The Effect of Health Insurance Disparities on the Health Care System

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Maintaining and improving the health of individuals is key to a healthy society. Health is connected to every aspect of people’s lives and affects their capacity to work, live, and play. The health of Americans is intrinsically tied to the American health care system and is influenced by the way social and economic resources have been organized. The United States is the only industrialized nation that does not guarantee health care for its citizens. As the divide between the “haves” and the “have-nots” grows wider in this society, everyone suffers as a result of the strain that is put on the health care system by those who do not have health care coverage.

Health insurance is the gateway to the US health care system. Without it, even routine health care services can be too expensive for many Americans, resulting in delayed care, prolonged illnesses, and poorer health outcomes. Uninsured patients are more likely than their insured counterparts to

• forego or delay treatment for acute illnesses or injuries,
• go without needed treatment for chronic conditions or illnesses, and
• die prematurely.¹

Nearly 45 million Americans were uninsured for all of 2005.² Many of the uninsured are working but are not able to afford health insurance. This is not only a burden for uninsured individuals, but it also affects private health insurance premiums.

Prices in the private health insurance market are spiraling upward, leading employers to raise the share paid by workers, cut back on benefits, or drop health insurance coverage altogether. As more people lose coverage and the cost of their care is added to premiums for the insured, still more employers will drop coverage. This is a vicious cycle, and the underlying issues contributing to this problem must be addressed. This nation cannot prosper without addressing health disparities and ensuring access to high-quality and affordable health care for its citizens.

Health Disparities

Health disparities have been defined in a number of ways.³ This article uses the National Institutes of Health definition of disparity, which states that disparities are

differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States.⁴

ABSTRACT

UNINSURED PATIENTS put a strain on the health care system that ultimately results in increased health care costs for everyone.

THE CHALLENGES faced by the Harris County Hospital District in Houston, TX, as a result of an increasing number of uninsured and underinsured patients include overcrowding in its health care facilities, decreased reimbursement from government programs, and patients who postpone seeking medical treatment until their situation is emergent and whose care is therefore more expensive.

STRATEGIES FOR ADDRESSING these problems may include instituting an “everybody pays” program, improving access to care for the uninsured, and reducing or eliminating unnecessary services. AORN J 86 (November 2007) 745-756. © AORN, Inc, 2007.
Nationally, the commitment to understanding and eliminating health disparities is strong. The Healthy People 2010 initiative, a set of health-promotion and disease-prevention objectives for the nation, aims to eliminate health disparities by the year 2010. This initiative has led to the development of a number of federal programs designed to support this goal through data collection and research. The US Department of Health and Human Services and its agencies spearhead these efforts.

Health disparities analyses typically compare groups and differences in their rates of incidence, prevalence, mortality, and burden of diseases and other health conditions. The most common type of disparity analysis makes comparisons among racial or ethnic groups. It is well documented that minority populations—generally classified as African Americans, Native Americans, Asian/Pacific Islanders, and Hispanics—have more chronic diseases, higher mortality, and poorer health outcomes than individuals classified as Caucasian. Race or ethnicity, though important, is not the only characteristic for which disparities can be assessed, however; health disparities can be examined by additional variables such as gender; income, education level, and other socioeconomic indicators; geographic area of residence; insurance status; primary language; and level of acculturation.

The purpose of this article is to examine disparities in health insurance coverage and access to health care services, specifically in the Houston, Texas, area, and the effect these disparities have on the health care system.

THE NATIONAL LEVEL

With an increasingly diverse population, the health of the United States depends on the ability to keep minority populations healthy. According to Census 2000 results, minorities represent approximately 25% of the nation’s population. Hispanics, now the nation’s largest minority group, represent 13% of the total population, with 12% of the US population citing Spanish as their primary language. Hispanics and Asians account for more than 50% of the nation’s population growth; between 2000 and 2050, it is projected that the Hispanic and Asian populations will more than triple, with Hispanics representing nearly a quarter of the total population and Asians representing 8%.

The US Census Bureau estimates that nearly 45 million Americans (ie, 15.3% of the population) are living without health insurance. Levels of health insurance coverage are lower among minority populations, and minority Americans account for half of the uninsured population. Approximately 17% of Asians and Pacific Islanders, 19% of African Americans, and 32% of Hispanics are without health insurance coverage at any given time compared with the national average of 15% and the average for Caucasians of 11%.

In addition to comprising the largest racial or ethnic minority group in the United States, Hispanics are the highest proportion of people lacking health insurance. In 2004, one-third of the 40.4 million Hispanics residing in the United States were uninsured. Although Hispanics make up 13% of the US population,
they account for 32% of the nation’s uninsured residents.2

Hispanics are a heterogeneous population, representing more than 15 countries of origin. Although Hispanics share many common experiences, there are notable sub-group variations in education, socioeconomic status, age, immigration status, and geographic localization that could be masked in analyses that aggregate Hispanics. Sub-group differences in access to health care also exist. By immigration status, 50% of immigrant Hispanics who are not US citizens lack coverage versus 23% of Hispanics born in the United States.18

THE UNINSURED IN TEXAS

Texas is the uninsured capital of the United States; nearly 25% of Texans currently are uninsured.19 Many Americans obtain health coverage for themselves and their families through their employer, but many uninsured Texans either work or live with a family member who works.20 Only 55% of Texans have access to employer-sponsored insurance, well below the national average of 63%. For small businesses, which are the bulk of Texas employers, the rate of employer-sponsored insurance coverage is even worse at 37%.20

In Texas, non-citizens are almost three times as likely to be uninsured as native US citizens.21 Immigrants, many of whom are Hispanic,
- often work in economic sectors, such as construction, that are less likely to offer health insurance;
- may be younger and less likely to feel the need for insurance; or
- may lack a family tradition of having insurance.20

Uninsured patients create higher health care costs for everyone as a result of the inherent cost shifting associated with this population. A study by Families USA in 2005 found that the health insurance premiums for employer-sponsored family coverage in Texas had increased by $1,551 from the previous year as a result of the uninsured.22

Another reason Texas has a high rate of uninsured patients is that a lack of insurance is not a barrier to health care in Texas. There are more than 40 federal health care programs for the uninsured in Texas. The largest single program is the Disproportionate Share Hospital (DSH) payment program, which spends more than $1.5 billion dollars a year and compensates hospitals that serve indigent patients.23

State law requires Texas counties to serve the indigent, which they do by forming hospital tax districts.24 Texas also requires nonprofit hospitals to provide indigent care equal to 5% of their revenue. In addition, state and local governments, charities, and nonprofit organizations provide health care.

Federal law requires emergency rooms (ERs) to provide some level of care to all who need it, regardless of whether they have a true emergency or the ability to pay for their care.25 All too often, the uninsured use the ER as their primary health care provider, at a cost that is roughly three times that of comparable clinic care. A Houston study stated that about

Who Are the Uninsured?

There is no such thing as a “typical” uninsured person. The uninsured are a diverse group that includes people who
- cannot afford private health insurance;
- work in small businesses that do not offer insurance;
- simply choose not to purchase health insurance, even though they can afford it;
- are eligible but are not enrolled in government-sponsored programs, such as Medicaid or the Children’s Health Insurance Plan (CHIP); and
- are recent immigrants.

Medicaid pays for health care services provided to low-income, elderly, and disabled persons, and the CHIP insures children of working families that cannot afford private health insurance but earn too much to qualify for Medicaid. Many of the 45 million Americans who are uninsured are working but simply cannot afford health insurance.1

half of the time, the uninsured use the ER for non-emergency conditions.26

**Houston/Harris County, Texas.** Of Texas’ largest metro areas, Houston has the highest share of uninsured residents, with a rate of 27.5%.20 Houston is located in Harris County, Texas, which, at 1,729 square miles and with an estimated population of 3,886,207 ethnically diverse individuals, is the third largest county in the nation and the largest county in Texas.27 The state of Texas has become a barometer for the nation, with demographic trends initiated in the state extending throughout the nation. The population demographics are rapidly changing. It is projected that the population of Harris County will be 48% Hispanic in 2020.28 The current population is 38% Hispanic, 38% Caucasian, 18% African American, and 6% Asian/Other.27 In Houston, 36% of people age five years and older speak a language other than English in their home compared with 18% of residents in the United States as a whole.27 The unemployment rate for Houston is 5.7%, and in Harris County, the median household income is $41,922.29 Poverty, language barriers, education levels, lack of insurance, and an inadequate public transportation system all have contributed to disparities in the health status of residents of Houston/Harris County.

An estimated 1.2 million residents of Harris County are medically uninsured or underinsured.30 There is no standard definition of “underinsured” and no consistent way to measure this population. Underinsured is a term generally thought to describe individuals who are exposed to significant financial losses or are unable to obtain needed care because their insurance coverage is inadequate.

Harris County has all of the primary social and health care factors related to poverty and a large immigrant population. Between 1993 and 1999, 23 hospitals serving the Greater Houston Consolidated Metropolitan Service Area conducted a Community Health Needs Assessment.31 Major health issues for the population of Harris County that were identified by the assessment included the following:

- **Limited access to care for the underinsured/uninsured/working poor**—Non-English speakers comprise a significant proportion of the unemployed in this county and thus are less likely to have medical insurance.
- **Limited access to primary care**—Although the county experienced an overall increase in the number of primary care practitioners, there was no increase in the number of primary care practitioners in neighborhoods with lower income levels and less likelihood of insurance coverage.
- **Teen births**—Of the children born to teenage mothers ages 17 and younger in 2002 in Texas, 65% were born to Hispanic mothers, 20% to white mothers, and 15% to black mothers.32 Children born to teenage mothers are at a greater risk for low birth weight, disability, and mortality during the first year of life.
- **Childhood immunizations**—Rates in Harris County across all races fall well below those for the state and the nation for all children.
- **Prenatal care**—Lack of information regarding proper prenatal care pervades those cultures with no access to health information.
- **Barriers to information/referrals**—The language barrier further compounds the difficulties for non-English speakers of getting information or referrals regarding accessible health care services.
- **Lack of information about diabetes and other chronic diseases**—Late detection of diseases such as diabetes and hypertension results in significant progression of the disease.
- **An aging population**—This issue is magnified in the health of older adults who have had limited preventive/primary care and are unable to communicate in English.

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**Underinsured individuals may be unable to obtain needed medical care because of their inadequate insurance coverage.**
The problems associated with the uninsured in Texas are exemplified by the challenges facing the Harris County Hospital District (HCHD). The HCHD, which was created by the Texas Legislature in November 1965, is a public health organization that provides health care services to residents of Harris County. The HCHD operates three hospitals with 906 surgical beds and 11 community health centers, and it is the nation’s fourth largest public metropolitan health system by admissions. In fiscal year 2007, there were more than 43,655 hospital admissions and 1,054,364 outpatient visits. Modern Healthcare has twice named the HCHD to its Top 100 Hospitals.

The three HCHD hospitals include Ben Taub General Hospital, Lyndon B. Johnson General Hospital (LBJ), and Quentin Meese Community Hospital. Ben Taub General Hospital has garnered the respect of the world as an elite Level I trauma center, one of only two in the Harris County area. This 619 licensed-bed acute care facility is the area’s busiest emergency center and houses the only psychiatric emergency center in Houston.

Lyndon B. Johnson General Hospital is a 292 licensed-bed acute care hospital that offers a full range of medical services. It is a verified Level III trauma center and was the first Level III trauma center designated in the state of Texas. It is the only emergency care facility in the northeastern quadrant of Harris County.

With more than 74,000 emergency patient visits each year and more than 14,900 inpatient admissions, LBJ handles approximately three to four times the patient load of any other Level III trauma center in the region.

Quentin Meese Community Hospital is a 49-bed geriatric/physical rehabilitation care facility. The HCHD also operates 12 community health centers throughout Harris County. Additionally, the HCHD maintains a health care program for the homeless, and in May 1989, it opened the Thomas Street Health Center, the nation’s first freestanding HIV outpatient clinic, which has served as a model for other HIV outpatient clinics nationally.

Providing care to the uninsured. One of the greatest risks facing the HCHD is that the rate of uninsured and underinsured people is projected to increase 2% to 3% during the next five years. This risk is accompanied by a prospective budget decrease in financial assistance for the uninsured and underinsured. An increase in the uninsured and underinsured patient population in Harris County would cause a domino effect for the HCHD, putting the organization at risk for an increase in the number of uninsured patients it serves as compared to other health care facilities in the city. This would lead to overcrowding in its emergency centers and community health clinics.

Because the HCHD is a public health organization, the majority of the uninsured population would be referred to the HCHD. Even though other health care facilities have low-income and indigent care financial assistance or charity programs, the majority of their patients are self-pay or insured. When uninsured emergency patients arrive at other facilities, these facilities can choose to accept the uninsured patient as charity care or stabilize the patient and transfer him or her to the HCHD. As a public health and community organization, the HCHD will not refuse comprehensive health care to any patient, regardless of his or her ability to pay. Thus, many uninsured and underinsured patients seek primary care through the emergency centers and community health clinics of the HCHD, which can cause overcrowding of these service centers.

The purpose of the emergency centers is to...
provide health care in emergent situations. The two general hospitals of the HCHD are designated as Level I and Level III trauma centers, and these facilities cannot sustain overcrowding resulting from nonemergent care because the level of care may be sacrificed for emergent and trauma patients. The purpose of the community health clinics is to provide primary care to the residents of its surrounding community; however, the clinics will often accept patients from other areas. The HCHD’s emergency centers and community health clinics cannot afford overcrowding because this would lead to patient waiting times being extended and a need for an increased number of health care staff members (eg, physicians, nurses, allied health professionals) to handle the increased patient load.

Providing Care to the Uninsured in the Perioperative Arena. A lack of access to care for the uninsured and underinsured population can have significant effects on providing care in the perioperative arena as a result of the extent of the patient’s medical condition at his or her time of presentation to the health care organization. Uninsured or underinsured patients may not seek medical attention for conditions that may require elective surgery until the condition warrants urgent or emergent surgery. In addition, patients with chronic medical conditions, such as diabetes, who are noncompliant with their treatment regimen may become frequent patients in the OR, requiring multiple treatments and surgeries as a result of advancing disease processes and lack of medical treatment.

Patients requiring elective surgery within the HCHD are required to pay a copayment before receiving surgical services. If patients are unable to pay the copayment, surgery is rescheduled for another date. This further delays treatment of their condition, which can possibly lead to urgent or emergent surgical treatment later on. Patients who cannot pay the copayment may decide to live with their condition or seek care in other health care organizations.

Financial Aspects. With the probable reduction of uninsured financial assistance by the state legislature coupled with an increased uninsured patient population, the HCHD would experience decreased revenues as a result of reduced reimbursements from Medicaid, other state programs, and DSH payments. Early projections indicate that the HCHD “could lose up to $150 million in the two-year period from 2004-2006” as a result of budget cuts in Medicaid reimbursement. In addition, accounts receivable would be increased by the uninsured or underinsured patients who do not qualify for state financial assistance and are unable to pay for services. Because the HCHD is a public health organization that is also funded by county taxes, the residents of the county would be at a risk for increased taxes to compensate for the financial strain placed on the organization.

Addressing the Problem

In order to meet the risks of an increasing uninsured and underinsured population, the HCHD must develop strategic initiatives that will minimize the situation while building and maintaining organizational strength. To build organizational strength, the HCHD will have to continue providing quality health care to its patient population without sacrificing health care services or staff members. Strategic initiatives will involve maintaining the financial stability of the organization while continuing to provide quality health care to uninsured and underinsured patients and minimizing overcrowding of the emergency centers and community health clinics.

Administrators of the three major facilities of the HCHD were asked to develop a contingency plan that includes reevaluating any programs
Under an “everybody pays” program, uninsured or underinsured patients would pay a monthly payment for services rendered based on their family size and income level.

or services provided and assessing the projects in this fiscal year’s capital budget. This reevaluation and assessment would help the HCHD administrators decide which services to continue and which services could be reduced or eliminated. Other contingency plans consist of looking at potential revenue sources, such as an “everybody pays” program and increases in pharmacy copayments.36

EVERYBODY PAYS. An “everybody pays” program calls for all patients to pay a monthly payment based on their family size and income. This type of initiative would assist the HCHD in resolving its financial instability with an increasing uninsured and underinsured population. Currently, uninsured patients treated at the HCHD pay nothing or a percentage of their billed charges, which has no relationship to the patient’s ability to pay. Under an “everybody pays” program, however, the cost of services provided to uninsured and underinsured patients at the HCHD would be determined by patients’ income levels. These individuals would be required to make monthly payments for services received based on their income. The initial payment would need to be made before services are rendered, with the exception of emergent care. Certain services, such as elective surgical procedures, would require a higher payment before services are rendered. The program also could compensate for a decrease in DSH payments by increasing the sliding scale payments. Overall, an “everybody pays” program would allow a minimal decrease in revenues and a minimal increase in accounts receivable.

Internal environmental factors that will affect this initiative include an increase in patients’ waiting time. Payment plans will have to be determined before the patient receives service, thereby increasing the amount of time the patient must be at the medical facility before being seen by a health care practitioner. Requesting that the patient come in at least 30 minutes before his or her visit may offset waiting times. This should allow sufficient time for the patient to make financial arrangements with the business office.

The degree of risk with this type of program will directly involve the attitudes and expectations of uninsured and underinsured patients. In 2003, the Texas Department of Insurance stated,

More than one-third (36 percent) of the non-poor uninsured report that they are satisfied with receiving their health care through public or free clinics. Furthermore, 25 percent report that they agree with the statement “people who don’t have health insurance have an easy time getting proper medical care.”

Paying for services will be a new concept for these patients. They will need to realize that without payment, services may be reduced, thus affecting their access to care. Initially, uninsured and underinsured patients may postpone seeking treatment for their health conditions until they become severe and require more expensive treatments. Thus, the next step would be for the HCHD to implement strategic initiatives to improve access to health care services.

IMPROVING ACCESS TO CARE. Improving access to care should reduce or eliminate overcrowding of the emergency centers and community health clinics. The goal would be to provide uninsured or underinsured patients with primary care or preventive measures before they seek services at the emergency centers or community health clinics. This can be accomplished through programs such as Gateway to Care, a 501(c)(3) collaborative organization composed of 167 public and private safety net health systems, coalitions, advocacy groups, and social service providers.38 This collaborative
organization works together to assist the approximately 2.2 million medically indigent residents in the Greater Houston Area in receiving medical care at the most appropriate setting. Other avenues to improve access to care include improving utilization of mobile clinics and implementing preventive health programs and outreach programs.

The degree of risk with the initiative to improve access to care depends on finding effective methods to reach these patients and provide these services. If patients are not aware of the services available, then this initiative would be ineffective. The HCHD, therefore, must also implement community awareness programs that market these primary services. This can be accomplished through community health fairs at central locations, such as grocery stores, churches, or community centers. The HCHD can use organization volunteers and nursing schools to provide staff members for these community events, thus avoiding high overhead costs.

Referring Patients to Other Public Health Facilities. If the HCHD is unable to minimize its proportion of emergency center and community health clinic uninsured and underinsured patients, it may wish to refer patients to other city or county public health facilities. Many of these facilities provide similar basic health care services, such as HIV/AIDS prevention, dental services, family planning, immunizations, maternity and prenatal care, and treatment for sexually transmitted diseases. The degree of risk will involve the number of patients that the HCHD sees for these services. If there are few patients who fall into this category, referring them to other public health facilities will not make a large impact on the organization and will decrease charge revenues.

Reducing or Eliminating Unnecessary Services. The final alternative for resolving the risks of an increasing uninsured or underinsured population would be to reduce or eliminate unnecessary services or programs. These services and programs would have low utilization or could be received at other local public health organizations. This initiative would decrease the number of uninsured and underinsured patients seeking care at HCHD facilities and decrease costs; however, a reduction in charge revenue also would be expected.

External factors to consider are the overcrowding of other public health facilities and lack of access to care for the eliminated services. This initiative may cause a reappearance of the eliminated services and programs at the HCHD if public health organizations cannot handle the number of patients seen or if patients cannot locate the eliminated services at other facilities. For the initiative to be effective, the HCHD would need to create an alliance with community health organizations to which it can refer its patients.

Before Implementation. The HCHD is prepared to do whatever it takes to remain solvent and overcome the problem of decreased funding coupled with an increased population of uninsured and underinsured patients. Any plans, however, will be thoroughly examined before they are implemented so the HCHD can continue to administer quality health care to the residents of the county. Implemented plans and cost-reduction strategies should not sacrifice required services or supplies to treat patients.

Implications for Perioperative Nursing

Perioperative nurses, as well as nurses in other specialties, need to be prepared to care for the diverse cultural population of the uninsured and underinsured. By the time these patients present to the health care organization, they usually have faced a multitude of challenges:

- seeking health care treatment;
- disclosing personal information (eg, income, expenses, living arrangements) to determine eligibility;
- conforming to current and prospective medical treatment; and
- missing work, which usually leads to a lack of income.

When these patients arrive in the perioperative area, they may be experiencing significant stress and anxiety in addition to the stress of undergoing a surgical procedure. Perioperative nurses need to have the ability to exhibit a high capacity of compassion, empathy, and understanding and assure these patients that they will be receiving quality care. It is important for perioperative nurses and professionals to remember that these patients did not choose to
become uninsured or underinsured and to experience the effects of this situation.

**Promoting Health Care Equity**

Despite the dramatic advancements in health and health care during the past century, health disparities in insurance coverage, access, and quality of care continue to exist in many communities and are among the many factors producing inequalities in health status in the United States. The persistence of health disparities affects all Americans by escalating national health care spending, and it adversely affects the health care system for everyone. The increasing diversity of this nation brings both opportunities and challenges for health care providers, health care systems, and policy makers to address these disparities. The health of every community is enhanced when health care providers work to promote health care equity for everyone. — [AORN](http://www.aorn.org) —

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