US HEALTH CARE AT THE CROSS-ROADS
Health Policy Studies No. 1

Health-care reform has moved to the top of the policy agenda in the United States, as the high and rising costs of financing the system have intensified a long-standing debate about the affordability of, and access to, health care.

The first of a new series, this report says that while the intensity of US health care -- as measured by physician education staffing per hospital bed and other standards -- rose substantially in the 1980s, an increasingly broad spectrum of the population has begun to worry about health-care finances. Many individuals are facing rapidly rising health-care insurance premiums and out-of-pocket expenses. There are also indications that insurers are less willing to cover bad health risks than before, as mounting costs force them to seek new ways of economising. Employers, who provide the bulk of health-care insurance for the non-aged, are increasingly worried about the soaring cost of premiums.

Federal and state governments, which run two large public programmes -- Medicare (purely federal) for those over 65 years of age and Medicaid (joint state-federal) for some of the poor -- are concerned about the growing strain on their finances. These developments affect those most in need of insurance; that is, those at risk of having, or those who already have, chronic and expensive illnesses. Against this general background the heightened fear of unemployment in the recent recession and its aftermath has also played a role in raising the profile of health care, as the heavy reliance on employer-provided group insurance plans means that losing, or even changing, a job can result in losing health-insurance cover.

The US health-care financing system has two characteristics that define the current policy concerns: high and rising costs and a substantial number of people without adequate health-care insurance. These characteristics also distinguish the United States from other OECD countries. Far more is spent on health care in the United States than elsewhere: per capita health expenditures are almost twice the OECD average. Moreover, as a share of GDP,
these expenditures are increasing rapidly in the United States, while they have stabilised, or at least slowed, in most other OECD countries during the last decade. These trends reflect the largely unconstrained, high and growing US demand for quality health care. Judging by indicators such as infant mortality and life expectancy, the larger outlays have not resulted in better health.

However, it is widely recognised that such indicators are far too crude to be useful in judging the effectiveness of health care, and those Americans who have insurance coverage may be getting more for their outsized expenditures than they would suggest. In fact, most Americans are fairly satisfied with their health care. On the other hand, there are some 35 million Americans who do not have any insurance coverage, and most of them receive relatively inadequate medical care and often at a rather late stage in their sickness. The share of Americans without health coverage has risen slightly in the past decade; most of them are young adults and are uninsured for relatively short periods of time. However, and in contrast, coverage in other OECD countries is essentially complete. The extension of coverage and cost containment without reducing the quality of health-care delivery are now seen as the two key issues facing US health-care policy, although increasing access raises demand for medical services, thereby putting additional pressure on expenditures.

An annex to the report describes the health-care financing systems of the United States and of the other larger OECD countries, except Italy (which is discussed extensively in the forthcoming OECD Economic Survey on Italy).

Journalists may obtain a copy of the report from the OECD Press Division, 2 rue André Pascal, 75775 Paris cedex 16 (tel. 45 24 80 88 or 80 89).

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