The Importance of Universal Health Care in Improving Our Nation's Response to Pandemics and Health Disparities

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Abstract

The COVID pandemic adds a new sense of urgency to establish a universal health care system in the United States. Our current system is inequitable, does not adequately cover vulnerable groups, is cost prohibitive, and lacks the flexibility to respond to periods of economic and health downturns. During economic declines, our employer-supported insurance system results in millions of Americans losing access to care. While the Affordable Care Act significantly increased Americans' coverage, it remains expensive and is under constant legal threat, making it an unreliable conduit of care. Relying on Medicaid as a safety net is untenable because, although enrollment has increased, states are making significant Medicaid cuts to balance budgets. During the COVID-19 pandemic, countries with universal health care leveraged their systems to mobilize resources and ensure testing and care for their residents. In addition, research shows that expanding health coverage decreases health disparities and supports vulnerable populations' access to care. This policy statement advocates for universal health care as adopted by the United Nations General Assembly in October 2019. The statement promotes the overall goal of achieving a system that cares for everyone. It refrains from supporting one particular system, as the substantial topic of payment models deserves singular attention and is beyond the present scope.

Relationship to Existing APHA Policy Statements

We propose that this statement replace APHA Policy Statement 20007 (Support for a New Campaign for Universal Health Care), which is set to be archived in 2020. The following policy statements support the purpose of this statement by advocating for health reform:

- APHA Policy Statement Statement 200911: Public Health's Critical Role in Health Reform in the United States
- APHA Policy Statement 201415: Support for Social Determinants of Behavioral Health and Pathways for Integrated and Better Public Health

In addition, this statement is consistent with the following APHA policies that reference public health's role in disaster response:

- APHA Policy Statement 20198: Public Health Support for Long-Term Responses in High-Impact, Postdisaster Settings
- APHA Policy Statement 6211(PP): The Role of State and Local Health Departments in Planning for Community Health Emergencies
- APHA Policy Statement 9116: Health Professionals and Disaster Preparedness
- APHA Policy Statement 20069: Response to Disasters: Protection of Rescue and Recovery Workers, Volunteers, and Residents Responding to Disasters

Problem Statement

Discussions around universal health care in the United States started in the 1910s and have resurfaced periodically.[1] President Franklin D. Roosevelt attempted twice in the 1940s to establish universal health care and failed both times.[1] Eventually, the U.S. Congress passed Medicare and Medicaid in the 1960s. Universal health care more recently gained attention during debates on and eventual passage of the Affordable Care Act (ACA).[2]

To date, the U.S. government remains the largest payer of health care in the United States, covering nearly 90 million Americans through Medicare, Medicaid, TRICARE, and the Children's Health Insurance Program (CHIP).[3] However, this coverage is not universal, and

many Americans were uninsured[4] or underinsured[5] before the COVID-19 pandemic.

The COVID-19 pandemic has exacerbated underlying issues in our current health care system and highlighted the urgent need for universal health care for all Americans.

Health care is inaccessible for many individuals in the United States: For many Americans, accessing health care is cost prohibitive.[6] Coverage under employer-based insurance is vulnerable to fluctuations in the economy. Due to the COVID-19 pandemic, an estimated 10 million Americans may lose their employer-sponsored health insurance by December 2020 as a result of job loss.[7] When uninsured or underinsured people refrain from seeking care secondary to cost issues, this leads to delayed diagnosis and treatment, promotes the spread of COVID-19, and may increase overall health care system costs.

The ACA reformed health care by, for instance, eliminating exclusions for preexisting conditions, requiring coverage of 10 standardized essential health care services, capping out-of-pocket expenses, and significantly increasing the number of insured Americans. However, many benefits remain uncovered, and out-of-pocket costs can vary considerably. For example, an ACA average deductible ($3,064) is twice the rate of a private health plan ($1,478).[4] Those living with a disability or chronic illness are likely to use more health services and pay more. A recent survey conducted during the COVID-19 pandemic revealed that 38.2% of working adults and 59.6% of adults receiving unemployment benefits from the Coronavirus Aid, Relief, and Economic Security (CARES) Act could not afford a $400 expense, highlighting that the COVID-19 pandemic has exacerbated lack of access to health care because of high out-of-pocket expenses.[8] In addition, the ACA did not cover optometry or dental services for adults, thereby inhibiting access to care even among the insured population.[9]

Our current health care system cannot adequately respond to the pandemic and supply the care it demands: As in other economic downturns wherein people lost their employer-based insurance, more people enrolled in Medicaid during the pandemic. States' efforts to cover their population, such as expanding eligibility, allowing self-attestation of eligibility criteria, and simplifying the application process, also increased Medicaid enrollment numbers.[10] The federal "maintenance of eligibility" requirements further increased the number of people on Medicaid by postponing eligibility redeterminations. While resuming eligibility redeterminations will cause some to lose coverage, many will remain eligible because their incomes continue to fall below Medicaid income thresholds.[10]

An urgent need for coverage during the pandemic exists. Virginia's enrollment has increased by 20% since March 2020. In Arizona, 78,000 people enrolled in Medicaid and CHIP in 2 months.[11] In New Mexico, where 42% of the population was already enrolled in Medicaid, 10,000 more people signed up in the first 2 weeks of April than expected before the pandemic.[11] Nearly 17 million people who lost their jobs during the pandemic could be eligible for Medicaid by January 2021.[12]

While increasing Medicaid enrollment can cover individuals who otherwise cannot afford care, it further strains state budgets.[11] Medicaid spending represents a significant portion of states' budgets, making it a prime target for cuts. Ohio announced $210 million in cuts to Medicaid, a significant part of Colorado's $229 million in spending cuts came from Medicaid, Alaska cut $31 million in Medicaid, and Georgia anticipates 14% reductions overall.[11]

While Congress has authorized a 6.2% increase in federal Medicaid matching, this increase is set to expire at the end of the public health emergency declaration (currently set for October 23, 2020)[13] and is unlikely to sufficiently make up the gap caused by increased spending and decreased revenue.[14] Given the severity and projected longevity of the pandemic's economic consequences, many people will remain enrolled in Medicaid throughout state and federal funding cuts. This piecemeal funding strategy is unsustainable and will strain Medicaid, making accessibility even more difficult for patients.

Our health care system is inequitable: Racial disparities are embedded in our health care system and lead to worse COVID-19 health outcomes in minority groups. The first federal health care program, the medical division of the Freedmen's Bureau, was established arguably out of Congress's desire for newly emancipated slaves to return to working plantations in the midst of a smallpox outbreak in their community rather than out of concern for their well-being.[15] An effort in 1945 to expand the nation's health care system actually reinforced segregation of hospitals.[15] Moreover, similar to today, health insurance was employer based, making it difficult for Black Americans to obtain.

Although the 1964 Civil Rights Act outlawed segregation of health care facilities receiving federal funding and the 2010 ACA significantly benefited people of color, racial and sexual minority disparities persist today in our health care system. For example, under a distribution formula set by the U.S. Department of Health and Human Services (DHHS), hospitals reimbursed mostly by Medicaid and Medicare received far less federal funding from the March 2020 CARES Act and the Paycheck Protection Program and Health Care Enhancement Act than hospitals mostly reimbursed by private insurance.[16] Hospitals in the bottom 10% based on private insurance revenue received less than half of what

hospitals in the top 10% received. Medicare reimburses hospitals, on average, at half the rate of private insurers. Therefore, hospitals that primarily serve low-income patients received a disproportionately smaller share of total federal funding.[16]

Additional barriers for these communities include fewer and more distant testing sites, longer wait times,[17] prohibitive costs, and lack of a usual source of care.[18] Black Americans diagnosed with COVID-19 are more likely than their White counterparts to live in lower-income zip codes, to receive tests in the emergency department or as inpatients, and to be hospitalized and require care in an intensive care unit.[19] Nationally, only 20% of U.S. counties are disproportionately Black, but these counties account for 52% of COVID-19 diagnoses and 58% of deaths.[20] The pre-pandemic racial gaps in health care catalyzed pandemic disparities and will continue to widen them in the future.

Our health care system insufficiently covers vulnerable groups: About 14 million U.S. adults needed long-term care in 2018.[21] Medicare, employer-based insurance, and the ACA do not cover home- and community-based long-term care. Only private long-term care insurance and patchwork systems for Medicaid-eligible recipients cover such assistance. For those paying out of pocket, estimated home care services average $51,480 to $52,624 per year, with adult day services at more than $19,500 per year.[22]

Our current health care system also inadequately supports individuals with mental illness. APHA officially recognized this issue in 2014, stating that we have "lacked an adequate and consistent public health response [to behavioral health disorders] for several reasons" and that the "treatment of mental health and substance use disorders in the United States has been provided in segregated, fragmented, and underfunded care settings."[23]

The COVID-19 pandemic has brought urgency to the universal health care discussion in the United States. This is an unprecedented time, and the pandemic has exacerbated many of the existing problems in our current patchwork health care system. The COVID-19 pandemic is a watershed moment where we can reconstruct a fractured health insurance system into a system of universal health care.

Evidence-Based Strategies to Address the Problem

We advocate for the definition of universal health care outlined in the 2019 resolution adopted by the United Nations General Assembly, which member nations signed on to, including the United States. According to this resolution, "universal health coverage implies that all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative, rehabilitative and palliative essential health services, and essential, safe, affordable, effective and quality medicines and vaccines, while ensuring that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor, vulnerable and marginalized segments of the population."[24]

Our current system is inaccessible, inflexible, and inequitable, and it insufficiently covers vulnerable populations. Here we present supporting evidence that universal health care can help address these issues.

Universal health care can increase accessibility to care: Evidence supporting universal health care is mostly limited to natural experiments and examples from other countries. Although countries with universal health care systems also struggle in containing the COVID-19 pandemic, their response and mortality outcomes are better owing to their robust universal systems.[25]

While individuals in the United States lost health care coverage during the pandemic, individuals in countries with universal health care were able to maintain access to care.[26–28] Some European and East Asian countries continue to offer comprehensive, continuous care to their citizens during the pandemic.

Taiwan's single-payer national health insurance covers more than 99% of the country's population, allowing easy access to care with copayments of $14 for physician visits and $7 for prescriptions. On average, people in Taiwan see their physician 15 times per year.[27] Also, coronavirus tests are provided free of charge, and there are sufficient hospital isolation rooms for confirmed and suspected cases of COVID-19.[28]

Thai epidemiologists credit their universal health care system with controlling the COVID-19 pandemic.[29] They have described how their first patient, a taxi driver, sought medical attention unencumbered by doubts about paying for his care. They benefit from one of the lowest caseloads in the world.[29]

Universal health care is a more cohesive system that can better respond to health care demands during the pandemic and in future routine care: Leveraging its universal health care system, Norway began aggressively tracking and testing known contacts of individuals infected with COVID-19 as early as February 2020. Public health officials identified community spread and quickly shut down areas of contagion. By April 30, Norway had administered 172,586 tests and recorded 7,667 positive cases of COVID-19. Experts

attribute Norway's success, in part, to its universal health care system.[26] Norway's early comprehensive response and relentless testing and tracing benefited the country's case counts and mortality outcomes.

Once China released the genetic sequence of COVID-19, Taiwan's Centers for Disease Control laboratory rapidly developed a test kit and expanded capacity via the national laboratory diagnostic network, engaging 37 laboratories that can perform 3,900 tests per day.[28] Taiwan quickly mobilized approaches for case identification, distribution of face masks, containment, and resource allocation by leveraging its national health insurance database and integrating it with the country's customs and immigration database daily.[28] Taiwan's system proved to be flexible in meeting disaster response needs.

Although these countries' success in containing COVID-19 varied, their universal health care systems allowed comprehensive responses.

Universal health care can help decrease disparities and inequities in health: Several factors point to decreased racial and ethnic disparities under a universal health care model. CHIP's creation in 1997 covered children in low-income families who did not qualify for Medicaid; this coverage is associated with increased access to care and reduced racial disparities.[30] Similarly, differences in diabetes and cardiovascular disease outcomes by race, ethnicity, and socioeconomic status decline among previously uninsured adults once they become eligible for Medicare coverage.[31] While universal access to medical care can reduce health disparities, it does not eliminate them; health inequity is a much larger systemic issue that society needs to address.

Universal health care better supports the needs of vulnerable groups: The United States can adopt strategies from existing models in other countries with long-term care policies already in place. For example, Germany offers mandatory long-term disability and illness coverage as part of its national social insurance system, operated since 2014 by 131 nonprofit sickness funds. German citizens can receive an array of subsidized long-term care services without age restrictions.[32] In France, citizens 60 years and older receive long-term care support through an income-adjusted universal program.[33]

Universal health care can also decrease health disparities among individuals with mental illness. For instance, the ACA Medicaid expansion helped individuals with mental health concerns by improving access to care and effective mental health treatment.[34]

Opposing Arguments/Evidence

Universal health care is more expensive: Government spending on Medicare, Medicaid, and CHIP has been increasing and is projected to grow 6.3% on average annually between 2018 and 2028.[35] In 1968, spending on major health care programs represented 0.7% of the gross domestic product (GDP); in 2018 it represented 5.2% of the GDP, and it is projected to represent 6.8% in 2028.[35] These estimates do not account for universal health care, which, by some estimates, may add $32.6 trillion to the federal budget during the first 10 years and equal 10% of the GDP in 2022.[36]

Counterpoint: Some models of single-payer universal health care systems estimate savings of $450 billion annually.[37] Others estimate $1.8 trillion in savings over a 10-year period.[38] In 2019, 17% of the U.S. GDP was spent on health care; comparable countries with universal health care spent, on average, only 8.8%.[39]

Counterpoint: Health care services in the United States are more expensive than in other economically comparable countries. For example, per capita spending on inpatient and outpatient care (the biggest driver of health care costs in the United States) is more than two times greater even with shorter hospital stays and fewer physician visits.[40] Overall, the United States spends over $5,000 more per person in health costs than countries of similar size and wealth.[40]

Counterpoint: Administrative costs are lower in countries with universal health care. The United States spends four times more per capita on administrative costs than similar countries with universal health care.[41] Nine percent of U.S. health care spending goes toward administrative costs, while other countries average only 3.6%. In addition, the United States has the highest growth rate in administrative costs (5.4%), a rate that is currently double that of other countries.[41]

Universal health care will lead to rationing of medical services, increase wait times, and result in care that is inferior to that currently offered by the U.S. health care system. Opponents of universal health care point to the longer wait times of Medicaid beneficiaries and other countries as a sign of worse care. It has been shown that 9.4% of Medicaid beneficiaries have trouble accessing care due to long wait times, as compared with 4.2% of privately insured patients.[42] Patients in some countries with universal health care, such as Canada and the United Kingdom, experience longer wait times to see their physicians than patients in the United States.[43] In addition, some point to lower cancer death rates in the United States than in countries with universal health care as a sign of a superior system.[44]

Another concern is rationing of medical services due to increased demands from newly insured individuals. Countries with universal health care use methods such as price setting, service restriction, controlled distribution, budgeting, and cost-benefit analysis to ration services.[45]

Counterpoint: The Unites States already rations health care services by excluding patients who are unable to pay for care. This entrenched rationing leads to widening health disparities. It also increases the prevalence of chronic conditions in low-income and minority groups and, in turn, predisposes these groups to disproportionately worse outcomes during the pandemic. Allocation of resources should not be determined by what patients can and cannot afford. This policy statement calls for high-value, evidence-based health care, which will reduce waste and decrease rationing.

Counterpoint: Opponents of universal health care note that Medicaid patients endure longer wait times to obtain care than privately insured patients[42] and that countries with universal health care have longer wait times than the United States.[43] Although the United States enjoys shorter wait times, this does not translate into better health outcomes. For instance, the United States has higher respiratory disease, maternal mortality, and premature death rates and carries a higher disease burden than comparable wealthy countries.[46]

Counterpoint: A review of more than 100 countries' health care systems suggests that broader coverage increases access to care and improves population health.

Counterpoint: While it is reasonable to assume that eliminating financial barriers to care will lead to a rise in health care utilization because use will increase in groups that previously could not afford care, a review of the implementation of universal health care in 13 capitalist countries revealed no or only small (less than 10%) post-implementation increases in overall health care use.[47] This finding was likely related to some diseases being treated earlier, when less intense utilization was required, as well as a shift in use of care from the wealthy to the poorest.[47]

Alternative Strategies

States and the federal government can implement several alternative strategies to increase access to health care. However, these strategies are piecemeal responses, face legal challenges, and offer unreliable assurance for coverage. Importantly, these alternative strategies also do not necessarily or explicitly acknowledge health as a right.

State strategies: The remaining 14 states can adopt the Medicaid expansions in the ACA, and states that previously expanded can open new enrollment periods for their ACA marketplaces to encourage enrollment.[48] While this is a strategy to extend coverage to many of those left behind, frequent legal challenges to the ACA and Medicaid cuts make it an unreliable source of coverage in the future. In addition, although many people gained insurance, access to care remained challenging due to prohibitively priced premiums and direct costs.

Before the pandemic, the New York state legislature began exploring universal single-payer coverage, and the New Mexico legislature started considering a Medicaid buy-in option.[49] These systems would cover only residents of a particular state, and they remain susceptible to fluctuations in Medicaid cuts, state revenues, and business decisions of private contractors in the marketplace.

Federal government strategies: Congress can continue to pass legislation in the vein of the Families First Coronavirus Response Act and the CARES Act. These acts required all private insurers, Medicare, and Medicaid to cover COVID-19 testing, eliminate cost sharing, and set funds to cover testing for uninsured individuals. They fell short in requiring assistance with COVID-19 treatment. A strategy of incremental legislation to address the pandemic is highly susceptible to the political climate, is unreliable, and does not address non-COVID-19 health outcomes. Most importantly, this system perpetuates a fragmented response to the COVID-19 pandemic.

An additional option for the federal government is to cover the full costs of Medicaid expansion in the 14 states yet to expand coverage. If states increased expansion and enforced existing ACA regulations, nearly all Americans could gain health insurance.[50] This alternative is risky, however, due to frequent legal challenges to the ACA. Furthermore, high costs to access care would continue to exist.

Action Steps

This statement reaffirms APHA's support of the right to health through universal health care. Therefore, APHA:

1. Urges Congress and the president to recognize universal health care as a right.

2. Urges Congress to fund and design and the president to enact and implement a comprehensive universal health care system that is accessible and affordable for all

residents; that ensures access to rural populations, people experiencing homelessness, sexual minority groups, those with disabilities, and marginalized populations; that is not dependent on employment, medical or mental health status, immigration status, or income; that emphasizes high-value, evidence-based care; that includes automatic and mandatory enrollment; and that minimizes administrative burden.

3. Urges Congress and states to use the COVID-19 pandemic as a catalyst to develop an inclusive and comprehensive health care system that is resilient, equitable, and accessible.

4. Urges the DHHS, the Agency for Healthcare Research and Quality, the Institute of Medicine, the National Institutes of Health, academic institutions, researchers, and think tanks to examine equitable access to health care, including provision of mental health care, long-term care, dental care, and vision care.

5. Urges Congress, national health care leaders, academic institutions, hospitals, and each person living in the United States to recognize the harms caused by institutionalized racism in our health care system and collaborate to build a system that is equitable and just.

6. Urges Congress to mandate the Federal Register Standards for Accessible Medical Diagnostic Equipment to meet the everyday health care physical access challenges of children and adults with disabilities.

7. Urges national health care leaders to design a transition and implementation strategy that communicates the impact of a proposed universal health care system on individuals, hospitals, health care companies, health care workers, and communities.

8. Urges Congress, the Centers for Disease Control and Prevention, the DHHS, and other public health partners, in light of the COVID-19 pandemic, to recognize the need for and supply adequate funding for a robust public health system. This public health system will prepare for, prevent, and respond to both imminent and long-term threats to public health, as previously supported in APHA Policy Statement 200911.

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