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The Moral and Practical Case for Universal Healthcare Coverage

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Citizens in the United States have debated about health policy for over a century – and for much of that time arguments have presumed that fixing health care necessarily entails competition between public and private insurance options.

Public programs such as Medicaid broaden access to health insurance for low-income Americans who could not otherwise afford it. But the coexistence of public programs with offerings from many independent private insurance companies means that access to health insurance in the United States is fragmented. This system raises costs for providers and often restricts access for the sick and some lower-income people. Unlike other advanced capitalist economies around the world, the United States does not have a systematic and coordinated system of health care insurance coverage – and it fails to deliver on a central promise almost all modern democracies make to their citizens.

My research investigates the main drawbacks to the U.S. system of public-private competition; and I argue that America should turn to an entirely public model – for both moral and pragmatic reasons. Health care as an intrinsic human right that should be publically guaranteed; and public provision could better manage administrative costs while expanding coverage to all Americans.

Health Care as Commodity or Right?

A century after President Theodore Roosevelt campaigned for national health insurance, the United States remains unique among advanced capitalist economies in its reliance on private insurance options to cover most nonelderly Americans. Rather than treat health care as an intrinsic right embodying the national commitment to life, liberty, and the pursuit of happiness, this approach follows another prevalent U.S. view – that *health care coverage is a commodity to be bought and sold.* Accordingly, many poor and working Americans suffer because they cannot afford health insurance and the access to good care it brings. They are left to get what they can afford in a system of market exchanges.

Treating health care as a commodity, as many economists do, leads to reliance on particular approaches to controlling costs of health care. These include consumer cost sharing, market competition, and insurance oversight of the medical choices made by providers. These approaches increase the administrative burden while denying coverage to millions of Americans.

Market assumptions about health care also encourage policymakers to think of universal health care as an undue cost to taxpayers and burden on government. Instead of trying to control costs associated with broadening coverage, policymakers have tried to shift the costs to people who need to be conceptualized as "consumers." The idea that healthcare is just one more commodity people can choose to buy or not leads to policies that force the sick to foot the bill for administrative expenses, treatments, and high drug prices.

High Costs for Incomplete Coverage

Since 1971, health care spending in the United States has increased by $1,283 for every additional year of life expectancy. Had spending per year of added life increased at only the rate of other countries U.S. healthcare spending would have been $4,500 less per person, with $18,000 saved for the average family of four.

From 1980 to 2005, U.S. health care administrative costs rose by 1300 percent, while prescription drug prices rose by nearly 2000 percent. To cover their profits, large private pharmaceutical companies charge high prices in the United States. And U.S. costs are also inflated by the administrative overhead and profits of private

insurance companies and provider systems for dealing with them. To manage bills and interactions with insurance companies, the average physician in the United States now spends $80,000 a year, four-times as much as the average Ontario, Canadian physician dealing with a single-payer system. The U.S. health care system now has 2.5 million administrative personnel, more than the number of nurses and four times the physicians. There are more health-care managers than physicians and surgeons.

Unfortunately, many economists ignore soaring drug and administrative costs and instead blame high health care spending on supposed overutilization of care by American patients. Ironically, by accepting the premise that monopoly prices and high administrative costs are inevitable, many economists conclude that universal health care coverage would be impossibly expensive. Restricting access is the only way they see to restrain health care costs is to restrict access, so they favor price increasing steps for consumers that have the effect of rationing care to those best able to pay. But the truth is that if the United States were to lower administrative costs and drug prices to the Canadian level, it could save nearly $600 billion dollars, more than enough to provide coverage to all of the uninsured while improving access for the millions of underinsured.

Fixing Health Care by Generating Cost Savings and Expanding Coverage

There are several reasons to turn to a more public version of U.S. health insurance:

- A single-payer system – like the Canadian system, or an expansion of U.S. Medicare to everyone – would produce huge administrative savings by simplifying billing operations within providers' offices and hospitals. It would also make it easier to bargain for price reductions with pharmaceutical makers and other companies.

- Savings produced by a single-payer system would correct some current problems. In addition to extending coverage to all of those currently uninsured, a universal system would improve coverage for those with inadequate insurance. Finally, the United States could correct inequities in the current financing system by reimbursing Medicaid providers equally.

Who would pay? A single-payer U.S. system could be sustained by a variety of taxes, including some that could promote efficiency in the overall economy. For instance, a "Tobin tax" on financial transactions could raise revenue while discouraging the financial speculations that led to the 2009 meltdown. Additional revenue could come from taxes on high-income earners and those who enjoy large investment incomes from capital gains, dividends, interest, profits, and rents. In the current system, health-care expenditures are a heavier burden on the poor and middle classes than on the wealthy. A tax-funded single-payer system would, by contrast, deliver savings to all Americans earning less than the wealthiest top five percent.

Read more in Gerald Friedman, "Single Payer Rhode Island: Impact and Implementation," Report for Physicians for National Health Plan Rhode Island, January 2015.