

Commentary—Response to  
Gusmano, Weisz, and Rodwin  
**Persistent Disparities in Access to Care  
across Health Care Systems**

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The United States is the only high-income country in the world that does not provide universal health care coverage to its citizens. With 47 million uninsured, the United States is more than an outlier—it's an international embarrassment (DeNavas-Walt, Proctor, and Smith 2008). Yet there continues to be debate among researchers and policy makers about what type of U.S. health care system could achieve universal coverage.

A health care system that provides universal health insurance coverage can be organized and financed in many different ways. There are several vocal advocates for a single-payer system in the United States—that is, a government-run health care system, providing universal benefits to all, financed by general tax revenue. With one payer, efficiencies can be achieved, it is argued, through simplified administration, uniform benefits, and explicit controls on costs. In addition, a single-payer system can achieve efficiencies through provider financial incentives to improve both primary care and prevention and through controls over supply of medical technology.

But as the paper by Gusmano, Weisz, and Rodwin (2009) points out, universal coverage through a government-run health care system need not include only one government payer, and the number and type of payers (public or private) may not be the critical component of achieving equitable access to care. In fact, while almost all the Organisation for Economic Co-operation and Development (OECD) countries have achieved universal health care coverage, there are persistent disparities in access

to care despite the number of payers and the organization and financing mechanisms of the health care system (Docteur and Oxley 2003). This variation in access is due in part to variation in the supply of providers; out-of-pocket payment requirements; and disparities related to bias in social characteristics including race, ethnicity, and immigration status. Studies such as Gusmano, Weisz, and Rodwin's (2009) are needed to build the evidence that will be necessary as U.S. policy makers assess the best components for a reformed health care system. If the number of payers is not a critical component of assuring access to care, what is?

Gusmano, Weisz, and Rodwin (2009) look at equity in access to care in three different types of health care systems—the single-payer national health service of Great Britain; the social health insurance model in France; and the multipayer U.S. health care system—and try to assess whether one model is superior in assuring equitable access to health care. In this commentary, I first provide a few more details on the financing of the three countries' health care systems; discuss equity in terms of both financing and access; provide brief comments on Gusmano, Weisz, and Rodwin's analysis; and conclude with comments about the United States moving toward a universal coverage system.

### **National Models of Health Care**

Gusmano, Weisz, and Rodwin picked three large metropolitan areas within three countries with distinct models of national health insurance schemes to assess whether single payer is superior in assuring equity in access to care. The three systems the authors selected vary in financing and organization and represent three basic models of health care financing: (1) the United Kingdom's national health system (single payer), (2) France's public health insurance program (social insurance model with multiple payers), and (3) the U.S. voluntary multipayer model. The health care systems in both the United Kingdom and France provide mandated universal coverage with a significant role for public financing. A brief overview is offered here.

#### **United Kingdom's National Health Service**

The UK's National Health Service (NHS) is publicly funded by general taxation (76 percent), national insurance contributions (19 percent), and user charges (5 percent). Health care spending accounted for 9.4 percent of the UK's gross domestic product (GDP) in 2006 (Griffen 2007). Each

year, the government sets a budget for the NHS and assures coverage of preventive services, inpatient and outpatient hospital services, physician services, inpatient and outpatient prescription drugs, mental health care, rehabilitation, and care for learning disabilities. There is little cost sharing in the system, except for some prescribed drugs and for dental care. Children (i.e., those less than eighteen years of age), older persons (i.e., those greater than sixty years of age), low-income persons, pregnant women, and persons with disabilities are exempt from this cost sharing. Providers are salaried in the NHS, with physicians paid through primary care trusts (PCTs) which are part of the NHS budget each year. Hospitals are primarily public as well. General practitioners act as gatekeepers in the system, controlling access to specialists as well as hospital services (Boyle 2008). There is a limited role for private insurance or private providers in the NHS.

### France's Public Health Insurance Program

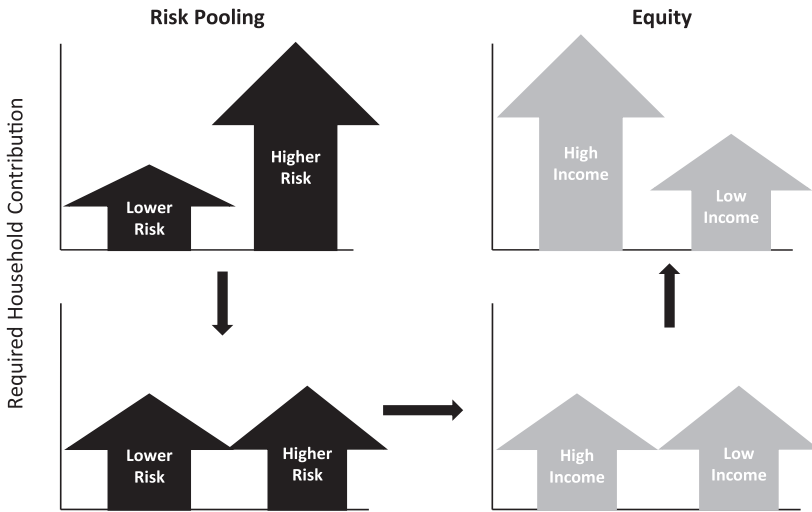
The public health insurance (PHI) program in France was rated the best health care system by the World Health Organization (WHO) in 2000 based on its reputation for universal coverage; responsiveness to patient needs; and positive population health outcomes, including longevity, infant mortality, and population health status (WHO 2000). In 2006, France's health expenditure represented 11 percent of the country's GDP, the largest in Europe (Griffen 2007). France's program is financed by a 13.55 percent payroll tax (employers pay 12.8 percent, individuals pay 0.75 percent) and a 5.5 percent general income tax assessment. The PHI covers roughly 75 percent of all health expenditures, with services including hospital care, outpatient services, prescription drugs, dental, vision, and nursing home care. Of the remaining expenditures, 10 percent is paid for by supplementary insurance (mostly mutual insurers), and the remaining 15 percent is paid directly by patients. Because of the relatively high out-of-pocket costs, supplementary health insurance has expanded to cover approximately 87 percent of the population (Insure the Uninsured Project 2008). Providers, including hospitals, are mostly private but draw their income from the public insurance scheme. The system is administered through a regulated system of private health insurers that are jointly managed by employers and union federations. The French health care system allows for unlimited care, with no gate-keeping mechanism or referral requirements.

## The U.S. Health Care System

The health care system in the United States is based on private voluntary health insurance, with supplemental public coverage for those with low incomes through Medicaid and the Children's Health Insurance Program (CHIP) for low-income families and children and through Medicare for the elderly and disabled. In 2006, 84 percent of the population had some type of health insurance coverage. Of those covered, over 70 percent (71.4) received coverage from an employer and an additional 10.7 percent of this population directly purchased coverage from the individual health insurance market. Those remaining had public coverage through either Medicare and/or Medicaid/CHIP. The uninsured rate was 16 percent (DeNavas-Walt, Proctor, and Smith 2008). In 2008, employers paid 73 percent of the average premium for family coverage, with employees picking up the remaining 27 percent (Kaiser Family Foundation 2008). For those policies purchased in the individual market, the premium costs are paid for entirely by the individual and determined based on underwriting practices that disadvantage those with health problems. The financing of the system is more evenly split, with the government accounting for 46 percent of total spending and private spending accounting for 54 percent of the \$2.2 trillion spent on health care (CMS 2008), a figure that represents 16.2 percent of the U.S. GDP.

## Equity as a Health Care System Goal

The universal coverage models of the UK and France guarantee health care coverage to all citizens regardless of income or health status. Access to health care in both countries is considered a fundamental right and is a component of the Charter of Fundamental Rights of the European Union (Or, Jusot, and Yilmaz 2008). Perhaps the most difficult aspect of moving toward universal coverage in the United States is the adoption of equity as an objective of the health care system. The World Health Organization has outlined the key financing objectives of a country's health care system (Gottret and Schieber 2006). A health care system should (1) assure equity in access to health care services, (2) prevent individuals from falling into poverty as a result of contributions to health care or catastrophic expenses, and (3) protect and improve the health status of individuals and populations by ensuring financial access to essential public and private health services. Most other high-income countries have not had to grapple with decisions about universal equitable coverage as the citizens in these coun-



**Figure 1** Models of Cross-Subsidization for Pooling Risk and Increasing Equity of Household Contributions for Health Services.  
 Source: ILO/STEP 2002

tries believe health care is a right, a public good that should be available to all, regardless of the individual's health condition.

Figure 1 illustrates the WHO objectives of equity in terms of both access to care regardless of health status and financing according to ability to pay. Equity will require both greater risk pooling than what presently exists in the United States and greater financial contributions from those with means to pay for those currently without access to care.

### Equity in Financing

As stated in the WHO *World Health Report*, "The way health care is financed is perfectly fair if the ratio of total health contribution to total non-food spending is identical for all households, independently of their income, their health status or their use of the health system" (2000: 36). Recent discussions of fair contributions in the United States have suggested that out-of-pocket costs for health care should not consume more than 5 percent of income for those with lower incomes and 10 and 20 percent as one's income increases. This contribution should not depend on health status and the percent should increase with income (Blewett, Ward, and Beebe 2006).

Equity in financing can also be thought of in terms of tax incidence and the amount of contributions required to finance the system. In single-payer systems, the main financing mechanism is tax funded. For those in the UK, the general fund covers access to care with little or no co-payments or deductibles and with government financing more than 95 percent of total health care spending. Accordingly, the tax incidence in the UK is fairly high but also progressive, with those with greater incomes contributing a greater share of their income.

Another goal of health financing is to protect individuals from contributing too much to health care and from bankruptcy and/or impoverishment in the event of a catastrophic health event (WHO 2000). The World Health Organization, in its comparative rankings across countries' health care systems, advocates equity in financial protection through maximizing prepayment for "insurable" health risks (risks associated with large and unpredictable expenses) as well as achieving the largest possible pooling of health risks within a population. This pooling of risk facilitates the redistribution of risk for high- and low-risk individuals, which in turn, through prepayment, redistributes costs from low- to high-income individuals (WHO 2000).

### Equity in Access to Care

Equity in access to care implies that all citizens should have the same access to needed health care services regardless of income; health status; or other factors, including race and ethnicity. In the United States, this goal also implies both reductions in inequalities in access to quality care that have been well documented and improvements to financial access to both public and private health services. Equity in access begins first with universal access to health insurance and a core set of covered health benefits such as exists in the UK and France.

There is a growing body of literature documenting the inequities in access to care in the United States. This includes great disparities in access to care for those with low incomes, for populations of color, and for those with high health care needs. In addition, there are significant geographic disparities in access between rural and urban areas and between states and regions (Agency for Healthcare Research and Quality [AHRQ] 2008). Even when controlling for factors that influence health insurance coverage, there are persistent inequities between states and for populations of color (Blewett, Davern, and Rodin 2004).

### Comments on Gusmano, Weisz, and Rodwin

Gusmano and colleagues (2009) add to the evidence of the persistent role of income disparities in countries with universal health care regardless of whether the financing is organized through a single-payer or multipayer system. An interesting aspect of this study was that the authors were able to drill down to a local level by looking at comparative data across cities as opposed to countries. This comparison allows for stratification on population demographics, such as income, age, and gender, relying on local census data. The data sources for health status, hospitalizations, and avoidable hospital conditions were not clearly described, but it is assumed that local data are available at the city level to allow for good comparative analysis. A key component of this level of analysis requires good comparable data, which are often difficult to find at the local level.

The findings of Gusmano and colleagues are consistent with other studies on income inequity in access to care—showing that universal coverage, in general, assured better access than the voluntary U.S. system but indicating mixed results on single-payer versus multipayer in assuring horizontal equity in access to care. The multipayer system in France was superior in some regards. There was more equity in access in the use of both primary and specialty services in Paris (multipayer universal) than either London (single payer) or Manhattan (multipayer voluntary). In addition, there were larger gaps in access by neighborhood in Manhattan, due in part to the large geographic concentration of poverty, supporting the concept of income disparity in access to care and highlighting the large disparities in the U.S. voluntary system.

One aspect of a health care system is the type of funding and the number of payers. But there are many other factors that contribute to equitable access to care, including the type and availability of primary care providers, mandated versus voluntary participation, the extent of use and level of co-payments, as well as the health status of different populations. Gusmano, Weisz, and Rodwin raise the point that health status may play a greater role in the use of hospital care for avoidable hospital conditions (AHC) than the availability of primary care. While Gusmano and colleagues found evidence of horizontal *inequity* in access to primary care in all three cities, as measured by avoidable hospital conditions, London's rates of hospital care for AHCs for those with lower incomes were slightly higher than those in Paris.

More study is required with enough data to control for other factors that may affect health status, being mindful about the role of poverty and

socioeconomic stress as well as access to either public or private health insurance. Such analysis will require more information on both individual characteristics and provider supply at the local level.

An example of this type of analysis can be found in a recent study by Or, Jusot, and Yilmaz (2008) using data from nationally representative household surveys in thirteen European countries to assess the individual determinants of generalist and specialist use, controlling for system and country-level covariates. Her findings suggest that the degree of social inequities in specialist use is smaller in countries with a tax-based National Health System and in countries where doctors play a “gatekeeper” role (e.g., the UK). Social inequalities in general practitioner (GP) and specialist use were larger in countries where out-of-pocket payments were higher and the level of public health resources was lower than in other countries. The results suggest that the organization and modes of financing health care do have an impact on the degree of inequity in health care utilization in Europe and that the GP’s position in the health system and the organization of primary care are particularly important in this respect, as well as cost-sharing arrangements.

### Additional Evidence

Gusmano, Weisz, and Rodwin’s findings are consistent with other research that demonstrates that single-payer government-run health systems do not guarantee horizontal access to quality health care. Income inequity continues to plague universal coverage systems. Van Doorslaer (2000), in his ongoing study of equity in European health care systems, found that, while there is income-related equity in the use of care provided by general practitioners, there is “substantial” evidence of income-related inequity in specialist visits—that is, after controlling for medical need, those with higher incomes reported more specialist visits than those with lower incomes (*ibid.*). More recent work affirmed these findings and concluded, “We find that in European countries, despite decades of universal and fairly comprehensive coverage, utilization patterns suggest that rich and poor are not treated equally. At equal levels of need, the access to and use of specialist services is greater for higher income groups” (Van Doorslaer, Koolman, and Jones 2004: 646).

Blendon et al. (2002) conducted a five-country comparative study and found that in four of the five countries persons with below-average incomes were significantly more likely than those with above-average incomes to report worse access to care. Difficulties with access to specialty care were

reported by 14 to 30 percent of low-income citizens across the five countries. U.S. citizens with below-average incomes were much more likely than their counterparts in the other four countries to report that it was extremely or very difficult to see a specialist. A statistically significant income disparity on this measure existed in all but one (Australia) of the five countries assessed.

The causes of the income disparities in access across countries with universal health care coverage are not well understood. Possible explanations for differential access to care include differential treatment by health care providers and differences in behavior, social networks, and environment that may make populations with lower socioeconomic status require more treatment or be more difficult to treat (Hussey et al. 2008).

We can also look to the U.S. Medicare program, which is our own U.S. single-payer health care system, with the federal government providing a standard set of benefits, near-universal participation, and tax-supported financing to those sixty-five years of age and older as well as the disabled. There is a growing body of evidence on inequities in access to care within the Medicare program, including inequities due to race and ethnicity as well as age and gender disparities. Some of the more recent evidence on these disparities includes the following:

- Nonwhites are less likely to be screened for colorectal cancer; among whites, women are significantly less likely than men to undergo screening. In addition, patients with higher incomes are more likely to be screened, but this finding was significant only for white beneficiaries (Ananthakrishnan et al. 2007).
- Medicare beneficiaries diagnosed with depression, those aged seventy-five and older, those of “Hispanic or other” ethnicity, and those without additional coverage to supplement Medicare are significantly less likely to receive treatment, controlling for other characteristics. And if these populations are treated, they are less likely to receive psychotherapy (Crystal, Sambamoorthi, and Walkup 2003).
- Another well-documented Medicare disparity is found in vaccination coverage. Pneumococcal vaccination coverage rates are 70.3 percent for whites, 40.8 percent for blacks, and 53.2 percent for Hispanics, and the proportion reporting provider recommendation for vaccination differs significantly according to race/ethnicity. Influenza vaccination coverage is 76.2 percent for whites, 50.7 percent for blacks, and 65.7 percent for Hispanics (Winston, Wortley, and Lees 2006).

The reasons for disparities in U.S. health care are more complex than either insurance or socioeconomic status. While insurance coverage is key, additional considerations include the adequate supply of providers as well as public health and community resources (Hasnain-Wynia et al. 2007). In addition, there is evidence that disparities in diagnosis and treatment are driven not only by treatment patterns of providers but also by where minority and nonminority patients seek care. Progress in diminishing health disparities will come only “when both the medical and nonmedical determinants of health are addressed” (Lurie and Dubowitz 2007: 452).

## Conclusion

With the exception of Mexico, Turkey, and the United States, all OECD countries had achieved universal (or near-universal) coverage of their populations by 1990. Yet most of these countries have found that universal and comprehensive insurance coverage is not sufficient to ensure equitable access to health care services. Gusmano and colleagues have added to the evidence of income disparities in access to care across all three types of health care systems: single-payer, social insurance model with multipayers, and the U.S. voluntary multipayer system. In addition to the number of payers and type of financing, there are clearly other factors that must be addressed in designing a system to achieve equity in access to health care. One of these components is an adequate supply of primary care physicians, which are “the underpinning of a health care system,” in that having a usual source of care increases the chance that people receive adequate preventive care (AHRQ 2000: 1). Other considerations include having culturally sensitive and competent care providers, coverage for prevention, and availability of quality providers.

In order to achieve universal coverage and reduce the profound inequities in access to care, the United States will need to first adopt equity as a fundamental objective of our health care system—that is, accept as an objective that people should have access to care regardless of health status and should contribute to the costs of the system based on their means. In addition, given that inequities in access persist in countries that have achieved universal coverage, efforts to reform the U.S. health care system must be particularly mindful that insurance coverage will not by itself guarantee equitable access to health care.

The United States has a long way to go—but while we may be the last high-income country to move to a universal health care system, we

will have learned from the successes and failures of other countries. The structure of universal health systems has grown incrementally over time based on the core beliefs and values of the citizens they serve. The United States' approach to universal coverage must also be based on the existing structures and strengths of the U.S. system. Some level of government intervention will be required, but a fully government-run and -financed single-payer system may not be the right model for the United States. And as Gusmano, Weisz, and Rodwin, as well as others, have shown, there are other models of financing that can achieve universal coverage and equitable access to care. A successful model will build upon the successes and strengths of the current system, will be in line with the unique values of the citizenry, and will provide universal access through a new commitment to the goal of equity in the financing of access to health care in the United States.

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