



America: Equity and Equality in Health 1

Inequality and the health-care system in the USA

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Widening economic inequality in the USA has been accompanied by increasing disparities in health outcomes. The life expectancy of the wealthiest Americans now exceeds that of the poorest by 10–15 years. This report, part of a Series on health and inequality in the USA, focuses on how the health-care system, which could reduce income-based disparities in health, instead often exacerbates them. Other articles in this Series address population health inequalities, and the health effects of racism, mass incarceration, and the Affordable Care Act (ACA). Poor Americans have worse access to care than do wealthy Americans, partly because many remain uninsured despite coverage expansions since 2010 due to the ACA. For individuals with private insurance, rising premiums and cost sharing have undermined wage gains and driven many households into debt and even bankruptcy. Meanwhile, the share of health-care resources devoted to care of the wealthy has risen. Additional reforms that move forward, rather than backward, from the ACA are sorely needed to mitigate health and health-care inequalities and reduce the financial burdens of medical care borne by non-wealthy Americans.

Introduction

As economic inequality in the USA has deepened, so too has inequality in health. Almost every chronic condition, from stroke to heart disease and arthritis, follows a predictable pattern of rising prevalence with declining income.¹ The life expectancy gap between rich and poor Americans has been widening since the 1970s,² with the difference between the richest and poorest 1% now standing at 10·1 years for women and 14·6 years for men.³ The health of poor communities is often neglected: for example, in Flint (MI, USA), a de-industrialised, impoverished, and predominately African-American city, public officials dismissed evidence that children were being exposed to toxic levels of lead in the city's drinking water for several months.⁴

Attention to economic inequality intensified after the Occupy Wall Street movement decried the rising wealth and power of the richest 1%. This movement popularised

research by the economists Piketty and Saez⁵ that revealed levels of income inequality unrivalled since the stock market bubble of the 1920s. The share of total income going to the top 1% of earners has more than doubled since 1970 (figure 1),⁶ while most workers in the USA have experienced slow income growth.⁷ As measured by the Gini coefficient, a standard metric of income inequality, the USA is now more unequal than all but three other countries (Chile, Mexico, and Turkey) in the Organization for Economic Co-operation and Development (OECD). The most equal countries are Denmark, Slovenia, Norway, and Slovakia.

The surge in top incomes has magnified inequality in wealth (ie, assets). Since 1986, the top 0·1% of households (those with assets exceeding US\$20 million) has

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This is the first in a [Series](#) of five papers about equity and equality in health in the USA

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Search strategy and selection criteria

We searched PubMed and Google Scholar using the following terms: "health care quality" OR "quality of care" AND "primary care" OR "specialty care" OR "specialist" OR "hospital" OR "surgery" OR "cancer" OR "outpatient" AND "inequality" OR "unequal" OR "disparities" AND "US" OR "United States"; "access to care" OR "health care access" OR "barriers to care" AND "inequality" OR "unequal" OR "disparities" AND "poor" OR "poverty" OR "wealthy" OR "income" AND "US" OR "United States"; "regressive" OR "progressive" AND "health financing" OR "health finance" OR "out of pocket"; and "medical bankruptcy" OR "medical debt". Our search included articles focusing on the USA published in English between Jan 1, 2011, and March 31, 2016, prioritising recent research. We identified additional sources, including important older manuscripts, from the reference lists of selected articles and from consultation with expert colleagues.

Key messages

- Economic inequality in the USA has been increasing for decades and is now among the highest in developed countries.
- Differences in life expectancy have been widening, with the wealthiest Americans now living 10–15 years longer than the poorest.
- Despite coverage gains from the Affordable Care Act, about 27 million Americans remain uninsured—a number that is likely to increase under the reforms advocated by Republicans now empowered in Washington, DC.
- Both overall and government health spending are higher in the USA than in other countries, yet inadequate insurance coverage, high cost sharing by patients, and geographical barriers restrict access to care for many.
- Financing of health care in the USA is regressive, with poor and middle-class individuals paying a larger share of their incomes for care than the affluent, thereby deepening inequalities in disposable income.
- Rising insurance premiums for employer-sponsored private coverage have eroded wage gains for middle-class Americans.
- Medical indebtedness is common among both insured and uninsured Americans, and often leads to bankruptcy.
- To achieve health-care equality, a non-market financing scheme that treats health care as a human right is essential.

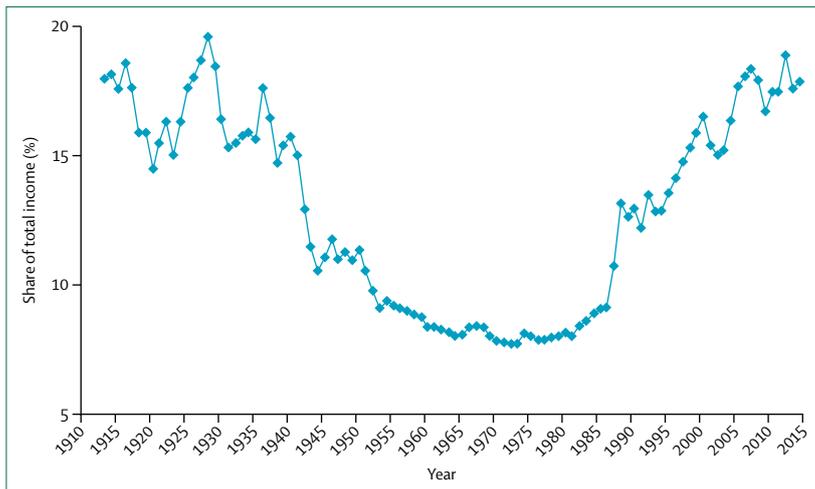


Figure 1: Share of total income received by the top 1% of earners in the USA, 1913 to 2014

Source: Saez (2016).⁶ Income is defined as pre-tax market income excluding capital gains and government transfers. In 2014, the top 1% included families with annual incomes above \$387 810, who collectively received 18% of total income in the USA.

accumulated nearly half of all new wealth, and now controls as much wealth as the bottom 90%, whose share has fallen steadily.⁸

Wealth inequality between racial and ethnic groups in the USA is especially striking, and is several times greater than income inequality. In 2013, median family wealth for the non-Hispanic white population was ten times that of Hispanics and more than 12 times that of African-Americans.⁹ The racial wealth gap results from historical factors dating back to slavery—many of which persist—including legalised racial segregation in the pre-civil rights era, pervasive job and housing discrimination, exclusionary city zoning laws, unequal education, and inheritance laws that perpetuate past inequalities.¹⁰

Although top incomes have risen, so has extreme poverty. More than 1.6 million households in the USA, including 3.5 million children, survive on incomes of less than \$2 per person per day—WHO's definition of extreme poverty; this number has more than doubled since the 1990s.¹¹

The health-care system could soften the effects of economic inequality by delivering high-quality care to all. Yet the institutions and financing patterns of the health-care system in the USA—by far the world's most expensive¹²—cause it to fall short of this ideal. Although inequalities exist to some extent in every health-care system, they are particularly stark in the USA. Unequal access to medical services is likely to contribute to disparities in health status, while rising costs (for both the insured and uninsured) reduce disposable incomes, particularly burdening low-income households.

Many patients cannot afford the care they need, and often forgo medical care altogether. For example, 19% of non-elderly adults in the USA who received prescriptions in 2014 (after full implementation of the Affordable Care Act [ACA]) could not afford to fill them.¹³ Millions of

middle-class families have been bankrupted by illness and medical bills.¹⁴ Meanwhile, very wealthy Americans are turning to so-called concierge practices that offer lengthy office visits and unfettered access to specialists.

This Series paper examines how the health-care system in the USA contributes and responds to inequality. We focus our attention on the association between inequality and the medical care system.

We first review how social position influences Americans' access to medical services and the quality of those services. The uninsured face the greatest barriers to care, but many insured Americans are also unable to afford medical care because of cost sharing. Although race-based disparities in quality are well documented, the low quality scores of doctors and hospitals serving poor communities might reflect patients' deprived social circumstances rather than their providers' performance. We also review how the health-care costs borne by households—in the form of insurance premiums, taxes, and out-of-pocket payments—exacerbate income inequality, forcing many Americans to cut back on food and other necessities, and contributing to most personal bankruptcies. We conclude by discussing the historical context for today's health-care inequalities, and propose options for reform.

Inequality and access to care

Income-related disparities in access to care are far wider in the USA than in other wealthy countries.¹⁵ Before the 2010 passage of the ACA, which progressively expanded health insurance coverage, 39% of Americans with below-average income reported not seeing a doctor for a medical problem because of cost, compared with 7% of low-income Canadians and 1% of those in the UK.¹⁶ Inequality in access to care is particularly stark in Southern states. For example, in Texas, Mississippi, and Florida, adults on a low income are more than twice as likely to face cost-related barriers to care as their counterparts in Maine (a relatively poor New England state) and Massachusetts.¹⁷

Disparities in access are largely due to high rates of uninsurance or inadequate health insurance among low-income Americans, although Americans with above-average incomes probably also have worse access to care than do their peers in other countries.¹⁶ Today, despite gains due to the ACA, 27 million Americans (down from 50 million before the passage of the ACA) remain uninsured. Most of the uninsured have annual incomes near or below the official poverty line (\$11770 for an individual in 2016).

The uninsured are far more likely than the insured to forgo needed medical visits, tests, treatments, and medications because of cost. Cost barriers are especially severe for the millions of uninsured Americans with chronic conditions.¹⁸ For example, middle-aged adults with no coverage for eye care report difficulties in reading or recognising a friend across the street

more frequently than do comparable individuals with coverage.¹⁹ Uninsured individuals with diabetes spend, on average, \$1446 out of pocket for medical services each year, and more than 30% do not have a primary care provider.²⁰ Similarly, low-income and uninsured Americans with psychiatric disorders are far more likely than the insured and those on higher incomes are to experience difficulties obtaining care.²¹ For poor Americans, gaining insurance boosts access to care (although it does not fully close the gap between poor and affluent patients), leading to more visits for preventive screenings and greater satisfaction with care than before gaining coverage.²²

Medicaid insurance for low-income Americans

Medicaid, the public insurance programme that covers 58 million low-income Americans, improves health outcomes and access to care for its beneficiaries.²³ Gaining Medicaid coverage reduces rates of clinical depression,²⁴ financial problems due to illness,²⁴ and mortality.²³ The generosity of the Medicaid programme, which is largely controlled by state governments, is a key determinant of access-related disparities. Before the passage of the ACA, most states restricted Medicaid eligibility to poor children and pregnant women, disabled people, and the poorest adults with children. Childless adults and parents with incomes above stringent state-specific thresholds (eg, 10% of the poverty level in Alabama) were generally excluded.

The ACA's expansion of Medicaid to all citizens with annual incomes at or below 138% (\$16 643 for an individual in 2017) of the poverty level promised to cover millions of previously uninsured Americans. However, the US Supreme Court ruled in 2012 that states could opt out of the Medicaid expansion, and the Trump administration is likely to further erode or repeal it. As of 2016, 19 states (mostly in the South) have opted out, cutting the number of citizens who would otherwise have gained coverage by about 5 million. An additional 5–6 million undocumented immigrants do not have insurance because the ACA specifically excluded them from its coverage expansion,²⁵ perpetuating major constraints on their access to care.²⁶ Fortunately, the ACA increased funding for community health centres, which deliver much-needed care to millions of low-income Americans, and extended mental health parity regulations aimed at improving insurance coverage for mental health and addiction treatment.

Although Medicaid improves access to care, specialist care is often unobtainable because the programme pays low fees to physicians,²⁷ who are free to turn away Medicaid patients. For example, 76% of orthopaedists' offices in a nationwide audit study refused to offer an appointment to a Medicaid-insured child with a fracture, whereas only 18% refused a child with private insurance.²⁸

Cost sharing and private insurance

In the private insurance market, cost sharing by patients (ie, through user fees) has increased substantially since the 2000s.²⁹ Many plans now impose co-payments of more than \$30 for primary care and more than \$45 for specialist visits.³⁰ More than 80% of employer-based plans include an annual deductible (the amount a patient must pay before insurance covers additional costs), which averaged \$1478 in 2016, an increase of 2.5 times since 2006.³⁰ Cost sharing by patients is even higher in plans sold through the insurance exchanges created by the ACA. In mid-level, so-called silver tier plans (which account for about 70% of exchange coverage), deductibles averaged \$3064 in 2016,³⁰ although some subsidies were available to cushion the deductibles for enrollees with incomes 100–250% of the poverty level.

Many private plans also reduce premium costs by restricting patients' choice of providers to narrow networks of doctors and hospitals, which often exclude academic and cancer referral centres.³¹ Enrollees who seek out-of-network care (either by choice or because of medical necessity) generally must pay the entire bill out of pocket.

Predictably, patients' use of care declines as their cost-sharing obligation rises, and people with the worst health are most likely to cut back on care.³² Paradoxically, this reduction in care-seeking can fail to cut system-wide use, instead shifting care from the sick and poor to the healthy and wealthy. At least in some cases, when poor patients avoid care, doctors and hospitals fill the empty appointment slots and beds with patients who are less price-sensitive³³—an example of supply-sensitive demand.³⁴ Strikingly, the USA has the world's highest health-care expenditures despite extensive cost sharing by patients.

Additionally, care forgone because of cost sharing might ultimately raise costs by increasing downstream health problems. When the Medicare programme (the public coverage for people aged 65 or older and those with long-term-disabilities) added new co-payments, outpatient visits decreased but hospital admissions increased.³⁵ Among patients who developed a myocardial infarction, elimination of medication co-payments after the cardiac event increased compliance, and (for racial and ethnic minority patients) led to a 35% reduction in major vascular events and a 70% reduction in total health-care spending.³⁶ Similarly, among children aged 5–18 years with asthma, those whose insurance required higher co-payments used fewer medications but had a 41% greater risk of asthma-related hospital admissions than did children with lower co-payments.³⁷ For nearly a third of children with asthma from low-income families with high cost-sharing coverage through the Kaiser Health Plan, parents reported delaying or avoiding outpatient visits, and 14.8% reported non-adherence to medications because of cost; 15.6% of all parents (including those

with higher incomes) reported borrowing money or cutting back on necessities to pay for their children's asthma care.³⁸

Defining underinsurance

Rising deductibles and other forms of cost sharing by patients have eroded the traditional definition of insurance: protection from the financial harms of illness. The term underinsurance describes this problem, but it does not have a standard definition. Some studies of underinsurance have focused on financial vulnerability (eg, measurement of deductibles as a fraction of income),³⁹ others on out-of-pocket costs incurred (either in absolute dollars or relative to income),⁴⁰ whereas others have highlighted barriers to care (because of cost or narrow insurance networks).⁴¹ No standard quantitative thresholds exist for these different concepts.

The various definitions of underinsurance highlight two related but distinct problems: people with inadequate insurance risk financial harm when they receive medical services, and they are therefore less likely to obtain needed care. Despite the absence of consensus on the definition of underinsurance, it is clear that these problems affect many Americans with private coverage and have increased.

Between 2004 and 2013, high rates of uninsurance, rising cost sharing (ie, underinsurance), and stagnant incomes all contributed to a decline in overall health-care consumption (as measured by the total amount spent by insurers and patients) for poor Americans, a trend that was reversed in 2014 when the major provisions of the ACA came into effect (figure 2).⁴² For the first time since the 1970s, per-capita medical expenditures for the poorest fifth of Americans (who are, on average, much sicker than the wealthiest 20%)

dipped below those of the wealthiest 20%.⁴² In Canada, by contrast, the poorest citizens receive the most medical services, commensurate with their increased health needs.⁴⁵ Meanwhile, health-care expenditures for the wealthiest 20% of Americans accelerated, raising their share of overall health-care consumption. The ACA, fully implemented in 2014, led to a surge in health-care expenditures for the bottom 20%, but expenditures for the middle class have flattened while health-care consumption by the wealthiest Americans continues to grow.

Access problems

Geography often affects access to care. Because physicians are concentrated in cities and affluent suburbs, many Americans living in rural areas find it difficult to obtain primary⁴⁶ and specialty care.⁴⁷ Many rural and Southern states also have a shortage of adequate family planning resources. Texas, for example, has imposed onerous regulations and funding cuts on family planning clinics, causing closure of many⁴⁸ and a subsequent increase in unwanted pregnancies.⁴⁹ Since the closure of the last local abortion clinic in 2013, women in Lubbock, Texas (population 244 000), are now more than 250 miles away from the nearest abortion provider.

Women are also at a financial disadvantage because of their greater health-care needs (including reproductive care) than those of men. Although fewer women than men are uninsured, those with insurance have higher out-of-pocket costs. For example, among people with employer-sponsored coverage, women's out-of-pocket costs were \$233 higher than men's in 2013;⁵⁰ among Medicare enrollees, such costs were \$640 higher for women than they were for men in 2011.⁵¹ These costs are especially burdensome because women's median incomes are 39% lower than those of men.⁵²

Illness-based disparities are particularly stark for mental illness and substance abuse. Historically, a large share of psychiatric care was paid for out of pocket or provided in underfunded public institutions. Jails remain the largest so-called inpatient mental health facilities in the USA. Although the 2008 Mental Health Parity and Addiction Equity Act mandated that most insurance plans provide equivalent coverage for mental and physical illness, implementation of this requirement was delayed until 2015, and its enforcement has proven difficult.⁵³ Moreover, most Medicaid programmes (which cover many people with mental disorders) are exempt from these regulations. Psychiatric—and particularly substance abuse—providers are in short supply on a national scale, especially in poor and rural areas;⁵³ these areas have been particularly hard hit by the epidemic of drug overdoses and self harm, which pushed up the overall death rate in the USA in 2015. The ACA, which applied the parity requirement to the plans sold through the

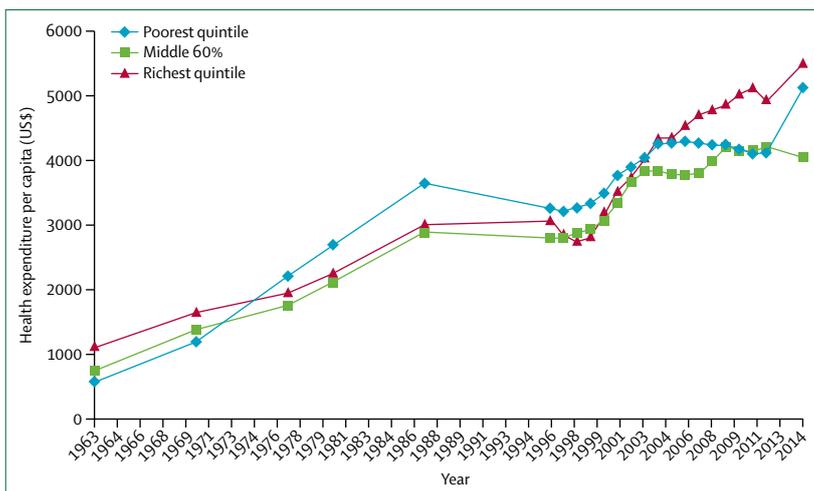


Figure 2: US health expenditures per capita, adjusted for inflation, by income group, 1963 to 2014

Sources: Dickman and colleagues (2016);⁴² and the Medical Expenditures Panel Survey^{43,44} (for years 2013–14).

Figures for 1996 to 2013 are 2-year moving averages; single-year figures are provided for 2014 to show the effect of the Affordable Care Act's coverage expansions in this year.

exchanges, increased access to mental health, but not to substance abuse treatment; substantial racial and ethnic disparities persist.⁵⁴

Inequality and quality of care

For many conditions, increased quality is implied by, and inseparable from, improved access to care. An increased frequency of primary care visits, for example, is associated with improved control of diabetes.⁵⁵ Similarly, among patients who developed an acute myocardial infarction, the uninsured were 38% more likely (and the underinsured 21% more likely) than the well insured to delay seeking emergency care.⁵⁶

Yet it is unclear whether income-related disparities in access to care are accompanied by other gaps in global quality, which are harder to measure. Poverty itself causes ill health, compromises non-medical social supports and resources that improve medical outcomes, and is associated with worse satisfaction with care.⁵⁷ Hence, differences in the socioeconomic profile of patients, rather than true differences in quality of care, might explain why hospitals⁵⁸ and physicians⁵⁹ caring for poor patients score lower on some quality metrics than do health-care providers serving affluent areas.

Assessment of quality differences is increasingly difficult because tying quality indicators to financial incentives can induce so-called gaming, which distorts measurement.⁶⁰ Nonetheless, payers have implemented pay-for-performance schemes that reward providers on the basis of proxy measures of quality, and facilities serving poor patients have been disproportionately penalised. For example, safety-net hospitals have seen their payments reduced under Medicare's Hospital Readmission Reductions,⁶¹ Hospital-Acquired Condition Reduction,⁶² and Hospital Value-Based Purchasing programmes.⁶³ Disturbingly, such programmes introduce perverse incentives to avoid poor patients, while shrinking funding for hospitals and physicians continuing to care for them.

In view of the pitfalls of quality measurement, what can be said about the association between social disadvantage and the quality of medical services? A classic study of patients admitted to hospital in 1984 found that uninsured patients were at higher risk (odds ratio 2·35) of receiving substandard medical care than their insured counterparts.⁶⁴ However, safety-net hospitals (and hospitals in the Veterans Administration [VA] system, which serves mostly non-affluent veterans) have risk-adjusted mortality rates for older patients similar to those of other hospitals. By contrast, small hospitals serving isolated rural areas appear to deliver a lower quality of care for medical conditions than other hospitals do, as measured by both process-of-care metrics and mortality.⁶⁵ Studies of differences in surgical quality and safety are inconclusive,⁶⁶ although risk-adjusted outcomes appear worse for poor patients across a range of surgical procedures.⁶⁷ Poor patients are more likely than affluent patients to receive dangerous

drugs: 27% of low-income Medicare beneficiaries with dementia, hip or pelvic fracture, or chronic renal failure received contraindicated medications compared with 16% of higher-income individuals.¹⁷ Poor Americans older than 50 years are also far less likely than their affluent counterparts to receive recommended influenza and pneumonia vaccinations, and cancer screening tests,¹⁷ although cost-related barriers might underlie these differences.

There is strong evidence showing that quality of care is worse for racial and ethnic minorities,⁶⁸ although racial disparities in the quality of hospital care could have narrowed between 2005 and 2010 as a result of improvements among hospitals serving patients from minority backgrounds and more equitable care within all hospitals.⁶⁹ Yet unequal access to care, along with institutional racism, remain important drivers of persistent disparities in health-care quality for racial and ethnic minorities. For example, although African-Americans tend to live closer than white patients to high-quality hospitals, they are less likely to have their surgeries there.⁷⁰ The intersection of race, racism, and the health-care system in the USA is reviewed elsewhere in this Series.

Health-care financing inequality

The USA finances medical care through a complex network of public and private insurance programmes, as well as substantial direct payments by patients. Figure 3 shows the proportion of Americans covered by the main insurance programmes, and the major sources that fund health care. Taken together, government insurance programmes—principally, Medicare, Medicaid, and military health care—account for 42% of personal health-care expenditures.⁷² Yet this figure substantially understates the government's share, because it excludes two large, tax-funded outlays for private insurance: government agencies' expenditures to purchase private insurance for public-sector employees (representing 28% of all employer payments for private coverage) and tax subsidies for private firms' purchase of insurance for their employees. Taking into account these two additional categories boosts the public share of total health funding in the USA to 65%.⁷³ Total health-care expenditures by the government in the USA exceed the total public and private spending per head of any other country except for Switzerland.⁷³ In light of this fact, the stark inequalities in health care faced by millions of Americans seem particularly unjust.

The complexity of health-care financing in the USA obscures not only the magnitude of public funding but also the regressive pattern of who ultimately pays. In fact, health care takes a substantially larger share of income from the poor than from the wealthy, exacerbating inequalities in disposable income.⁷⁴ Although comparative international studies are scarce and mostly old, financing schemes in other wealthy countries are generally less regressive (although cost sharing is rising in some European countries⁷⁵). Health-care systems financed

primarily through income taxes, as in Ireland, the UK, and Portugal, tend to be the most progressive, whereas those relying on private insurance and out-of-pocket payments, as in Switzerland and the USA, are more regressive.⁷⁶

The redistributive effect of specific health-care financing programmes

Direct out-of-pocket spending is the most regressive form of health-care financing. The uninsured (who are disproportionately poor) pay for much of their care out of pocket and, because they do not have insurers' negotiating leverage, are charged the highest prices.⁷⁷ As

noted previously, insured patients often bear a heavy (and regressive) out-of-pocket burden for deductibles, co-payments, and out-of-network care. Even older patients, almost all of whom are covered by Medicare, face high out-of-pocket costs for their share of the premiums, as well as co-payments and deductibles,⁷⁸ a burden that falls most heavily on low-income senior citizens. For Medicare enrollees, out-of-pocket medical expenses consume 11.2% of income among those with incomes above 300% of the poverty level, and between 22.7% and 26.8% among those with incomes below 200% of the poverty level.⁵¹

In an effort to reduce the burden of catastrophic medical bills, the ACA imposed limits on out-of-pocket medical costs in private plans (\$6850 per year for individual plans and \$13700 for families in 2016). Yet these limits, which do not apply to out-of-network and so-called non-essential services, vastly exceed most families' savings.⁷⁹

Private insurance premiums are also regressive⁷⁴ and have risen faster than earnings (figure 4); premiums for employer-based plans increased by approximately three times between 1999 and 2016.²⁹ The poorest fifth of Americans spend, on average, 6% of their income on private insurance premiums, while the wealthiest fifth spend just 3.2%.⁷⁴ Although employers typically make sizeable contributions to their employees' premium costs, economists believe that this expense is mostly passed on to employees in the form of lower wages.

Medicaid is the most progressively redistributive health insurance programme in the USA. It requires little cost sharing by patients, is financed through federal and state taxes (with progressive income taxes providing the largest share),⁸¹ and most of the benefits go to poor citizens.

Medicare is funded largely through federal general revenues and a payroll tax, which remains less progressive than Medicaid's funding base (despite the ACA's extension of the payroll tax to some investment income). Medicare covers both affluent and poor senior citizens, but its high and regressive cost-sharing requirements discourage many low-income beneficiaries from seeking care.⁸² Moreover, the growing gap in life expectancy between the rich and the poor means that wealthier Americans will, on average, live to enjoy many more years of publicly funded benefits after becoming eligible at the age of 65 years.⁸³ As a result, among men born in 1960, lifetime Medicare outlays are expected to be 28% higher for the wealthiest fifth than for the poorest fifth, a reversal of the pattern 30 years earlier.⁸³ Similarly, immigrants (especially the undocumented) collectively contribute billions more in taxes to Medicare each year than they receive in benefits.⁸⁴

Medical bills and financial hardship

The health-care financing system in the USA leaves millions of Americans facing medical bills that deplete their assets and drive them into debt. One in four non-

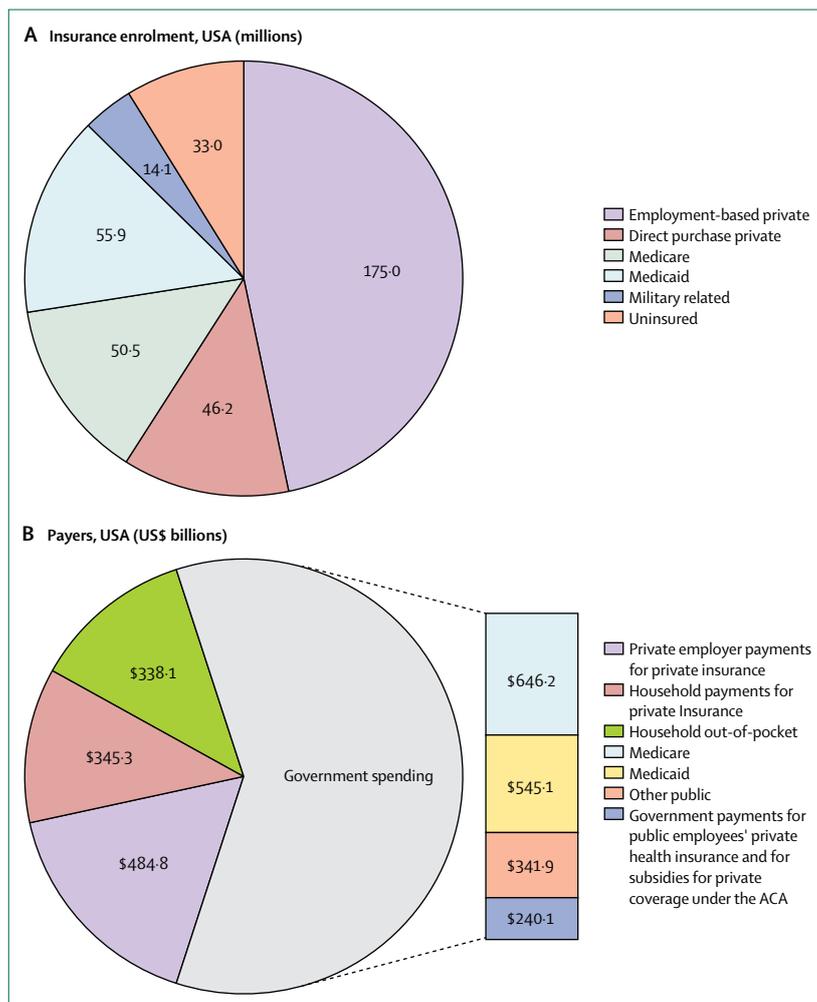


Figure 3: Proportion of Americans covered by the main insurance programmes (A) and main sources of health-care funding (B)

(A) Source: US Census Bureau, Current Population Survey, 2015.⁵² Individuals may have had more than one type of insurance. "Medicaid" excludes individuals with both Medicare and Medicaid. (B) Source: National Health Expenditure Accounts, US Centers for Medicare & Medicaid Services, 2015.⁷¹ The government spending figure excludes \$326.2 billion in tax subsidies. "Other public" includes maternal and child health, vocational rehabilitation, the Substance Abuse and Mental Health Services Administration, the Indian Health Service, federal workers' compensation, other federal programmes, public health activities, the US Department of Defense, the US Department of Veterans Affairs, the Children's Health Insurance Program (CHIP), as well as investment programmes (research, structures, and equipment), public and general assistance programmes, school health programmes, and other state and local programmes. ACA=Affordable Care Act.

elderly adults younger than 65 years (and one in three with annual household incomes <\$50 000) reported difficulty paying medical bills in 2015; more than half of these individuals owe more than \$2500.⁸⁵ People with deductibles higher than \$1500 (or families with deductibles >\$3000) and worse health than the overall population are particularly at risk^{85,86} (figure 5), as are African-Americans and Hispanics.⁸⁶

Medical bills are a major contributor to household debt and bankruptcy,¹⁴ comprising more than half of all unpaid personal debts sent to collection agencies⁸⁷ (figure 6). One in ten families with medical bill problems has declared bankruptcy.⁸⁸ Although the uninsured are at greater risk than the insured of declaring bankruptcy,³⁹ most medical bankruptcies involve debtors who are insured.¹⁴

Financial hardship is especially common among people with serious illness.⁸⁹ Among non-elderly adults with cancer, more than a third borrowed money or went into debt because of their treatment, and 3% filed for bankruptcy.⁹⁰ Such financial catastrophe appears to increase mortality for treatable cancers,⁹¹ perhaps because it leads to forgone care. Medicare⁹² and Medicaid⁹³ coverage provide better (although still imperfect) protection from financial hardship.

Medical bills force families to make difficult choices: 34% of insured Americans with difficulty paying medical bills were unable to pay for food, heat, or housing, 15% took out high-interest payday loans,⁹⁴ and 42% took on extra jobs or worked additional hours.⁸⁵ Most people reporting problems with medical bills say they have skipped or delayed needed medical care.⁹⁵ Moreover, defaulting on medical bills and medical bankruptcies often has long-term repercussions; these blemishes remain on credit reports for many years, compromising access to credit, insurance, housing, and employment.

Although medical costs impoverish many Americans, this issue is not captured by the US Census Bureau's official measure of poverty. In response, the US Census Bureau has introduced alternative poverty measures that subtract medical costs and other mandatory expenses from income, and add non-cash government aid (eg, housing vouchers). These alternative measures indicate that more Americans experience poverty than are reflected in official statistics,⁹⁶ with medical costs being the largest contributor to the difference between the official and alternative measures, pushing an additional 10 million Americans below the poverty line.⁹⁷

The medical system in the USA also influences inequality as an employer of nearly 17 million Americans. Although physicians and nurses are generally well paid, many other health-care workers are not. The health-care system employs more than 20% of all black female workers; more than a quarter of these health-care workers subsist on family incomes below 150% of the poverty line, and 12.9% of them are uninsured (Himmelstein DU; unpublished analysis of the 2015 Current Population Survey).

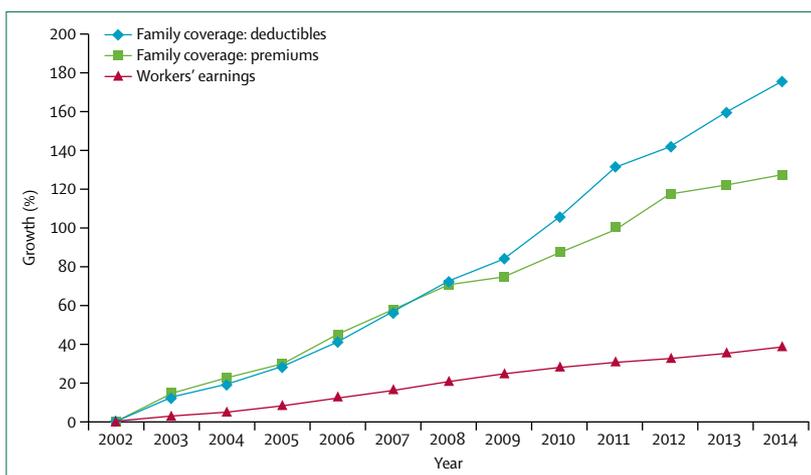


Figure 4: Growth in American workers' earnings, premiums, and deductibles for private insurance coverage, 2002–14

Sources: Medical Expenditures Panel Survey^{43,44} for years 2002–14 (2007 data unavailable), and US Bureau of Labor Statistics, Current Employment Statistics Survey⁸⁰ (data from April, 2002, to April, 2014).

A longer lens on health reform

A century ago, medical care in the USA had little influence on health or wealth. Burgeoning medical capabilities and costs in the 20th century made health care an industry ripe for corporate investment and profit. The transformation from a largely charitable service to a market-driven enterprise ensued.

Markets distribute goods on the basis of purchasing power, and for mostly non-discretionary purchases, such as medical care, this results in particularly lopsided financial burdens. In many other wealthy countries, social democratic and labour parties have successfully implemented policies that offset these market tendencies by creating national health programmes, or by tightly regulating private insurers and health-care providers. The USA does not have such a party, perhaps because the low-income voters most buffeted by the market are divided by racial animosities. After the 2010 passage of the ACA, congressional stalemates blocked incremental reforms that might have restrained medical markets and democratised care. Republicans, now in control of both houses of Congress and the executive branch in Washington, DC, promise to replace the ACA with measures that are even more market-friendly than the ACA, which would tilt care further towards the wealthy.

The health-care dilemma in the USA, characterised by unequal access and unfair financing, echoes that of the 1950s and 1960s, prior to the passage of Medicare and Medicaid, when one in four Americans (and half of older people and minorities) did not have health coverage.

After 8 years of Republican rule, the Democratic President Kennedy was inaugurated in 1961. The impetus for reform was bolstered by the popular mobilisation for civil rights and enabled by the Democratic Party's landslide victory in the 1964 election.

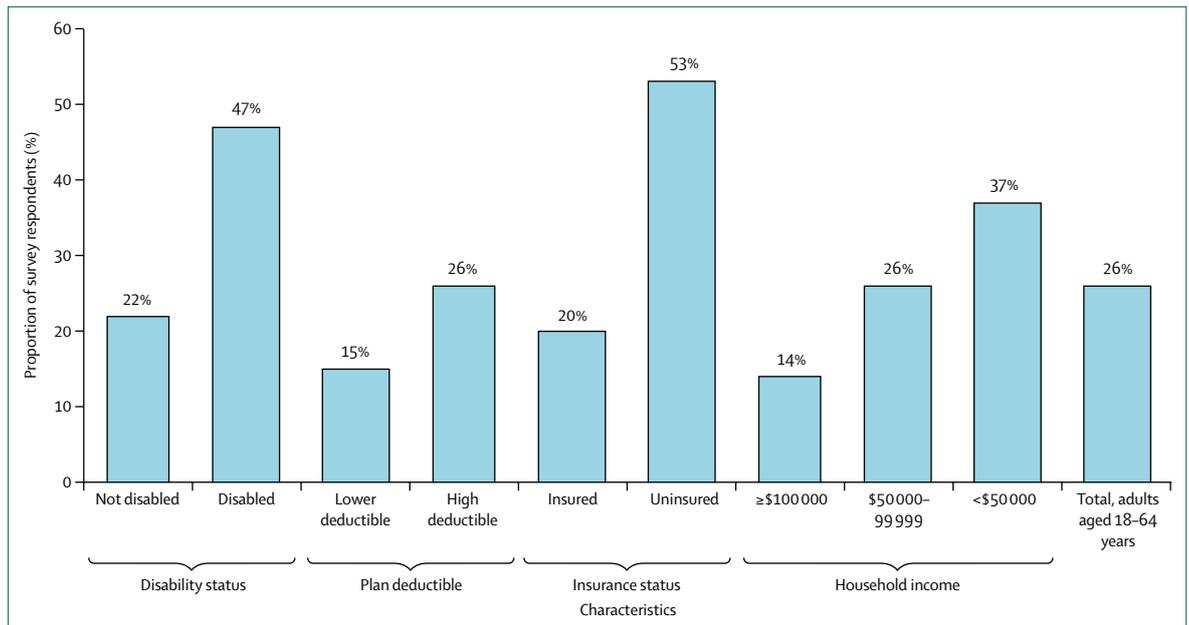


Figure 5: Share of adults in the USA aged 18–64 years reporting problems paying medical bills in 2015, by selected characteristics
 Reproduced with permission from the Kaiser Family Foundation/New York Times Medical Bills Survey, 2016.⁸⁵ High deductible defined as higher than \$1500 for an individual or higher than \$3000 for a family.

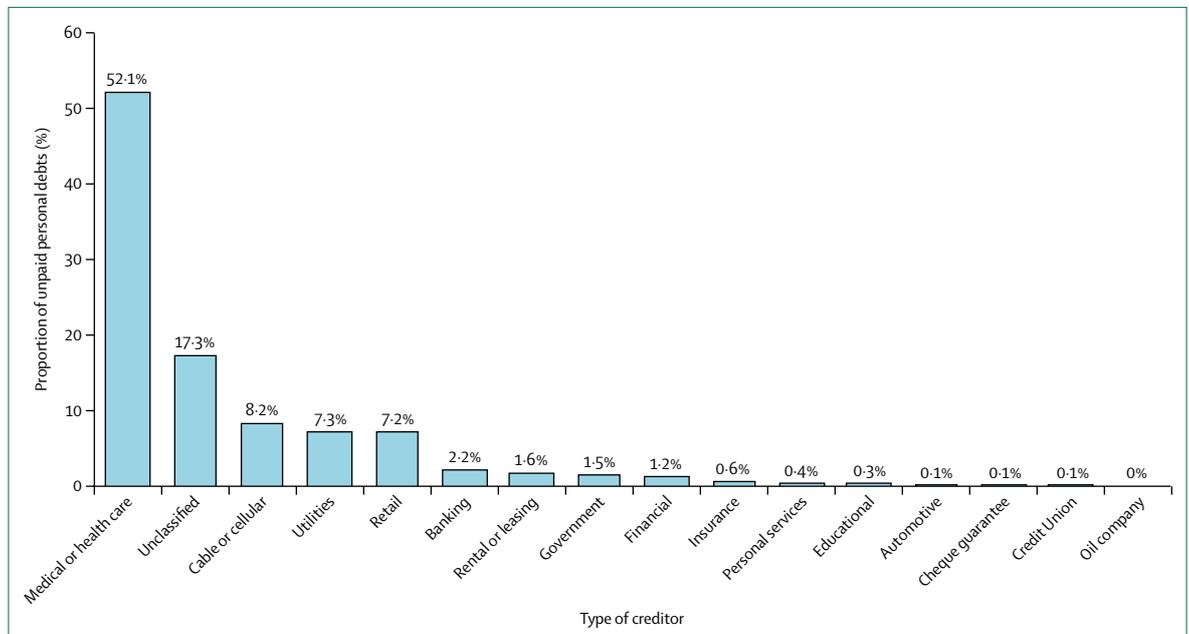


Figure 6: Composition of unpaid personal debts sent to collection agencies in the USA, by type of creditor
 Source: US Consumer Financial Protection Bureau, 2014.⁸⁷

The 1965 passage of Medicare and Medicaid vastly improved access to care and desegregated hospitals. But these health-care initiatives were just one part of a broad legislative agenda that transformed American society, including the Civil Rights and Voting Rights Acts, laws that improved opportunities for women in universities and the military, the first major federal aid programmes for local (particularly poor) public schools and college

students, fairer immigration laws, and the establishment of the National Endowment for the Arts. The redistributive agenda, dubbed the War on Poverty, also vastly expanded non-cash benefits such as food subsidies, free pre-school programmes for poor children, and community health centres, and boosted social security benefits, lifting 2.5 million senior citizens out of poverty. When President Kennedy came into office in

1961, 40 million Americans were poor. When his successor President Johnson left office in 1969, that number had fallen to 24 million. In 1972, the gap in remaining life expectancy at the age of 60 years was only 1.2 years between men with incomes above and below the median.²

Half a century on, neoliberal policies have eroded these gains. Today, 43.1 million Americans are poor, many health and social inequities persist, and some have worsened. Even after the ACA's coverage expansion—reviewed elsewhere in this Series—27 million Americans remain uninsured and, for many with insurance, access to affordable care remains elusive. At the same time, unneeded and even harmful medical interventions remain common (due, in part, to the fragmented health-care delivery system), bureaucracy consumes nearly a third of health spending, and wealthy Americans consume a disproportionate and rising share of medical resources.

Conclusion

Many physicians in the USA are working to advance health-care justice. But increased efforts in this direction are needed. The brave cadre of colleagues who face constant threat for delivering abortion services (which are disproportionately needed by poor women) must be supported and augmented, especially as anti-choice politicians now hold sway in Washington, DC. Doctors should follow the lead of trainees, such as those in the WhiteCoats4BlackLives movement, who have spoken out against the structural racism that still tarnishes many medical institutions and policies that deny care to immigrants. Physicians should reflect on the ways we—and the institutions we practice within—embrace or evade the responsibility to care for the disadvantaged.

Doctors should also join in demanding reforms that move forward, not backward, from the ACA. Republicans aspire to roll back the law's coverage expansions, fully privatise Medicare and the VA, and give state governments free rein to cut Medicaid—changes that must be resisted to avoid a public health disaster.

However, Hillary Clinton's 2016 presidential election defeat suggests that defending the health-care status quo cannot win the day. Moreover, proposals for incremental steps that could cushion the worst inequities—such as tighter insurance regulations, allowing a government insurance plan to compete in the market, regulation of drug prices, and extension of public coverage to immigrants—failed to excite voters. Until November, 2016, mainstream politicians and pundits deemed such steps politically feasible, and more thoroughgoing reform unattainable. Now, a more inspiring and egalitarian vision—a health-care reform that address the problems felt by most insured Americans—seems a more effective rebuttal to the Republican mantra of “Repeal and replace [the ACA]”. A bolder step towards health-care equality—straight on to universal public insurance—could offer the best way forward.⁹⁸

Contributors

SLD, SW, and DUH developed and drafted the paper, contributed to revisions, and approved the final manuscript.

Declaration of interests

DUH and SW were founders of, and remain active in, Physicians for a National Health Program, a group that advocates for a single-payer national health insurance system for the USA. DUH and SW served as unpaid advisors to Senator Bernie Sanders during Sanders' presidential campaign. SLD declares no competing interests.

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