# American's and their Lack of Insurance

University of Nebraska Medical Center College of Medicine
Jason A. Williams MPAS, Ph.D
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The purpose of this article is to explore the many health insurance systems that have been utilized in major countries around the world and to explore the short comings of the employee sponsored insurance system utilized in the United States. Japan, Sweden, and Canada each have a health insurance system that is based largely on universal health care as compared to the employee sponsored insurance driven health system within the United States. In having reviewed the health care systems within Japan, Sweden, and Canada, it can be concluded that further consideration should be given within the United States to the adoption and implementation of a universal health care system. Implementing such a system would resolve current problems associated with uninsured and underinsured citizens within the United States. While many objections have been raised in the past as to the costliness of universal health care, the experiences of Japan, Sweden, and Canada would seem to suggest that it is possible to finance such a system, even in countries that are not as wealthy as the United States.

# Insured/Underinsured

Within this paper, an effort will be made to address the question as to how the US should respond to the ongoing growth of uninsured and underinsured persons within the overall population. In order to address this issue, initially, an overview will be provided of the current health insurance system existing within the US. This will be followed by a discussion of the factors that influence and are associated with the current system. After this, information will be provided on the health insurance systems of other countries who have been found to have better health outcomes than the US. The paper will conclude with recommendations for the adoption of a universal health insurance system within the US.

**Overview of the US Health Insurance System**

Health insurance has increasingly emerged as a major concern of most American families and individuals. As evidenced suggests, in the US, health insurance has most often been obtained via coverage through employers.[1] In fact, employer sponsored insurance (ESI) has served as the foundation for the health insurance system within the US for the past fifty years. However, in the last 20 years, this trend has reflected a significant decrease, even though some stabilization occurred after 1993 as a result of a high-employment economy and a continuing movement toward two-worker families.[2] Analyses conducted on information from the Current Population Survey (CPS) for 1979-1998 have suggested that those employees working within the private sector have

[1] Medoff, J., Shapiro, H., Calabrese, M. & Harless, A. (2001). How the new labor market is squeezing workforce health benefits. Publication #449. Center for National Policy, Washington DC.

[2] Ibid

continued to experience a decline in the availability of ESI, with the number of insured falling from two-thirds (66%) in 1979 to just over half (54%) in 1998. [3]

As a consequence of the decreasing availability of ESI, there are approximately 43 million Americans or nearly one out of six of the US population who lack health insurance coverage.[4] The problems confronting the uninsured are immense with most unable to afford or gain access to necessary preventive and curative care. Of the uninsured, nearly half report that they were unable to get medical attention for a problem in the previous year because of the costs of care.[5] As well, research has documented that the uninsured within the US face a higher risk of overall mortality, a higher risk of mortality from specific causes, and higher risks of serious medical problems.[6] Additionally, the uninsured not only face severe health consequences, but may experience financial disaster if they become ill.[7] It is estimated that the uninsured are twice as likely to go without needed care as are their insured counterparts. Nearly one-third of the uninsured have reported that they have been contacted by bill collectors about unpaid medical bills.[8]

Lack of access to health insurance represents a further documentation of the disparities between the rich and the poor in the US, leading to alarming health problems

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[3] Ibid

[4] Glied, S. (2000). Challenges and options for increasing the number of Americans with health insurance. Joseph L. Mailman School of Public Health, Columbia University Report Series from The Commonwealth Fund Task Force on the Future of Health Insurance.

[5] Budetti, J., Duchon,L. Schoen, C. & Shikles, J. (1999). Can't Afford to Get Sick: A Reality for Millions of Working Americans. The Commonwealth Fund.

[6] Franks, P., Clancy, C. & Gold,M. (1993). Health Insurance and Mortality—Evidence from a National Cohort. *Journal of the American Medical Association 270*, 737–741.

[7] Ibid, Glied

[8] Ibid, Budetti et al.,

within the US population.[9] Health indicators within the US provide an image of a country that far outspends any other nation in terms of health care yet performs poorly compared to other developed countries in areas such as infant mortality and life expectancy rates.[10] In one such comparison, the US ranked below nearly all rich countries and a few poor ones, with US health indicators among the worst of the nations of the Organization for Economic Co-Operation and Development (OECD).[11]

When comparisons have been made amongst different groups within the US, the problems are even more startling. Asian-American women born in Westchester County, NY can expect to live on average 90.3 years. Yet African-American men in Washington, DC face an average life expectancy of 57.9 years, lower than the life expectancies of men living in Ghana (58.3 years), Bangladesh (58.1 years), and Bolivia (59.8 years).[12]
As well, nearly one in five Americans, or 56 million people, is considered clinically obese while 31 million Americans, including one in six children, face chronic hunger in any given year.[13]

**Factors Influencing Health Insurance in the US**

With the ongoing increase in the numbers of the uninsured within the US, there has been a growing interest in factors influencing the health insurance system in order to develop and implement new strategies and reforms focused on improving coverage for Americans. As a result of this interest, efforts have been directed towards understanding

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[9] Kawachi, I. & Kennedy, B. (2002). *The health of nations: Why inequality is harmful to your health.* NY: The New Press.

[10] Ibid

[11] Ibid
[12] Ibid

[13] Ibid

who is and is not well-served by the current employer-based system, how people perceive the performance of this system, and their perceptions about various proposals to expand coverage for workers and their families. One such endeavor was the 1999 National Survey of Workers' Health Insurance conducted by the Princeton Survey Research Associates.[14] With a national sample of 5,002, adults ages 18 to 64, the findings from the survey help to provide a current overview of the health insurance situation of working-age adults'. The major findings were as follows:

1. The results of the survey suggested that approximately one-half of all adults remain in favor of employers continuing to serve as the main source of coverage for the working population. Employers emerged as the leading choice for the future even among the uninsured.
2. There were harsh disparities found in the availability of job-based health coverage for the one-third of middle- and low-income adults who are uninsured, even when working full-time. There is a greater risk in this group for dropping job-based coverage because of inability to pay their share of insurance premiums.
3. Moreover, insurance is often insecure and of uneven quality, and frequent changes in health plans are a shared concern nationwide.
4. Other findings suggested that adults strongly prefer group insurance—whether employer or public—over purchasing insurance on their own. Two-thirds (67%) want either employers or the government to sponsor insurance plans, while only one of four (23%) would prefer workers purchasing coverage individually.

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[14] Duchon,L., Schoen, C., Simantov, E., Davis, K. & An, C. (2000). Listening to workers' voices: Findings from the Commonwealth Fund 1999 National Survey of Workers' Health Insurance, The Commonwealth Fund.

5. Excluding the self-employed, one-fifth of employees, or 20 million workers, have not been offered a plan or are ineligible for coverage through their job. Low-wage and Hispanic workers are the most likely to be without access to job-based coverage.
6. Even when working for larger employers, low-wage employees often remain outside employer coverage. One-third of workers earning less than $20,000 who are employed by larger, private firms reported that no plan was available to them.
7. As evidenced within the findings, the costs associated with participating in ESI can be prohibitive. One of seven workers declined coverage, usually because of the cost. Another 16 percent were finding it difficult to pay their share of premiums for employer coverage. Ultimately, nearly one-third of low-wage workers are stretching their budgets to pay their share.
8. Forty-two percent of full-time workers with incomes below $20,000 were uninsured, as were one-third of all full-time Hispanic workers.
9. Nearly seven of 10 uninsured adults went without needed health care due to costs or were unable to pay their medical bills.
10. Insurance quality varies widely. Less than one-third of those with employer plans rated their coverage as "excellent," with negative ratings reaching 30 percent among low-income adults.
11. Results also suggest that even for those who are insured, coverage is unstable. Less than half of all adults have been in their current health plan for at least three years. [15]

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[15] Ibid

Other researchers have initiated efforts to develop an understanding of the influence of the restrictions of the US's largely ESI health insurance system on the functioning of the labor market. The high level of health insurance costs for employers currently mounts to 6.7 percent of compensation, resulting in impacts on wage, employment and hours determination in labor market equilibrium.[16] Another important set of potential outcomes associated with an ESI driven health insurance system are those related to labor supply and job mobility decisions. On the basis of prior research in this area, due to health care costs for many workers, health insurance can be a key factor in the decision to work, to retire, to leave welfare, or to switch jobs.[17]

In 2002, the World Health Organization (WHO) released a report on the health systems of 191 member countries.[18] On the basis of these findings, WHO provided a useful overview of what factors associated with good health systems. Three primary outcomes were identified as representative of such systems including the following:

1. Good Health: making the health status of the entire population as good as possible across the whole life cycle;
2. Responsiveness: responding to people's expectations of respectful treatment and client orientation by health care providers; and,

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[16] McDonnell, P. & Fronsteing, P. (1999). EBRI Health Benefits Databook, Washington DC: Employee Benefits Research Institute.

[17] See: Slade, E.P. (1995). An Analysis of the Consequences of Employer Linked Health Insurance Coverage in the U.S.NLS Discussion Paper No. 96-33. Washington DC, U.S. Bureau of Labor Statistics; Madrian, B. & Lefgren, L. (1998). The Effect of Health Insurance on Transitions to Self-Employment. NORC/University of Chicago, Population Research Center; Madrian, B. C. (1994). Employment-Based Health Insurance and Job Mobility: Is there Evidence of Job-lock? *Quarterly Journal of Economics, 109,* 27; Cooper, P. & Monheit, A. (1993).Does Employment-Related Health Insurance Inhibit Job Mobility? *Inquiry 30*, 400-416.

[18] World Health Organization (2002). The world health report. Geneva, Switzerland: WHO Headquarters.

3. Fairness in Financing: insuring financial protection for everyone, with costs distributed according to one's ability to pay.[19]

Furthermore, as conceptualized by WHO on the basis of study findings, a good and fair health system is one that has:

1. overall good health (e.g., low infant mortality and high-disability – adjusted life expectancy);
2. a fair distribution of good health (e.g., low infant mortality and long life expectancy evenly distributed across all population groups);
3. a high level of responsiveness;
4. a fair distribution of responsiveness across population groups;
5. a fair distribution of financing health care.[20]

Recent findings have also suggested that the US falls significantly short in terms of health and well-being when compared with other countries.[21] Reportedly, the US ranks an average of 12th out of 13 countries on 16 available health indicators.[22] Countries in order of their average ranking on the health indicators (with the first being the best) are Japan, Sweden, Canada, France, Australia, Spain, Finland, the Netherlands, the United Kingdom, Denmark, Belgium, the United States, and Germany.[23]

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[19] Ibid
[20] Ibid

[21] Gruber, J. & Madrian, B. (2002). Health insurance, labor supply and job mobility: A critical review of the literature. NBER Working Paper No. w8817, National Bureau of Economic Research, Cambridge, MA.

[22] Ibid

[23] Ibid

## An Alternative US Health Care System

In order to respond to the health care needs of the uninsured and underinsured within the US population, it appears important to consider the health insurance systems used by other countries that have been ranked higher than the US on health indicators for determining possible alternatives to the current health insurance system. For the purposes of this paper, the health insurance systems used by the top three countries (i.e., Japan, Sweden and Canada) will be reviewed.

### Japan

On the basis of information provided by the National Institute of Population and Social Security Research (NIPSSR) (2003), Japan has a health insurance system based on universal health care and public insurance. Via this system, the public mandatory insurance program allows for medical services to be obtained through an occupation-based and region-based insurance system. For those covered under occupation-based system, that which is known as Employees' Health Insurance is offered. As explained in information provided by NIPSSR, employers of a certain size and over offer their employees access to a health insurance association which is known as association-managed health insurance. There are currently approximately 1800 associations operating within Japan. For those who work at smaller firms, the government provides a collective health insurance which is called Government-managed Health Insurance. In addition, special professions such as civil servants, day-laborers and seamen form separate nation-wide professional associations. Those who are not covered by the Employees' Health Insurance are required to participate in a region-based insurance, called the National Health Insurance, for which the municipalities (more than 3,000) act as the independent

insurers (NIPSSR, 2003). As explained by NIPSSR (2003), in terms of the financing of Japan's public health insurance system, multiple options are used including premiums, subsidy from the general budget of the government, and co-payment from patients.

As explained by NIPSSR (2003), other features of Japan's health insurance system include the following:

1. As health insurance in Japan is universal, users are able to choose any medical service providers.
2. The coverage of health insurance and the prices of medical services are standardized by law, and thus, all persons receive the same medical service at equal price.
3. Under the system, the health care costs for those aged 70 and over are separated from health care system and shared by all insurance schemes due to the rising costs associated with providing health care for the elderly. As well, Long-Term Care Insurance requires contribution from those aged over 40 and covers a variety of at-home and institutional services for those over 65 and judged as in need of long-term care.

**Sweden**

On the basis of information provided by the Swedish Institute (2001), while Sweden is most often thought to have a well-developed welfare state of which a universal social insurance system is a recognized component, the Swedish welfare state has never been entirely universal, since the right to various social benefits in Sweden is not only based on residence but also on assessed needs, participation in the workforce and voluntary affiliation. However, as noted by the Swedish Institute, even though severe

economic conditions during the 1990s impacted the social insurance system, the system continues to incorporate features that remain extensively universal while facilitating a high level of public support.

As explained in information provided by the Swedish Institute (2001), the welfare state in Sweden had its beginnings in the late 19th century when the State first started to pay out contributions to voluntary health insurance schemes under legislation passed in 1891. Subsequent legislation further established the system when compulsory employer responsibility in the event of occupational injury was implemented in 1901, an essentially general pension system (though with a wealth restriction) in 1913, and a system for sickness benefits in 1931. This was followed by a national basic pension and national child allowance in 1947 and an extension of income-related occupational pensions and sickness benefits in the 1950s and 1960s. During the 1970s, parental insurance, public sector childcare and other social service production (with an attendant high level of employment for women) was implemented. As reported by the Swedish Institute, the Swedish Social Democratic Party largely influenced the ongoing development and implementation of a universal social insurance system with the Social Democrats remaining in control politically with few interruptions since 1932. However, the system is said to have maintained cross-political party legitimacy with all political parties jointly attacking the system in the 1990s as a primary factor influencing Sweden's economic problems.

According to the Swedish Institute (2001), with the emergence of an economic crisis during the 1990s, cuts were directed at the social insurance system, including qualification periods, when no benefits were paid, were reintroduced into the health and

unemployment insurance systems, and the levels of benefit and indexation of pensions were reduced for a time. While economic recovery has occurred, restoration of benefits has only partially occurred.

As a component of the social insurance system in Sweden, health insurance and health care are financed via compulsory employers' contributions and individual social security contributions deducted from incomes (Swedish Institute, 2001). As further explained by the Swedish Institute, the 18 county councils that administer social insurance programs finance the costs of medical care directly from an income tax levied on all those living in the county who are in paid employment. According to the Swedish Institute, approximately 80 percent of tax revenues go to running the health care system and to subsidizing patient fees. Patients assume a proportion of the health costs when consulting a health care service, ranging from approximately 8 to 38 dollars. While all of Sweden's residents are entitled to compensation for medical care, those individuals who have earned at least $750 annually through gainful employment are entitled to cash benefits for loss of income while ill.

**Canada**

According to information provided by the Canada Health Act Division (CHAD) (2003), the Canadian health care system currently represents efforts that have been initiated and which have evolved during a forty year period. In 1947, the province of Saskatchewan became the first to develop and implement public, universal hospital insurance. As noted by CHAD, in 1957, the Canadian government passed legislation allowing the federal government to share in the cost of provincial hospital insurance

plans. By 1961, all 10 provinces and two territories had public insurance plans that provided comprehensive coverage for in-hospital care.

As further explained by CHAD (20030, Saskatchewan once more set the pace for Canada in 1962 by providing insurance for non-hospital related health care services. In 1968, the Canadian government followed by enacting legislation for insurance for non-hospital health care, with all provincial and territorial insurance plans extended to include doctors' services by 1972.

On the basis of a health services review in 1979, as reported by CHAD (2003), it was determined that while health care in Canada ranked among the best in the world, extra-billing by doctors and user fees levied by hospitals were creating a two-tiered system that threatened the accessibility of care. In response to these concerns, Parliament passed the Canada Health Act in 1984 to discourage hospital user charges and extra-billing by physicians. As explained by CHAD, the Act provides for an automatic dollar-for-dollar penalty if any province permits such charges for insured health services.

According to CHAD, the Canada Health Act represents Canada's federal health insurance legislation. The primary objective of the policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.

As explained by CHAD, the Act establishes criteria and conditions related to insured health care services and extended health care services that the provinces and territories must meet in order to receive the full federal cash contribution under the Canada Health and Social Transfer (CHST). As well, as noted by CHAD, the Act aims to ensure that all eligible residents of Canada have reasonable access to medically necessary insured

services on a prepaid basis, without direct charges at the point of service for such services.

According to CHAD (2003), there are five principles associated with the Canada Health Act which have come to represent the cornerstone of the Canadian health care system. The principles are as follows:

1. public administration: the administration of the health care insurance plan of a province or territory must be carried out on a non-profit basis by a public authority;
2. comprehensiveness: all medically necessary services provided by hospitals and doctors must be insured;
3. universality: all insured persons in the province or territory must be entitled to public health insurance coverage on uniform terms and conditions;
4. portability: coverage for insured services must be maintained when an insured person moves or travels within Canada or travels outside the country; and
5. accessibility: reasonable access by insured persons to medically necessary hospital and physician services must be unimpeded by financial or other barriers.

Via these principles, the Act is intended to further insure the following:

1. The Act aims to ensure that all residents of Canada have access to necessary hospital and physician services on a prepaid basis.
2. The Act provides the provinces and territories with criteria and conditions that they must satisfy in order to qualify for their full share of federal transfers under the Canada Health and Social Transfer (CHST).

As explained by CHAD, the Canada Health Act also contains provisions that ban extra-billing and user charges, including no extra-billing by medical practitioners or dentists for insured health services under the terms of the health care insurance plan of the province or territory; and, no user charges for insured health services by hospitals or other providers under the terms of the health care insurance plan of the province or territory.

**Summary and Conclusions**

Japan, Sweden and Canada each have a health insurance system that is based largely on universal health care as compared to the ESI driven health insurance system within the US. Japan's universal health care and public insurance system allows for medical services to be obtained through an occupation-based and region-based insurance system. For employed individuals in Japan, the system is financed through a fixed percent of employee's salary which is shared equally by the employer and employee while those who are not employed are eligible for National Health Insurance which is paid for by local governments. Similarly, Sweden has a universal health care plan that is a component of the country's welfare model of social insurance. All citizens are eligible to receive health care regardless of employment status. Sweden's system of insurance is financed through taxation as well as small co-payments for medical services when received. As was also documented within the study findings, Canada has a public insurance system that is paid for jointly by provinces/territories and the federal government. The plan provides for both in-hospital and out-of-hospital care.

The health care insurance systems established in Japan, Sweden and Canada are very different than that found in the US. While the US system has increasingly been characterized by the decreasing availability of ESI, with approximately 43 million

Americans or nearly one out of six of the US population lacking health insurance coverage, no such similar reports exist for Japan, Sweden and Canada. The universal health care systems within these countries provide a means for those who do not have access to medical insurance through employment to be covered and continue to have access to the health care necessary. Alternatively, within the US, the problems faced by those who are uninsured remain immense with most unable to afford or gain access to necessary preventive and curative care. The costs of care within the US are reportedly astronomical, further complicating the efforts of the uninsured to obtain medical services and leading to the greater potential for higher mortality rates and financial disaster when severe illness does strike the uninsured.

In having reviewed the health care systems within Japan, Sweden and Canada, it can be concluded that further consideration should be given within the US to the adoption and implementation of a universal health care system. Implementing such a system would resolve current problems associated with uninsured and underinsured citizens within the US. While many objections have been raised in the past as to the costliness of universal health care, the experiences of Japan, Sweden and Canada would seem to suggest that it is possible to finance such a system, even in countries that are not as wealthy as the US. At a very basic level, it does not seem to make good sense that countries less wealthy than the US are able to provide a more effective health care system that results in better health outcomes for citizens than found currently within the US population. As the current ESI system is failing to meet the needs of US citizens, one must question who or what the system most benefits. Ultimately, efforts should be facilitated to implement a universal health care system within the US.

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