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One Nation, Underinsured: A Proposal for Rights-Based Universal Healthcare

The United States is the wealthiest and most technologically powerful economy on the planet, and yet, the U.S. is the only developed country today without universal access to healthcare, and a significant portion of the population lacks health insurance or access to quality care. Additionally, it is one of only four countries in the Organization for Economic Cooperation and Development (OECD) (of which there are 38) that do not constitutionally guarantee healthcare as a basic human right. A frequently-cited and well-respected study from The Commonwealth Fund published in 2021 ranked eleven high-income countries' healthcare systems based on access to care, care process, administrative efficiency, equity, and healthcare outcomes, including peer nations such as Australia, Canada, Germany, and the U.K., and the results are of potent poignance: the study ranked the U.S. dead last despite spending vastly more on healthcare than any other peer nation (18.3% of GDP). An article from the Ross School of Medicine expounds on this study, noting that "Americans…get by far the least return on their investment…the United States finished so far behind 10th-place Canada that it had to be excluded from the survey average because it skewed the numbers for the other countries" ("US vs Canadian"). The current system is financially wasteful and unnecessarily expensive, ineffective, complex, and most importantly, its modus operandi is unethical and does not align with the United Nations' (UN) or World Health Organization's (WHO) declared moral values of Universal Health Coverage (UHC) as a basic human right. Who lives and dies should not be decided by how much money is in a person's bank account. It's time for the U.S. to solidify

access to healthcare as a basic human right and adopt a plan for UHC to save taxpayer money, improve health outcomes & quality of care, and promote the equitable, ethical, and moral values of rights-based healthcare.

Healthcare and health insurance have been a topic ripe with controversy and discord in the political sphere for over a century, but particularly within the last decade it has again surfaced in political discourse, but what exactly is UHC? Firstly, UHC is not a form of health insurance: health *insurance* is offered by private providers as a paid service. Rather, it is a guarantee of access to essential healthcare services without facing financial hardship. Secondly, UHC is not synonymous with free healthcare, and even if a nation's implementation of UHC means free healthcare in their case, it is not really "free"; it needs to be funded from somewhere, and how it is funded is where UHC plans differentiate themselves: they are either single-payer or multi-payer. In a single-payer model, such as the one implemented in Canada, there is one body responsible for all healthcare costs, typically the government, and every citizen pays for it in their taxes. In a multi-payer model, such as in Germany, France, or Japan, healthcare costs are covered by a combination of public and private funds, one source of which might be government funding, but which is supplemented by private insurance options. The United States currently has by far the most convoluted system: an impressively complex hybrid-payer model comprised of mostly private coverage, but also incorporating elements of single-payer such as with Medicare and Medicaid, elements of socialized medicine such as with the Department of Veterans Affairs–which covers the cost of Veterans healthcare but the government itself employs the healthcare workers–and also a partial self-payer model as is the case with copays and premiums where the patient pays some out-of-pocket expenses.

Having covered some context and background, it is important to note that the current hybrid-payer system is financially wasteful–so much so, that it is unsustainable and will *require* serious changes at some point in the nearing future. A few main points evidence this: an academic publication from the *Annals of Internal Medicine* assessed several data points reflecting the cost of healthcare and found a few metrics worth considering: firstly, they note that spending on healthcare per capita is overwhelmingly higher in the U.S. than in other wealthy countries–18% of GDP–and that number has been steadily increasing at an unsustainable rate. They go on to mention that "The United States has a higher mortality rate for medical conditions for which there are recognized health care interventions than Germany, the Netherlands, Japan, France, and Australia," which emphasizes that the greater expenditure does not result in increased yield or improved outcomes for patients. There are countless studies and benchmarks available from innumerable sources that corroborate this claim: The U.S. spends violently more than any other developed country on healthcare, yet has the worst system of all peer nations to show for it. The *Annals of Internal Medicine* also reported that since 2006 "total cost sharing", those things like copays and premiums that the beneficiary bears the burden of cost for, have increased faster than wages, and a 2017 Health Care Cost and Utilization Report from the *Health Care Cost Institute* found that the number of people treated at hospitals "fell 5% between 2013 and 2017", yet the total cost of inpatient care per person rose 16% in the same period.

So *why* is the current system so expensive? Firstly, unlike most other peer nations, the U.S. has no central body that negotiates with insurance and pharmaceutical companies on pricing, meaning corporations, which solely serve profit margins, can arbitrarily set their own prices for things like health insurance or life-saving medicines. A Statista analysis from 2022 notes that the U.S. spent $1,432 per capita on pharmaceuticals alone, which is over 200% more

than the average of seventeen other peer countries assessed in the study, including Germany, Canada, and France (Mikulic). For Medicare Part D, federal negotiation with pharmaceutical companies over the price of formulary medications is *legally forbidden* in the bill that established it, likely as a compromise with lobbying entities from the pharmaceutical industry. The examples and experience of other nations with UHC achieving significantly lower drug costs can be attributed–at least in part–to their ability to federally negotiate with pharmaceutical companies over prices. Another reason for the high costs is the large number of administrative workers needed to manage the complex chain of billing and communication between clinics and a diversity of insurance companies. A 2023 brief from The Commonwealth Fund assessing sources of excess spending in healthcare observed that approximately 30% of the cost of health insurance and healthcare in the U.S. is just to cover the administrative process ("High U.S."), as opposed to other countries like Canada, who only spend about half that on the same process annually (Woolhandler et al.). Single-payer models offer the most impactful correction to this waste, as a single-payer model eliminates the necessity for most, but not all, administrative personnel. The government raises money for a healthcare fund, primarily through taxes, and when a patient enters a doctor's office looking to treat a fever or a sprained limb, the office does not need multiple third parties communicating to confirm whether or not insurance will cover a diagnostic screening or treatment: treatment would have a guarantee of coverage. A multi-payer system would also significantly lower administrative costs by simplifying, standardizing, and streamlining the paperwork process. For example, Germany, the second-highest spender on administration, incurs only $306 per capita annually, compared to $1,055 per capita in the U.S. ("The Role"). Both forms of UHC would ensure everyone has access to care regardless of income status while doing so in a much more cost-effective manner.

As previously stated, despite spending vastly more on healthcare, the U.S. ranks the worst on healthcare outcomes compared to other wealthy nations, evidencing that the increased cost is not justified by increased yield or better outcomes for patients. According to the CIA's *The World Factbook*, as of 2024, the U.S. has the highest infant mortality rate out of any OECD country, and another study by Ranabhat et al. in *Frontiers in Pharmacology* found that between 1990 and 2010, life expectancy increased at a slower rate than in countries that had established UHC. Also previously mentioned is the fact that the United States has a higher rate of deaths from afflictions which have recognized medical interventions than several other peer nations with UHC. One key reason for this is likely the fact that almost one in ten Americans do not have any kind of health insurance, and therefore, might not have a Primary Care Provider (PCP) or enough money to seek medical care. Striking directly at this point is a Kaiser Family Foundation poll-based study that concluded two particularly relevant points: firstly, one in four Americans say they skipped out on seeking medical care in the past twelve months due to fear of the expenses, and secondly that six out of ten uninsured persons say they did not seek medical care when they needed it because they could not afford it (Lopes et al.). It can be reasonably inferred then, that the primary reason almost 30 million Americans remain uninsured is due to the high cost of medical insurance; they are simply unable to afford health insurance payments congruously with their costs of living, which statistically results in more people dying from chronic illness, secondary afflictions like obesity and diabetes, other intervenable conditions, and even injuries. Another interesting point differentiating UHC nations from the U.S., particularly single-payer systems, is that when governmental bodies are able to maintain primary funds dedicated to medical care and maintenance of residents, they are also more empowered to direct funds to preventative services–curtailing rates of preventable and chronic diseases like obesity

and diabetes, and reducing long-term costs of healthcare. These services may directly impact the population like increased funding to subsidize the cost of healthy foods (similar to the SNAP and WIC programs), or indirectly have an impact, such as with awareness campaigns. Implementation of UHC would mean that anyone, regardless of financial status, could seek medical treatment without worrying about financial hardship, directly impacting the life expectancy, health, and well-being of U.S. residents.

The current healthcare system in the United States is fundamentally inequitable, unethical, and immoral because access to treatment is contingent on one's ability to pay. To further complicate matters, most doctor's offices cannot see a patient at all if they have a certain type of health insurance not accepted by that office–particularly Medicaid (insurance meant specifically to cover low-income and disadvantaged individuals) is only accepted by a few select providers–unless the patient expressly acknowledges responsibility to pay all costs of care out-of-pocket. This principle constitutes what can be understood as a "class-based" healthcare system, which inherently creates disproportionate obstacles to care for individuals with less financial resources, evidencing its inequity. It's also clear that the concept of class-based healthcare no longer aligns with the views of most Americans, as one Pew Research study published in 2020 found that "63% of U.S. adults say the government has the responsibility to provide health care coverage for all" (Jones), a number which has been steadily increasing for the past few decades. With this in mind, it is also important to understand that even in the medical ecosystem "justice" is one of the four core pillars of medical ethics, which is the principle that all people should be treated equally and equitably, regardless of who they are, which includes their socioeconomic status. This ethical tenet was legally upheld for the first time in 1986 with the passing of the Emergency Medical Treatment and Active Labor Act

(EMTALA), which obligates emergency medical facilities to stabilize patients in critical condition regardless of their ability to pay, but this still leaves too much room for interpretation, as it creates uncertainty regarding what defines “critical condition”, or at what point the patient becomes stable enough to warrant a cease of care without payment. There is also significant debate among experts in the conversation about “care versus cure”, the main argument being: if a cure is available for an affliction, is a medical care facility ethically obligated to provide the cure to a patient who cannot afford it, or are they obligated only to care for the patient and treat their symptoms? This dilemma only perpetuates the issue because again, those who can afford a cure will enjoy better health outcomes due to their socioeconomic status, perpetuating inequity.

Even as far as common Western morality is concerned, the idea that someone could be treated with less quality medical care because of their financial situation is immoral. Abrahamic religions, which collectively establish the moral systems of the majority of the U.S. population, all share the belief that there is a moral imperative to tend to the sick, distressed, and poor. The King James Bible in Matthew 10:8 says “Heal the sick, cleanse the lepers, raise the dead, cast out devils: freely ye have received, freely give.” In Leviticus 19:15, the Torah commands, “...do not stand idly by your neighbor’s blood”, going on to explain that it is the obligation of man even to hire someone else to protect or save your neighbor if you are able, which explicitly speaks in favor of UHC. In the Qur’an, charity is defined as one of the Five Pillars of Islam; taxes under the 7th century Caliphate were used in part to distribute income for needy persons like the poor and disabled, something seen as the responsibility of all followers of God. But very important to note is that morality is not mutually exclusive to religion: even among secular moralists, the belief that wealth should determine who can access quality healthcare is likely very uncommon, but where people draw the line varies significantly. UHC would address the moral imperative of

justice in the healthcare system and ensure that everyone could access high-quality healthcare regardless of socioeconomic status.

Opponents of UHC will often argue that the overhead cost of reworking the entire healthcare administrative system is cost-prohibitive, and while the overhead investment would be significant, it would pay for itself by increasing the health of the population, therefore reducing the high cost of caring for an unhealthy nation over time. There is much disagreement as to how it would be funded, but the primarily discussed option is by raising taxes; however, preliminary cost assessments have suggested that the commonly discussed rates of a "7.5% payroll tax plus a 4% income tax" alone would be insufficient to fund UHC in the U.S. (Zieff et al.). Within the scope of this paper, it is impossible to speculate the exact cost of such a system, but significant proponents of implementation have made intuitive suggestions such as targeted tax increases or reducing medical malpractice premiums–to name a few– to make implementation financially realistic.

Another frequented qualm with UHC is that it would suffer from bureaucratic inefficiency, drastically increasing wait times for patients, but this is mostly a common misconception. Canada is almost exclusively used as an example in the literature of how UHC has this intrinsic side effect, but that is a misleading perspective. For instance, Canada's UHC system performed the worst out of all UHC nations in the Commonwealth Fund study mentioned in the intro, so while Canada *does* suffer from bureaucratic inefficiency, Canada's system needs much improvement, but its shortcomings are not reflective of the innate nature of UHC. In fact, according to a plethora of sources, among them, an assessment from the World Population Review in early 2024 found that while the U.S. does outperform some UHC nations in certain metrics of wait times, like seeing a specialist in less than a month, it often ranked the same as or

worse than most developed UHC nations when it comes to the time it takes to be seen by your Primary Care Provider, such as the U.K., France, Australia, Germany, and the Netherlands ("Health Care Wait"). The only country the U.S. outperforms by this metric is Canada, so again it remains evident that Canada is not a fair comparison of the impact on wait times that UHC has. It should be noted, however, that in the first few years after transitioning to UHC, wait times would likely increase as the new system finds its footing and refines best practices.

This criticism relates partially to the objection to government involvement in the healthcare system due to the perceived hindrance of choice and the "free market" as a result. Some more fervent opponents of UHC equate it to something like socialism and believe it to be antithetical to capitalism. This first point is difficult to debate, as it is founded on personal beliefs about what authority the government should have, which is beyond the scope of this work, but what can be referenced is the fact that every nation that the U.S. partners with, several of which have thriving capitalistic economies like Germany or the U.K., utilizes government intervention in the healthcare system to facilitate equitable and affordable access to quality care. It is a necessary evil if one hopes to achieve a more equitable and sustainable healthcare system. One could argue that government intervention in other areas, such as crime prevention, dissuades many would-be criminals from taking advantage of others for monetary gain, and similarly, without government intervention, there is little reason for health insurance companies to lower or slow inflating rates as long as people continue to pay for them, which they *will* do to maintain access to healthcare. To address the second point about socialism versus capitalism, it should be mentioned once again that in *all* UHC nations there remain options for individuals to choose private insurance plans for access to better care. One could argue that if the government provided a basic level of care, insurance companies would be motivated to offer competitive benefits, such

as better rates or additional services, to retain their value to customers; essentially, this would increase competition, and, therefore, *benefit* the free market. UHC simply ensures that no one gets left behind due to being financially disadvantaged, and it is completely symbiotic with capitalism.

Adopting UHC is not just a policy change; it is a moral imperative. We live in a time of unprecedented technological growth, and this is especially true of medical technology. From 3D-printed organs to gene therapies, technology is facilitating exponential increases in the potential quality of life for people suffering from any number of afflictions, but the possibility that a person's finances may prevent accessing this quality of life remains worrisome. Creative works like *Elysium* and *Altered Carbon* depict dystopian futures where the rich live immortally, free of ailment, while the rest of humanity suffers. Both of these works are creative interpretations, not only of what our *future* might look like as a nation if we do not address the issue of accessible quality healthcare, but also of the system that we live in *today*. Half a million U.S. families are devastated by bankruptcy each year because of medical expenses (Gottlieb)–these unfortunate individuals are victims, not only of the hands they were dealt but also of the broken healthcare financing system in the U.S., but it does not have to be this way. Several times since Truman in the 1940s has the idea of implementing some form of UHC in the U.S. grown in popularity. Bernie Sanders and more than 120 members of the House and Senate brought a bill proposing Medicare-for-All to the floor in 2023, and it is currently under review by the Senate's Committee on Finance. Regardless of which plan the American people choose to endorse, the time to act is now. We have the resources, the evidence, and the moral obligation to ensure healthcare is a right, not a privilege. Adopting UHC is a commitment to pursuing a more equitable and compassionate society where the lives of all citizens are safeguarded, and to

uplifting the lowest among us instead of leaving them behind. And I'd like to leave you with a final thought–on July 4, 1965, Martin Luther King Jr. delivered his famous Independence Day speech in which he addressed the freedoms afforded by our nation in the context of its shortcomings, and in it, he said the following:

> All I'm saying is simply this…as long as there is extreme poverty in this world no one can be totally rich…As long as diseases are rampant and millions of people cannot expect to live more than 28 or 30 years, no one can be totally healthy…We must come to see this if we are to realize the American dream.

Every American, rich or poor, is a physical piece of the country, invariably interconnected–reliant on one another, capable of amazing things when working together in pursuit of a better future, but we *must* ensure that no one gets left behind. Together, it *is* possible.

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