparities in care and outcomes related to the socioeconomic positions of patients. The U.S. public must identify their

■ Health-care reform is a major political topic in the United States.

It's Your Health

Universal Health Care

The lack of health-care coverage is detrimental to individuals, their families, and the community at large. Due to the high costs of health care, uninsured individuals and their families have difficulties getting quality health care when they are sick. They tend to delay treatments until their illnesses become serious, and they are less likely to seek routine preventive health services that can avert or detect major illnesses early on. As a result, they tend to die sooner than people with health insurance.

The lack of health insurance aggravates the financial burden placed on the community as a whole. Because the uninsured tend to delay necessary treatment, they are often sicker and therefore more expensive to treat when they finally seek care. Also, they frequently turn to the nearest hospital emergency room, which is an expensive and inefficient way to get care. Furthermore, the primary providers of care to the uninsured—such as public hospitals, teaching hospitals, academic health centers, and nonprofit community hospitals—incur heavy losses from high rates of uncompensated care. In turn, these providers are forced to cut back on their services to all patients or even close their facilities.

The American Public Health Association has advocated the following:

- Universal coverage for everyone in the United States, to include comprehensive benefits, affordable prices, and quality services
- Organization and administration of health care through publicly accountable mechanisms to assure maximum responsiveness to public needs, with a major role for federal, state, and local government health agencies
- Attention in the organization, staffing, delivery, and payment of care to the needs of all populations, including those confronting geographic, physical, cultural, language, and other nonfinancial barriers to service.

Source: American Public Health Association; www.apha.org. Related APHA Policy: Support for a New Campaign for Universal Health Care. 20007, 9502. Accessed Jan. 1, 2000.

Gender Dimensions

Health Differences Between Men and Women

The population of the United States is getting older as disease prevention, health promotion, and innovative treatments prevent or delay disease and prolong life. In 2006, the average life expectancy for all Americans was 78.1 years of age: 76 years for white men and 70 years for black men, and 81 years for white women and 76.9 years for black women.[7] On average, women now live six years longer than men. In 2000, there were only 70 men per 100 women over age 65; there were only 41 men per 100 women age 85 or older (see **Figure 2.10**). Note, however, that these figures are an aggregate of all U.S. women. When examined by race and ethnicity, life expectancy varies among both women and men.

As a result, most of the burden of aging rests on women, and increasingly women are aging into their oldest years without the support or help of spouses.[8] The aging trends have enormous economic ramifications. As women age, they become more likely to suffer from chronic disease such as heart disease, cancer, and arthritis. These illnesses create significant morbidity as well as costs to affected individuals.[9] Currently, Medicare provides health insurance for all Americans over the age of 65, ensuring that all older Americans have at least some access to health care. Because Medicare covers only 80% of costs, however, a significant financial burden is often imposed on older patients when seeking care.[10]

The economic realities faced by elderly women also affect women's health. As women age, they are likely to need increased access to prescription drugs, perhaps specialty medical assistance, durable medical equipment (such as walkers and orthopedic beds), and other expensive goods and services.

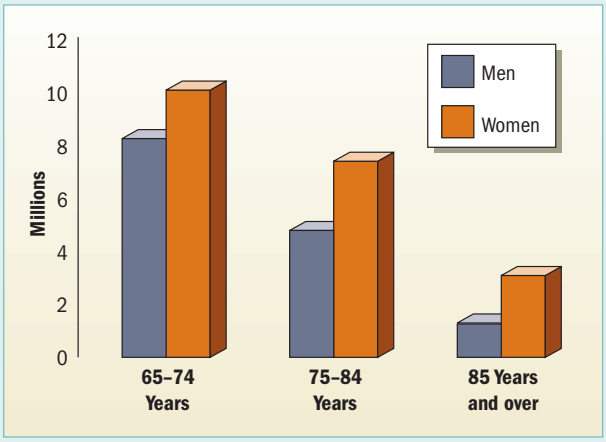


Figure 2.10

Population 65 years and over by age and gender, 2000.

Source: U.S. Census Bureau, U.S. Census 2000 Summary File.

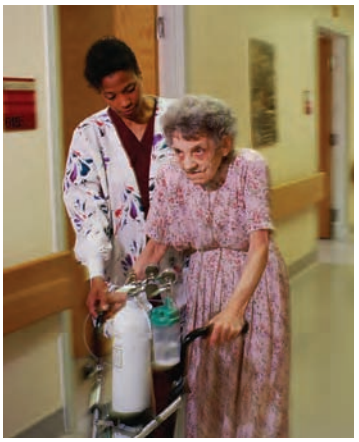
Many women are "sandwiched" with requirements for elder care and child care.

priorities as they relate to health care, whether that entails equity, access to new technology, or improved outcomes. Reform should attempt to manage rising costs while recognizing and addressing the diverse needs of women within the system.

Taking Care of the Population: Long-Term Care and Women as Caregivers

Once an individual or her family becomes unable to take care of an elderly or disabled person any longer, long-term care or assisted living communities are available. In direct correlation to the percentage of women and men in the oldest age categories, the vast majority of residents in these facilities are women.

Long-term care provides ongoing care for people who need lengthy or even lifelong assistance with daily living due to an illness, injury, or severe cognitive impairment (such as Alzheimer's disease). It can be provided either in a nursing home, in an assisted living facility, or at the patient's home. According to the Federal Long-Term Care Insurance Program, sponsored by the U.S. Office of Personnel Management, the average annual cost for home care substantially exceeds $20,000. The national average



■ Most older women in nursing homes spend down their life savings to pay for services until Medicaid begins to cover the remaining costs of care.

annual cost for care in a nursing home exceeds $75,190 for a private and $52,000 for a semi-private room, according to a recent survey by MetLife's LifePlans. This was an increase of 6% from the year before. Costs are expected to continue to increase dramatically, with a semi-private room costing $190,600 by 2030.[11] Two insurance options are available to cover these expenses:

- Private long-term care insurance programs are very expensive, and are predominantly purchased by wealthier Americans.
- Medicaid covers Americans in long-term care facilities once they have spent out all other resources. Most older women in nursing homes spend down their life savings to pay for services until Medicaid begins to cover the remaining costs of care.

As the U.S. population ages and life spans increase, informal caregiving by family members has become a vital component of the health-care delivery system in general and elder care in particular. One national study estimates the value of unpaid caregiving at approximately $350 billion per year. That is twice as much as is spent on home care and nursing home services.[12] Women continue to provide the majority of this informal caregiving today, even though most working-age women now participate in the labor force. As a result of shouldering the stress and burden for caregiving, women caregivers tend to suffer more adverse health events than non-caregivers.[9] According to the Commonwealth Fund, one-fourth (25%) of women caring for a sick or disabled family member rate their own health as fair or poor, compared with one-sixth (17%) of other women. More than half (54%) of women caregivers have one or more chronic health conditions, compared with two-fifths (41%) of other women. In addition, half (51%) of all caregivers exhibit high depressive symptoms and sleeplessness, while 38% of other women do so.

Informed Decision Making

Choosing health insurance is often a baffling undertaking, with many options meaning little to the individual other than being associated with different monthly premiums. Most people receive their health insurance through their employers, so they usually have a small menu of plans from which to pick.

When choosing a health insurance plan, it is important to consider the following:

- *Deductibles.* Often different plans have a certain amount that the individual must pay out-of-pocket before the benefit kicks in. For example, if a woman has a $500 deductible on her insurance plan, she must pay for the first $500 worth of health-care services she receives before the insurance plan will begin to pick up the cost. Usually, the less expensive the plan, the higher the deductible. Deductibles are common in all types of insurance programs.
- *Benefits.* Look closely at the list of covered services. For example, does the insurance plan cover prescription drugs? Does it cover open access to relevant specialists or provide medical equipment needed for specific health problems?
- *Network.* Consider the implications of a restrictive network to the costs of care and access to care. Does the insurance plan restrict access to a specific network of physicians? Is the preferred doctor a member of that network? If not, what are the costs for going to a doctor that is out of the network? Are the major local hospitals part of the health plan's network?
- *Co-insurance.* Many plans today require patients to pay a set percentage of charges, often 10–20%. While this can keep premiums affordable, patient costs can be very high if hospitalization or long-term care is required. Consumers should inquire whether their insurance plan has a maximum amount that a patient is required to pay if a hospitalization or other high-cost event occurs.
- *Emergency Services.* Often health insurance programs have very restrictive criteria for use of emergency ser-

Choice of health insurance plans is often a baffling undertaking; there are many important factors to consider other than simply the monthly premium.

vices. What is the process for receiving emergency services? Is prior authorization needed before going to the emergency room?

- *Co-payments.* Co-payments are fixed amounts of money a patient is required to pay to receive health-related goods or services. Co-pays usually have to be paid out-of-pocket, either at the doctor's office, at the pharmacy, or at the hospital.
- *Benefit Cap.* Is there a maximum amount of money for which the insurer is liable, after which the patient has to pay for services? This is usually only a concern for very ill people, or people who have very serious accidents.

By considering these factors when choosing health insurance, a woman is more likely to get a package that is right for her and her family.

Summary

The delivery of and access to health care in the United States is significantly affected by the way it is funded. The U.S. system includes both public and private health insurance that helps individuals to afford high-quality health care. The way health insurance is structured affects the amount that individuals have to pay out-of-pocket for health-care goods, such as prescription drugs, and services, such as physician office visits. There are still significant inequity issues within the health-care system, as demonstrated by the fact that more than 47 million Americans do

Profiles of Remarkable Women

Katherine Swartz (1950–)

Katherine Swartz is a Professor of Health Policy and Economics at the Harvard School of Public Health. She is a demonstrated leader in health policy research, with a focus on the issue of the uninsured. She has been involved in research concerning health insurance issues since she graduated from college and went to work at what was then the U.S. Department of Health, Education, and Welfare (now the Department of Health and Human Services). For the last 20 years, Prof. Swartz's research interests have focused on the population without health insurance and efforts to increase access to health-care coverage. Her research contributed to policy makers' understanding that people without health insurance are not all alike—many different types of people lack insurance. Prof. Swartz also was the first researcher to show that people differ in terms of the length of time they may go without health insurance. In fact, many spells without health insurance last less than six months but a significant percentage of uninsured spells last more than two years. The dynamic nature of health insurance coverage means that over the course of a year, many more people are at risk for the financial costs of medical care than the number estimated to be uninsured when a survey is conducted.

Prof. Swartz's interest in how health insurance might be made more affordable and more accessible to the uninsured has led her to analyze the markets for health insurance, particularly for individuals who may not be covered through work in a group insurance plan. This research has focused on insurance companies' fear of being left with the sickest and therefore most expensive people in these markets. Findings from her research have emphasized the need for government policy to reduce such fears so as to allow the nongroup insurance markets to expand health insurance coverage. One such policy that Prof. Swartz has proposed is that government act as the reinsurer and take responsibility for the extremely high-cost people each year in the nongroup markets. Her most recent book, *Reinsuring Health: Why More Middle-Class People Are Uninsured and What Government Can Do*, was published in 2006.

not have health insurance. Among the elderly population, issues of access to and payment for health-care goods and services continue to be a major problem. Although most are covered by Medicare and Medicaid, the elderly, who are predominantly women, face a unique set of economic challenges in managing their health.

Topics for Discussion

1. How can a person's health insurance status affect his or her health status?
2. Should everyone have access to health insurance, even if she can't afford it?
3. Is access to health care a right or a privilege?
4. What are some common health-related items that often are not covered by health insurance?
5. What role do employers have in the delivery of health care?
6. What are potential implications of Medicare becoming more like a managed care program and less of a fee-for-service program?
7. How can health insurance status be affected by women's different stages of life?
8. What are some central issues related to the elderly population's health-care needs?

Web Sites

Academy Health: http://www.academyhealth.org

America's Health Insurance Plans: http://www.ahip.org

Center for Medicare and Medicaid Services: http://www.cms.hhs.gov

Kaiser Family Foundation: http://www.kaisernetwork.org

National Center for Quality Assurance: http://www.ncqa.org

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