Journal of Midwifery & Women's Health www.jmwh.org
Review

Universal Health Care for the United States: A Primer for Health Care Providers

Amy Alspaugh[1], CNM, PhD, MSN, Nikki Lanshaw[1], MPH, Jan Kriebs[2], CNM, MSN, Cheri Van Hoover[2], CNM, MS

The United States is one of a very few high-income countries that does not guarantee every person the right to health care. Residents of the United States pay more out-of-pocket for increasingly worse outcomes. People of color, those who have lower incomes, and those who live in rural areas have less access to health care and are therefore at even greater risk for poor health. *Universal health care*, a term for various models of health care systems that provide care for every resident of a given country, will help move the United States toward higher quality, more affordable, and more equitable care. This article defines a reproductive justice and human rights foundation for universal health care, explores how health insurance has worked historically in the United States, identifies the economic reasons for implementing universal health care, and discusses international models that could be used domestically.
J Midwifery Womens Health 2021;00:1–11

Keywords: universal health care, health policy, health equity, cost and cost-effectiveness of health care

INTRODUCTION

The coronavirus disease 2019 (COVID-19) pandemic has laid bare many of the inequities that exist in the United States: an underfunded public health infrastructure, racial and ethnic health disparities in morbidity and mortality resulting from profound and unchecked systemic racism and corresponding policies, and the economic vulnerability of both lower- and middle-class families. At a time when access to affordable, quality health care has never been more essential, millions have lost their insurance coverage because of unemployment. Between February and May of 2020 alone, an estimated 5.4 million US workers lost coverage because of pandemic-related unemployment.[1] More recent data suggest that rates of uninsured people did not fall as steeply as unemployment rates, although it is hypothesized that this is due to the fact that job losses fell more frequently in sectors with low baseline rates of insured employees, such as retail, service, and hospitality.[2] In Texas, one of the worst affected states, 29% of adults under the age of 65 lacked health insurance as of August 2020.[3] Even before the COVID-19 pandemic, US Census Bureau data revealed that the proportion of people without health insurance increased in 19 states from 2018 to 2019, representing 8.0% of the population, or 26.1 million uninsured people.[4]

Pushing its way into the intersection of health and the economy, COVID-19 has magnified the precarious and unjust nature of an employer-based health insurance system. The current US system, better referred to as a health insurance system rather than a health care system,[5] does not produce quality outcomes, nor does it serve all people equally. A health care system provides the services that support physical and mental health, whereas health insurance is a system of financing the cost of such services. Universal health insurance coverage is, therefore, an essential step toward enhancing the health of all Americans. The purpose of this article is to lay out the moral and ethical foundation for universal health care, explore historical foundations of health insurance in the United States, identify economic reasons for implementing universal health insurance, and discuss international models that could be used domestically.

DEFINING THE FOUNDATION FOR UNIVERSAL HEALTH CARE

Theoretical Framework

The need for universal health care is apparent when the reproductive justice framework is used to contextualize individual and public health. The reproductive justice movement began in 1994 when reproductive health and rights advocates gathered in Chicago to hear about the Clinton administration's proposal for a universal health care plan, "which de-emphasized reproductive health care in an attempt to head off Republican criticism."[6,7] Twelve Black women in attendance were concerned about the erasure of reproductive health issues and developed a movement and political framework centering the "most marginalized women, families, and communities."[8] The theoretical framework that evolved out of this conference includes 4 main tenets: (1) the human right to maintain bodily personal autonomy, (2) the right not have a child, (3) the right to have a child, and (4) the right to parent children in a safe and healthy environment.[8,9]

Reproductive justice is distinct from the concepts of reproductive health, which deals with the provision of reproductive and sexual health services, and reproductive rights,

[1]Family Health Care Nursing, School of Nursing, University of California, San Francisco, San Francisco, California
[2]Midwifery Institute, Jefferson College of Health Professions, Thomas Jefferson University, Philadelphia, Pennsylvania

Correspondence
Amy Alspaugh
Email: amy.alspaugh@ucsf.edu

ORCID
Amy Alspaugh https://orcid.org/0000-0003-4427-4807
Nikki Lanshaw https://orcid.org/0000-0002-7853-2870

Quick Points

- The United States pays more toward health care, with increasingly worse outcomes, compared with nations with universal health insurance.
- Numerous existing international systems of universal health care could serve as models for the United States.
- Continuing disparities in health insurance coverage reflect the racist limits on early employee health care coverage for Black people.
- Despite spending more money than peer countries on health care, outcomes for people who are poor or rural and for people of color are disproportionately worse than in those other countries.
- Universal health care would move the United States closer toward health equity; it is a necessary component of efforts to achieve economic justice, racial justice, and reproductive justice.

which advocates for specific enumerated rights in legal contexts. People have a human right to quality reproductive health services.[10] Reproductive rights are codified in the law in order to protect people from state or interpersonal interference in accessing those services.[9(p 290)] Reproductive justice is the end goal: a state of existence in which one may "have a child under the conditions of one's choosing" or choose not to "have a child using birth control, abortion, or abstinence" and can parent a child in "safe and healthy environments free from violence."[9(p 290)] Reproductive justice can be achieved when a comprehensive range of family planning services are offered without coercion or violence, when reproductive rights to those services are respected, and when systems of oppression preventing the ability to have a child (or not) in an ideal environment are dismantled.

Therefore, reproductive justice offers a theoretical framework for promoting policies to create environments in which its core tenets can be achieved. The creation of a universal health insurance program in the United States covering comprehensive reproductive health services while alleviating the economic burdens associated with the current US insurance system would advance the goals of reproductive justice. Health care, in this framework, "is properly a human right, not a commodity for purchase."[9(p 17)] However, reproductive justice acknowledges that equitable access to high-quality health care alone is not sufficient policy to ensure full bodily autonomy, the ability to choose to parent or not to parent, or to choose to parent in a safe and healthy environment; other policy interventions in housing, education, a living wage, and the environment are essential.

The reproductive justice framework emphasizes the intersectional factors that influence health. These include race, class, gender, sexuality, status of health, and access to health care. Furthermore, the reproductive justice framework requires a systemic and structural analysis of the institutions that cause health disparities, including the US health insurance system.[11] The necessity for health care that would include every person in the United States is rooted in the following corollary: "No right can achieve the status of a right if it doesn't apply to all people … And no right is secure if it is not secure for everybody."[9(p 129)] The current US health insurance system does not apply equally and is not secure for all, as demonstrated by the vast disparities in health insurance coverage that contribute to health inequities. People of color (POC), those who have lower incomes, and those living in rural areas suffer greatly from these disparities. To maintain and support the current health care system is contrary to the reproductive justice framework and contrary to the ethical values of fairness and justice that should guide every health care provider.[12]

Human Rights and Universal Health Care

International law defines human rights as those that are guaranteed to all human beings without regard to race, sex, nationality, ethnicity, language, religion, or any other status.[13] In 1946, the World Health Organization asserted that "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[14] This declaration of human rights was reaffirmed and expanded by Article 12 of the United Nations' Covenant on Economic, Social and Cultural Rights (Table 1).[15]

Although the US government guarantees all citizens access, albeit unequal, to education, military and police protection, a postal service, and a national park system, there is no guaranteed access to health care. The enactment of the Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986 demonstrated a shift in legal obligation of hospitals to their communities. EMTALA requires all Medicare-accepting hospitals with emergency departments to provide care to all people regardless of their ability to pay for such services.[16] In passing this bill, legislators affirmed the rights of people to receive care and the moral and legal obligation of hospitals, which are largely funded with public money, to provide necessary life-saving care. This shift, although slight, shows that the moral and ethical foundations of US law already broadly lean toward a human right to health care.[17] In terms of ensuring access to the full spectrum of health needs, it does not go nearly far enough.

Health care delivery and health insurance go hand in hand in the largely privatized, capitalist US system (Table 2). As it stands, much of the health insurance system treats health care, and therefore health, as a commodity, meaning that care is evaluated in terms of cost instead of equitable outcomes and justice. Health care rationing in the United States is based

Table 1. Article 12 of United Nations International Covenant on Economic, Social and Cultural Rights

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

a. The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

b. The improvement of all aspects of environmental and industrial hygiene;

c. The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

d. The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Source: United Nations.[15]

Table 2. Why Insurance Coverage Matters

Those who are insured
Are more likely to utilize health care, including primary and preventive services as well as hospitalizations.[39,59]
Have lower out-of-pocket expenses related to this care.[39,59]
Have lower medical debt, including having fewer bills sent to collections.[39,59]
Gaining insurance
Shows an almost immediate improvement in mental health, most notably for depression.[78,79]
Improves cancer-related mortality, with Black women demonstrating the greatest benefit.[80]
Lowers a person's chance of dying.[81]
Those who are uninsured
Are at increased risk of dying; the odds of dying among the insured relative to the uninsured are 0.71 to 0.97.[82]

upon ability to pay, geographic location, and other personal factors unrelated to equity or justice. People may wait a lifetime for needed care if they lack health insurance, have lower incomes, or live in a rural location.[18] Although nations with universal health care systems must also confront the reality that health care funding is not an unlimited resource, they consider equity, justice, and transparency to be prime considerations when making decisions about which services will be covered and how those services will be prioritized.[19]

All health care providers should be aware that the inequitable structure of the US health care system, one not based on the human right to health care, creates sizeable inequities and disparities in coverage, access to services, and health outcomes (Figure 1). In the United States, a Black person is twice as likely as a white person to lose their health insurance in a given year, and a Hispanic person is almost 3 times as likely to lose coverage.[20] It is estimated that nearly one-third of Hispanic people are currently uninsured.[20] Black people can expect to live 12 years before age 65 without insurance and Hispanic people a staggering 22 years, compared with slightly less than 8 years for white people.[20] In states that have not expanded Medicaid under the Patient Protection and Affordable Care Act (ACA), twice as many people in rural locations go without insurance compared with urban-dwelling peers.[21] High rates of maternal mortality in the United States, which affects Black birthing people at staggering rates, are partly attributable to lack of access to quality health care,[22] making increased access through universal health care an essential component to adequately addressing the maternal mortality crisis.[23] Black, Hispanic, and Indigenous women are more likely to experience gaps in coverage; 1 out of 10 Spanish-speaking Hispanic women have no insurance coverage from preconception to postpartum.[24] Women with continuous Medicaid are more likely to utilize postpartum services, including contraceptive services, than women with pregnancy-only Medicaid.[25] The goals of reproductive justice will not be achievable without a system that includes basic health care coverage for all people.

HEALTH CARE COVERAGE IN THE UNITED STATES

The Origins of employer-based Health Insurance

The reproductive justice framework necessitates evaluation of power structures,[8] and the modern manifestation of health insurance provision or denial is a core power structure requiring examination. The concept of government-sponsored health insurance arose in Europe during the late 1800s and early 1900s, with many countries adopting plans to protect their citizens in case of sickness or injury. Progressive reformers in the United States called for similar programs in this country during the early 20th century but were unsuccessful, in large part because of resistance from both the American Medical Association[26] and wealthy landowners who considered it an attempt to redistribute wealth to formerly enslaved people.[27,28] During World War II, wartime production surged, but much of the adult male workforce was serving in the military and unavailable to take these jobs. Government-imposed caps on wages made it necessary for employers to find creative ways to attract workers. Thus, employer-sponsored health insurance became a standard incentive. After the war, new Internal Revenue Service rules further cemented this system by

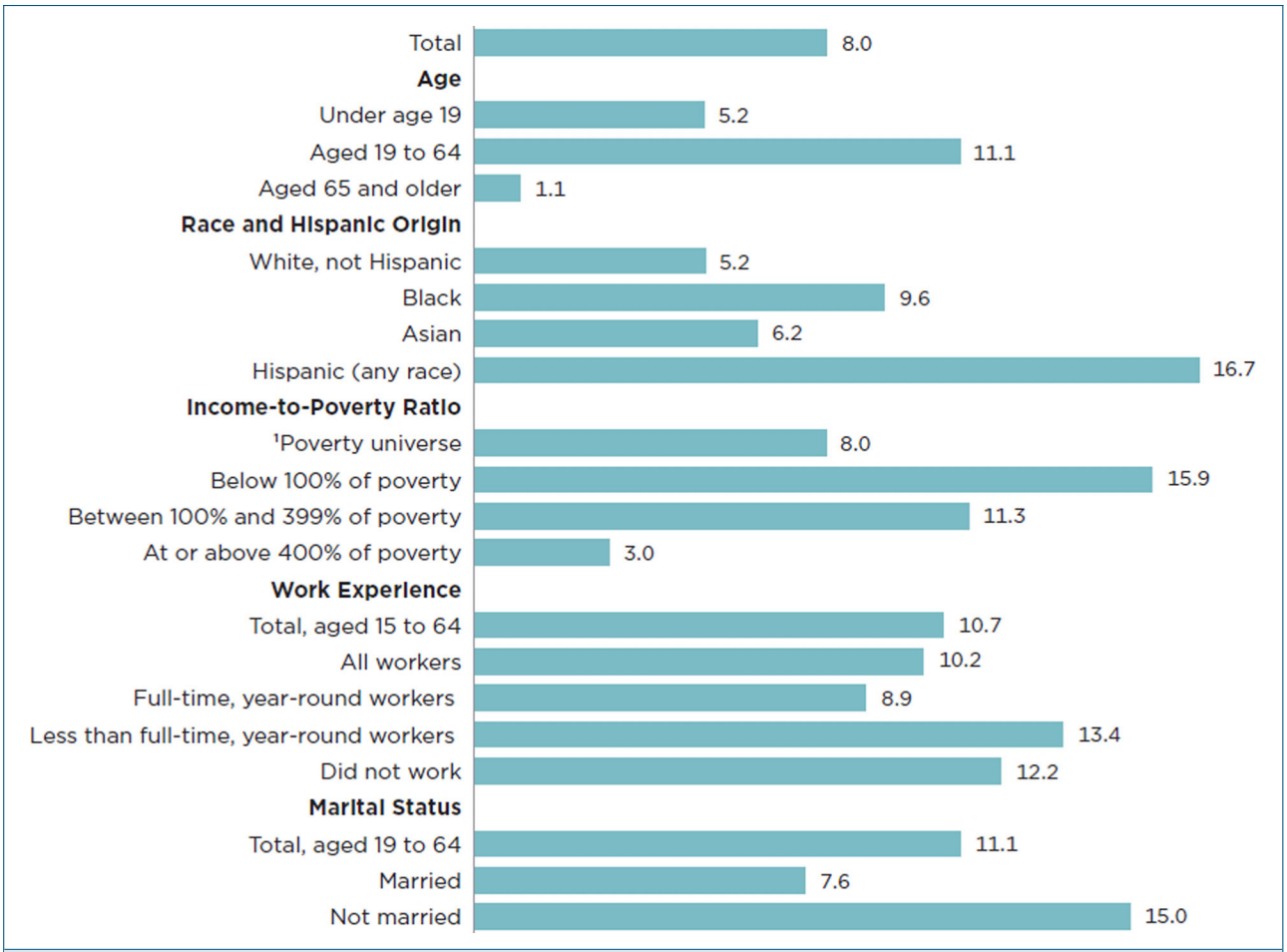

Figure 1. Percentage of People Without Health Insurance Coverage by Selected Characteristics: 2019

[1]The poverty universe excludes unrelated individuals under the age of 15 such as foster children.
Source: US Census Bureau, Current Population Survey, 2020 Annual Social and Economic Supplement.

allowing employers to pay health insurance premiums with pre-tax dollars.[27] By not levying taxes on money spent on insurance, employer-based health insurance has become an affirmative action that benefits primarily those who are white, well off, and most likely to have jobs that pay a living wage.[29]

Other nations emerged from World War II with a renewed commitment to government-sponsored, universal health care. To understand why the United States stands alone among its peers in treating health as a capitalist commodity, it is essential to explore its roots. Health, like so much of society before the Civil Rights Act of 1964, was segregated along the lines of race. Government policy at the federal, state, and local levels ensured that POC, especially Black people, were not afforded the same access to or quality of health care.[30]

The Black Codes, modeled after earlier laws restricting the lives of enslaved people and instituted immediately after the Civil War across the South, were followed shortly thereafter by the Jim Crow laws. These statutes provided the legal framework for segregated, and thus inherently unequal, health care for Black Americans.[31] The large voting bloc made up of Southern Democratic, segregationist states ensured that farm and domestic workers, who composed more than half of the Black workforce at the time, were excluded from New Deal policies such as Social Security, collective bargaining, the Fair Labor Standards Act, and the GI Bill.[29] Even when Black workers were able to obtain jobs that included health insurance, such as the Pullman porters in Chicago, segregated clinics and hospitals precluded access to the same health care facilities used by white workers.[32] Rationing of health care services extended to other nonwhite groups as well, such as Mexican American and Indigenous communities.[33] By routing health care coverage through jobs unavailable to nonwhite Americans because of Jim Crow laws[9] and by limiting access for those who were able to obtain insurance for their employers, America's health insurance system was designed with unequal access baked into its framework. It should not be surprising that these racist origins created a system that continues to keep health insurance, and thus health, out of reach for POC. Thus, racism, classism, and tax subsidies promote and perpetuate a health care system that is inequitable, ineffective, and immoral. To reach fuller health equity, a new system based in equity and access must be created.

Other Health Insurance Systems in the United States

In 1934, Franklin D. Roosevelt proposed universal health insurance coverage at a federal level as part of Social Security.[34] Universal coverage was dropped from the final legislation,

however, then attempted again to no avail during the presidencies of both Harry Truman and John F. Kennedy.[34,35] In 1965 a public option for health insurance coverage was finally created when, under the Johnson administration, Medicare and Medicaid were passed as Titles XIX and XVIII, respectively, of the Social Security Act.[36] Medicare, an entirely federally funded system, originally provided health insurance to those over 65, as well as disabled workers and their spouses and dependents.[37] Medicaid, a jointly funded federal-state program, originally covered only children from families who have low incomes and their caretakers.[37]

Expansions to Medicare passed in 1972 increased access to those with long-term disabilities and end-stage renal disease.[35] Most significant, however, was Medicaid expansion under the ACA, which allowed people younger than 65 with incomes up to 138% of the federal poverty level to enroll in the program starting in 2014. Currently, all but 12 states have agreed to expand Medicaid,[38] leaving people living in non-expansion states at greater risk of lacking health insurance (Figure 2).[39] However, a considerable number of people would remain without insurance coverage even if all states expanded Medicaid. Prohibitively expensive plans, limited access, and restrictions on undocumented immigrants keep universal coverage through ACA Medicaid expansion out of reach for many.[39]

Other examples of health care systems supported by the US government include the Indian Health Service (IHS) and the network of health care systems that cover active duty troops, veterans, and their dependents. American Indians and Alaskan Natives are the only people who have a legal right to health care in United States, a right granted from a series of laws and statutes.[40] The IHS provides health care services but is not an entitlement program, like Medicare and Medicaid, nor is it an insurance program. It provides limited health care to 2.56 million American Indians and Alaskan Natives who live in Indian reservations or rural areas, the majority of whom are uninsured or do not have access to other health services.[41] As with many federal policies related to the issues Indigenous people face, the IHS has never been adequately funded and therefore has not solved serious problems of access and poor health outcomes.[42] Conversely, the Veterans Health Administration is the largest integrated health care system in the country.[43] It includes 1255 health care facilities, 170 medical centers, and 1074 outpatient sites that are owned by the government and staffed mainly by government employees who provide care to 9 million enrolled veterans every year.[43,44] Active duty military and their dependents receive health care through either the Military Health System or TRICARE, a government-provided insurance plan that pays for service provided outside of the Military Health System.[44]

THE ECONOMIC CASE FOR UNIVERSAL HEALTH CARE IN THE UNITED STATES

National Wealth

In the United States, people spend more for health care out of their own pockets and from the national coffers than any other country in the world. Twenty percent of the US gross domestic product is spent on health care, more than double that of the average high-income nation.[45] At a price tag of $3.5 trillion per year, the United States spends more than Japan, Germany, France, China, the United Kingdom, Italy, Canada, Brazil, Spain, and Australia combined.[46] Per capita, US citizens spend almost 3 times as much as citizens of similarly wealthy countries with universal health care, $10,207 to their $3558.[47]

The ACA did much to expand access to health care but did little to address national health expenditures. Although the growth of federal spending on Medicare and Medicaid has decreased since the implementation of the ACA, annual spending growth of private health insurance companies has increased from 3.5% to 5.8% between 2009 and 2018, as have out-of-pocket expenditures by individuals.[48] There is also evidence of widespread inefficiencies in the health care systems. A 2019 study estimated that between $760 billion to $935 billion in US health care spending was wasted because of problems with care coordination, overtreatment, low-value care, failure of care delivery, pricing, or fraud and abuse.[49] For all this investment, people in the United States have a higher chronic disease burden, a shorter life span, and higher infant and maternal mortality than their peers in other high-income countries.[50]

Many people incorrectly believe that universal health care would be more expensive than the current US system. One recent analysis estimates that universal health care would likely create a 13% savings in national health care spending, the equivalent of more than $450 billion per year.[51] Universal health care would achieve much of these savings by creating widespread price controls on health services, which currently are based on market tolerance rather than the actual cost of care.[45,52] The savings would be most notable for those with lower incomes, who pay a disproportionately large percentage of their income on health care.[53] Wage stagnation, a multifaceted problem that is partly due to the rising cost of providing health coverage to employees, should improve and allow salaries to finally start to trend upward.[54] Additionally, data predict that 68,000 lives would be saved every year because of increased access to care.[51]

Individual Wealth

The ACA has not brought enough relief for the average American. The percentage of Americans reporting medical expenditures as a leading contributor to bankruptcy has remained roughly the same: 65.5% before ACA and 67.5% after.[55] This amounts to about 530,000 medical bankruptcies every year and includes people who do and do not have insurance.[55] Roughly 8 million people have used fundraising websites (eg, GoFundMe) to pay for medical care for themselves or someone in their household, with an additional 12 million starting a campaign for someone outside their home.[56] Large swaths of Americans report serious problems paying medical bills, including 57% of adults with lower incomes and 48% of adults in the middle class.[57] Even among the wealthiest Americans, 10% said they did not fill a prescription or did cut back on medication dosages in the previous year because of cost.[57]

Among adults aged 65 or younger without insurance, 70% work for an employer who does not offer health benefits. For those workers who choose not to take offered coverage, 9 out of 10 report that the out-of-pocket cost is the main reason

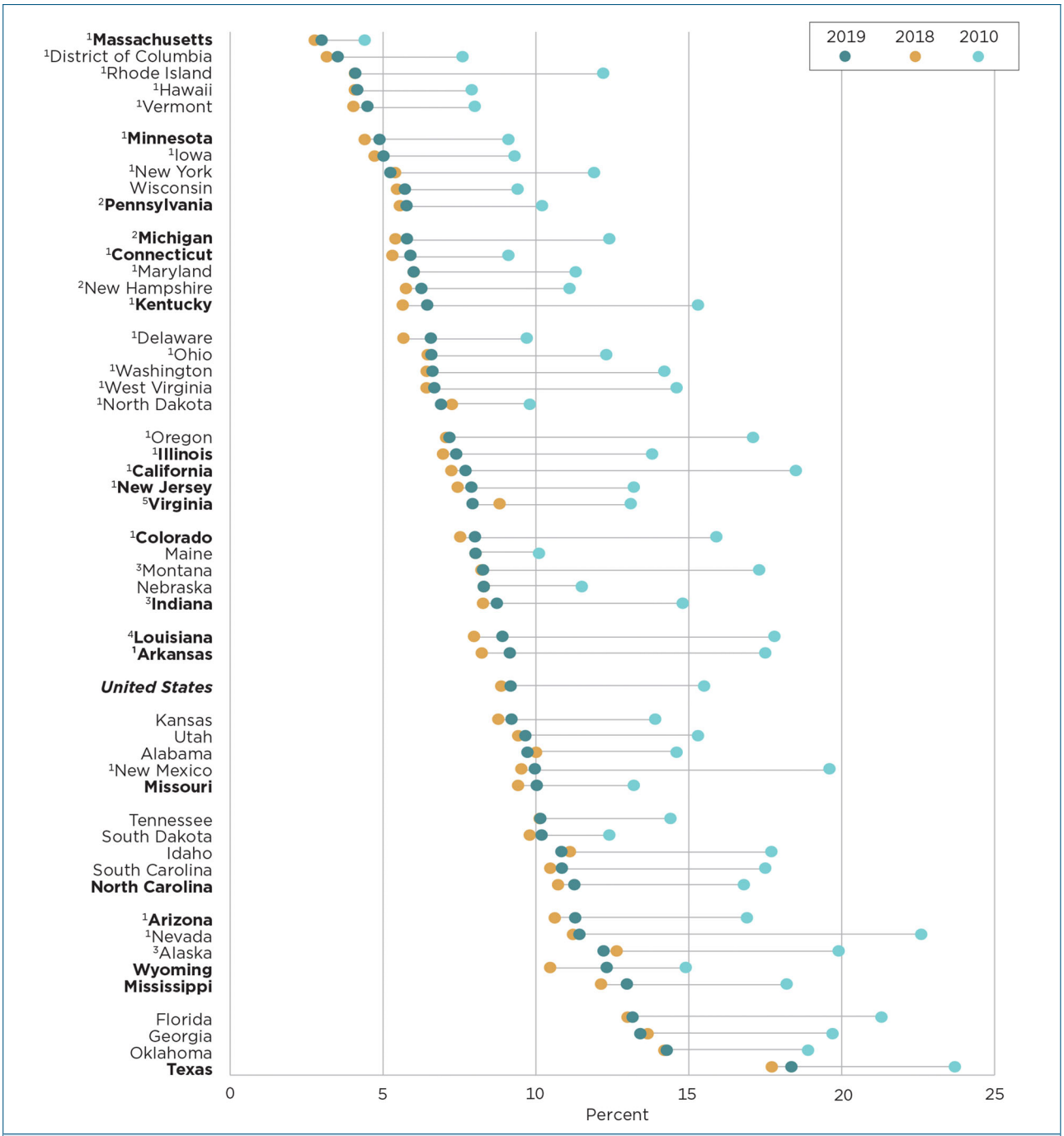

Figure 2. Percentage of People Without Health Insurance Coverage by State: 2010, 2018, and 2019

[1]Expanded Medicaid eligibility as of January 1, 2014.
[2]Expanded Medicaid eligibility after January 1, 2014, and on or before January 1, 2015.
[3]Expanded Medicaid eligibility after January 1, 2015, and on or before January 1, 2016.
[4]Expanded Medicaid eligibility after January 1, 2016, and on or before January 1, 2017.
[5]Expanded Medicaid eligibility after January 1, 2018, and on or before January 1, 2019.
Source: US Census Bureau, 2010, 2018, and 2019 American Community Surveys, 1-Year Estimates.

for their declination.[39] Families below 200% of the federal poverty level who do use employer-based coverage spend a significantly higher share of their overall income on premiums and out-of-pocket expenses compared with families at 400% or more of the federal poverty level; these expenses equate to more than a third of their income for those in the poorest fifth of the population.[53,58] In comparison, out-of-pocket spending in countries with universal health care is half that of their peers in the United States.[52] Consumer satisfaction also differs between the US system and countries with universal health care, with Americans 4 times as likely to report major dissatisfaction with their health insurance.[52]

Although cost is certainly a barrier for many to obtaining insurance, the cost of not having insurance can be devastating. In 2014, the year the ACA was fully implemented, slightly more than half of overdue debt on credit reports was

due to medical bills; 1 in 5 Americans carried medical debt on their credit report.[59] Data collected in California indicated that Medicaid expansion was associated with an 11% drop in the number of payday loans taken out, a reduction in the number of unique borrowers, and a reduction in the amount of these loans.[60]

Even with the implementation of the ACA, the current health insurance system in the United States uses a regressive financing structure, in which people with the lowest incomes or who need the most care pay the most. Poorer patients spend almost double the percentage of their incomes on health care than the wealthiest do.[8] The different categories of ACA plans (platinum, gold, silver, and bronze) are determined by how the costs of care are divided between the payer and the insurance company.[61] Many people with lower incomes opt for bronze plans with lower premiums, opening themselves up to higher health costs if they get sick or injured. Uninsured patients, "who are disproportionately poor,"[59(p 1436)] are affected in 2 ways. First, they have to pay for most of their care out-of-pocket because they do not have access to cost-sharing programs through insurance. Second, they are charged higher prices for care because they are not a part of a plan that has negotiated prices with providers.[62] The system is also regressive with regard to age. Because older adults are statistically more likely to be less healthy and use more services than younger adults, the ACA allows insurers to charge as much as 3 times higher premiums for these enrollees compared with those for younger individuals.[63]

This tiered health insurance system creates disparities in access to coverage based on age, socioeconomic status, race, and gender instead of extending the same level of coverage to everyone.[64] A universal health care system that provides equitable opportunities to obtain coverage for all residents regardless of their identities would help create a health care environment in which people could exercise the rights enumerated in a reproductive justice framework.

UNIVERSAL HEALTH CARE AROUND THE GLOBE

The route to universal health care is created through adopting a universal health insurance system. Proponents of domestic universal health care frequently state that a single-payer system is the way other wealthy nations accomplish coverage for all, perhaps reflecting a national appreciation of the US Medicare system. The reality is actually far more nuanced, with industrialized countries following highly individual paths to achieving universal coverage.[52,65] The 3 basic models of universal health coverage are national health insurance, national health service, and social health insurance. These basic models may be further characterized by their organizational structure, their scope of coverage, and the role of private insurance. There is enormous variety within these models, with each national configuration providing a different structure for organization and payments, as seen in Table 3.[52,65]

National health insurance is commonly referred to as the single-payer system. In this model, a single tax-financed insurance plan reimburses health care providers. Everyone is eligible for this insurance, and the government determines the type of benefits and health care services available to enrollees.[52] Although the health insurance is publicly financed, most hospitals and health care providers are private. In the United States, Medicare is an example of a single-payer model.

National health service models may also be called single pool or Beveridge systems, named for the British economist who proposed this system in 1941. Health care services are provided at publicly financed institutions by clinicians employed by the state. At the point of service, these services are typically free or very low cost. A comparable US model is the Veterans Health Administration system.[52]

Social health insurance is a highly regulated multipayer model also known as the Bismarck system, named for the German statesman credited with devising the world's first public health insurance in 1883.[27] In these systems, workers are covered by nonprofit health insurance plans paid for by employee and employer contributions; pooled financing covers those who are not employed. Wide variations exist in the degree of government regulation, the number of plans available to consumers, and the types of services offered among countries using this model. In the United States, the ACA is most similar to a social health insurance model, but without the tight regulation that keeps costs down and enhances access to care in other nations.

Additional factors further modify these 3 major models. Locus of control may be at the federal or regional level. Although single-payer national health insurance systems are typically thought of as having centralized federal control, each of Canada's territories administers health care independently under broad federal constraints. In Australia, a federally controlled system allows for regional variation. Only geographically compact Taiwan has a system with the centrally concentrated control considered classic for this model.[65]

Within each of the 3 models, covered services and cost sharing vary dramatically. Whereas some models offer a narrow range of benefits (Canada), others offer comprehensive services that may even include sick pay (Germany). Although national health service systems usually offer care that is free at the point of service, the other 2 systems require some sort of cost sharing, most often in the form of copayments. There are exceptions, however. The national health service systems of Norway and Sweden require cost sharing. Canada's national health insurance system is largely free to consumers at the point of service.[52,65]

Privately purchased insurance is common in all of these systems of universal health care. The insurance offered in each country may be complementary, supplementary, or both. Complementary health insurance covers out-of-pocket expenses incurred because of cost sharing. Supplementary health insurance typically covers services limited or excluded by the public insurance plan. It may also provide access to a broader range of providers, speed access to care, or purchase more luxurious services such as private hospital rooms. In England and Germany, private health insurance may be entirely substituted for the public insurance. In Australia, the government uses tax incentives to actively encourage purchase of private insurance to replace the public plan.[52]

Choosing a system of universal health insurance best suited to the United States will require much thought, discussion, and policy development by health and policy leaders. As

Table 3. International Systems of Universal Health Care

System and Country	Structure of Health System	Scope of Coverage	Role of Private Health Insurance
National health insurance			
Australia	Central policy with regional flexibility	Broad public insurance with moderate cost sharing for inpatient, outpatient, and drugs.	Complementary and supplementary private insurance available; individually purchased private insurance may fully substitute for the public health plan
Canada	Regional control under broad national constraints	Narrow national benefits package with no cost sharing for inpatient, outpatient, and drugs. Coverage varies by province.	Supplementary private insurance
Taiwan	Largely federal	Broad public insurance with moderate cost sharing for comprehensive care.	Supplementary private insurance
National health service			
Denmark	Central policy with regional flexibility	Comprehensive, free, or low cost at point of service. Includes mental health, dental, and outpatient drugs.	Complementary and supplementary private insurance available
England	Central policy with regional flexibility	Comprehensive, free, or low cost at point of service. Includes mental health, outpatient drugs, and rehab.	Supplementary private insurance; individually purchased private insurance may fully substitute for the public health plan
Norway	Central policy with regional flexibility	Broad public insurance with moderate cost sharing. Includes subsidized dental and drugs.	Supplementary private insurance
Sweden	Regional control under broad national constraints	Broad public insurance with moderate cost sharing. Includes subsidized dental and drugs.	Supplementary private insurance
Social health insurance			
France	Largely federal	Broad public insurance with moderate cost sharing. Includes rehab, drugs, and some dental.	Complementary private health insurance
Germany	Regional control under broad national constraints	Comprehensive, free, or low cost at point of service. Includes mental health, dental, and sickness pay.	Supplementary private insurance; individually purchased private insurance may fully substitute for the public health plan
Netherlands	Largely federal	Broad public insurance with moderate cost sharing. Includes drugs and pediatric dental.	Supplementary private insurance

(*Continued*)

Table 3. International Systems of Universal Health Care			
System and Country	**Structure of Health System**	**Scope of Coverage**	**Role of Private Health Insurance**
Switzerland	Regional control under broad national constraints	Broad public insurance with moderate cost sharing. Includes some mental health and drugs.	Mandatory, government-subsidized private insurance is the primary form of health insurance, composing the entire universal coverage scheme
Singapore	Largely federal	Broad public insurance with moderate cost sharing for comprehensive services.	Supplementary private insurance

Sources: Fox and Poirier,[52] Glied et al.[65]

other nations have done, the United States must chart its own unique path to universal health care.

BEYOND UNIVERSAL HEALTH COVERAGE

Universal health care alone cannot, of course, address the multitude of issues facing the United States. Income inequality, food insecurity, affordable housing, climate change, systemic racism, sexism, heterocentrism, and ableism all affect the ability of people and the public to achieve high levels of health and wellness. A long history of unethical medical experimentation and mistreat at the hands of health care providers, implicit bias, and institutional racism have created a well-founded lack of trust in health care providers that will continue to cause disproportionate harm to POC and those who are marginalized.[66–71] Acknowledging past and present injustices is essential but must be combined with meaningful action to prevent future injustice. Removing the barrier of limited access to care is an important step, but it is far from the only measure necessary.

Lack of diversity in the health care workforce will continue to be a problem even after universal health care is implemented. Superior outcomes for white patients in a health care system largely run by white providers and the inverse, of poor outcomes for patients of color who are inadequately represented in the health care workforce, have been insufficiently examined.[72] Recent research into race-concordant care indicates that the mortality rate of Black infants could be halved simply by the act of being cared for by a Black physician.[73] Although workforce diversity will improve outcomes for certain populations, it is not a singular solution, nor does it erase the obligation of all health care professionals to provide equitable, high-quality care.

Additionally, improved safeguards are needed to ensure sexual and reproductive health in accessible in every community. Although COVID-19 inspired a new wave of abortion and contraceptive restrictions, a trend toward less access to these essential services has been occurring for several years.[74,75] Limited access, especially to abortion, disproportionately affects POC, those who are uninsured, and those who live in rural areas.[76] Because accessible and equitable reproductive health is a fundamental component of achieving reproductive justice, this area in particular will require targeted efforts to improve and expand access.

CONCLUSION

Health care professionals across the country should support universal health care as an issue of justice, equity, cost-effectiveness, and professional opportunity. When comparing universal health care overseas with both the origins and present-day realities in the United States, the necessity for change is clear. Viewed through the reproductive justice lens, the human rights–based argument for a health care system that is accessible and secure for everyone means that we are all more secure. An evaluation of the economic realities suggest that the current system is unsustainable for individual pocketbooks and the nation as a whole. It is hard to imagine how the United States can advance as a more equitable society without universal health care.

Public opinion is quickly changing. A survey in 2018 estimated that 6 in 10 Americans feel that it is the responsibility of the government to make sure all Americans have health insurance; almost 1 in 3 supports a single-payer system.[77] With the economic and health consequences of COVID-19, these numbers will surely increase. Health care providers play an important role in their communities and with policymakers and must use this leverage to further the cause of universal health care. With political will and public support, universal health care is an important step in the pursuit of justice and equity.

CONFLICT OF INTEREST

The authors have no conflicts of interest to disclose.

ACKNOWLEDGMENTS

Many thanks to Ebony Marcelle, Susan Kamin, and Nikki Christian-Genius for their thorough review and suggested edits for this article.

FUNDING

This work was supported by the ACTIONS Postdoctoral Fellowship,University of California, San Francisco School of Nursing.

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