Center for Health Ethics
Health Management and Informatics
University of Missouri

April 2006

David A. Fleming, MD
315 Clark Hall
Columbia, MO 65211

Ethical Issues: "…but I have no insurance."

As a state health care institution with a mission to serve the citizens of this state, we often become the "hospital of last resort" for patients who other providers have refused to see due to patients' lack of health insurance or who otherwise have no ability to pay. These patients are often challenging because many times they present with uncontrolled chronic conditions, such as diabetes mellitus or hypertension, and not infrequently they are noncompliant because they can't afford their medications or other interventions that are needed and recommended. They also often present quite ill because they have not been managed or cared for properly due to their lack of access to regular health care services. Patients who have been marginalized in this fashion often have a negative and mistrustful attitude about health care systems and providers due to repeatedly being denied adequate health care and other needed services. Presently there are 44 million uninsured in the United States, a disproportionate number of which are of low income.[i] This problem has placed a huge burden on the health care system of this country and continues to foster a growing segment of our population who live day to day with chronic uncontrolled illnesses and use the emergency room as their main resource for health care.

A question has come to me asking what I do as a physician to meet the health care needs of uninsured patients in my practice, of which there are many. I see several each day, but typically don't know they are without insurance until diagnosis and treatment options are discussed, at which time either the patient informs me or I am challenged by the business office. I have made it my practice (often to the chagrin of the business office) to never inquire as to my patient's insurance status prior to seeing them, unless there is a "need to know" for the sake of the patient. I have found that awareness of insurance status tends to bias critical thinking -- historically physicians tend to "do more" when patients have a healthy reimbursement plan, and "do less" when not[ii], which is why uninsured patients tend to have delayed diagnosis of severe disease and poorer outcomes overall.[iii] Our training and discipline to apply "diagnostic excellence and therapeutic parsimony" should pertain universally for all patients, regardless of payment plan. Prudent use of scarce resources and concern for controlling the use of unneeded tests and treatments is important for the welfare of all patients, not to mention the health care systems that too often must bear the financial brunt of expensive diagnostics and therapeutics when there is no form of reimbursement.

Techniques to assist patients who struggle with compliance due to an inability to pay for health care services are limited, but some may be useful. Having drug samples available can help tide a patient over until they have money to buy drugs, however this is often only a band aid intervention because too often once the samples are gone they still cannot afford to get prescriptions filled for the same medication. Some pharmaceutical companies have programs available that will donate drugs to patients with special needs, however these programs may be limited as to length and frequency of supply, and the paper work needed to access these programs may be onerous. Representatives from social services in the hospital and family services in the community are often incredibly valuable, but state funded services are limited, and they typically do not include payment for prescription drugs or diagnostic tests without Medicaid coverage, for which the patient may not be eligible.

Perhaps the most useful service I, as a physician, can provide my patients who do not have health insurance is to advocate for them at all levels. Often this means finding a way to get patients from visit to visit with minimal testing ("diagnostic excellence") and maximum home monitoring and self management in an attempt to minimize the number of prescription written and the need for hospitalization ("therapeutic parsimony"). Physicians should go bat for their uninsured patients who need help, such as when they ultimately do need to be hospitalized or have expensive diagnostic testing. These are times when the patient needs a physician who will mediate, negotiate, and even mandate appropriate care and treatment when necessary. Ultimately physicians are obligated to do that which is medically indicated for their patient, regardless of the patient's ability to pay. Physicians should encourage hospitals to work with patients to set up payment systems when necessary, and encourage other providers to do their part in sharing in the responsibility of caring for patients who do not have health insurance yet still need health care. Advocating at both the state and national level as a physician, through organizations such as ACP and AMA, is also important to encourage the formation of policies that will address the growing concern of inadequate access to health care for the uninsured.

---

[i] Holahan J and Brennan N. Who are the Adult Uninsured? The Urban Institute Web Site, posted 3-1-00. http://www.urban.org/url.cfm?ID=309526

[ii] Mort E. et al. Physician Response to Patient Insurance Status in Ambulatory Care Clinical Decision-Making: Implications for Quality of Care. *Medical Care*. 1996;34(8):783-797

[iii] Ayanian J, et al. Unmet Health Needs of Uninsured Adults in the United States. *JAMA.* 2000;284:2061-2069