# FRONT MATTER

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# Healthcare Policy in the United States

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# PRO/CON

# Universal Healthcare: An Argument for a US Transition In Light of COVID-19


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*One year ago today, countries were on lockdown and COVID-19 cases were rising around the world. This pandemic, a once-in-a-century global health crisis, has highlighted some of the best and worst aspects of various countries' healthcare systems. In light of the US's particularly disappointing response to COVID-19, many people have drawn stark comparisons between America's healthcare system and universal healthcare. Given the numerous failures of the US's healthcare system that the pandemic has only helped to highlight, it is clear that the US should transition from its current multi-payer healthcare system to a single-payer (universal) healthcare system. A universal healthcare system would decrease costs while increasing effectiveness and create a more equitable distribution of healthcare access. Such a health care system would be especially beneficial amid the COVID-19 pandemic.*


### A Brief Overview

Universal healthcare has appeared in mainstream media under multiple aliases: single-payer healthcare, universal health coverage, and Medicare-for-all (in the US). Nevertheless, all of the terms reference the same core idea: a single public or quasi-public agency finances healthcare for every individual in a country. Over thirty countries worldwide

have adopted universal healthcare, including six out of seven of the G7 countries (Canada, France, Italy, Germany, Japan, and the UK) (Department of Health). Notably, the US is missing from this list. To contrast a single-payer healthcare system, the US employs a multi-payer healthcare system where individuals rely on private health insurance companies to cover their medical expenses.

## An Argument for Universal Healthcare

As of June 4, 2021, the US had 33.4 million confirmed COVID-19 cases and 596,483 COVID-19 deaths ("Coronavirus in the US"). The US is the world's leader in COVID-19 cases with individual states logging more cases and deaths than entire countries. These large figures reveal the deep fractures in the American healthcare system and tangibly illustrate the need for change.

### *A. Cost*

First, a universal healthcare system will lower healthcare costs and ensure greater efficiency in spending. The monetary costs of the American healthcare system appear on many fronts: out-of-pocket spending for treatment and drugs, administrative costs, and costs for preventable illnesses. Greater costs on all of these fronts in the US's current system result in the US per capita healthcare spending being about twice as high as the comparable country average: in 2019, US per capita healthcare spending was $10,966 compared to the comparable country average of $5,697 (Kamal).

In the realm of out-of-pocket spending, Americans face much higher drug and treatment prices than people in countries with universal healthcare. Higher prices in America are primarily because private insurers can individually negotiate prices with pharmaceutical companies and hospitals. A profit-seeking pharmaceutical company or hospital will offer its products and services to the highest bidder, so insurance companies cannot offer to pay very low prices. However, in a universal healthcare system, a mix of regulations and contract negotiations from the single healthcare provider can ensure that pharmaceuticals and hospitals cannot charge obscenely high prices. A 2017 study by researchers from the University of British Columbia and Harvard University reveals the benefits of a single-payer system. The study found that among ten countries with universal healthcare, those that relied on a single-payer

system for prescription drug coverage had the lowest per capita spending on six categories of primary care medicine (Horn). Note that even in a universal healthcare system, parts of the system can be multi-payer or more fragmented. Nevertheless, this study indicates that healthcare systems that have more single-payer aspects have lower per capita spending.

Next, look at administrative costs. The US healthcare system is incredibly complex, with different healthcare plans, multiple private health insurance providers, in- and out-of-network providers, and various healthcare regulations. Navigating these complexities and running administrative networks costs health insurance companies significant amounts of money. Comparatively, a universal healthcare system has one large administration and avoids the costs associated with having multiple providers all acting independently. It is therefore not surprising that 8 percent of US healthcare spending goes toward administrative costs versus 1 and 3 percent of healthcare spendings in ten other comparable countries ("6 Reasons Healthcare Is So Expensive").

Finally, universal healthcare will provide an incentive for the government to promote preventative healthcare policies like policies to encourage healthy eating and reduce obesity. In a universal healthcare system, everyone contributes to a large pool of money that is used to fund everyone's healthcare. Thus, it is in the nation's interest to promote preventative healthcare policies since fewer people falling ill will result in everyone having to contribute less into the pool of healthcare funds. In a universal healthcare system, as the sole healthcare provider, the government also has more leverage, authority, and influence buttressing its preventative measures compared to a private insurer trying to incentivize healthy behaviors. While they currently are not universal providers, the US Medicare and Medicaid programs highlight the positive impact on overall health that a large government provider promoting healthy behaviors can have. The Affordable Care Act included initiatives to incentivize people to quit smoking, and in states that expanded Medicaid coverage, prescriptions for smoking cessation medications increased by 36 percent compared to states that did not expand Medicaid coverage (Chait and Glaid). Greater attention toward prevention and a healthier populace undoubtedly decreases healthcare spending.

Especially during a recession caused by the COVID-19 pandemic, reductions in healthcare spendings are especially beneficial. Currently, 68 percent of Americans say healthcare costs would be somewhat or very important in their decision to seek treatment for COVID-19 (King). Lower healthcare prices could ensure that more people are willing to seek necessary treatment or get tested for COVID-19, which could aid in the US's battle against the

virus. Furthermore, in a time when millions of Americans face financial hardships from the COVID-19 recession, reductions in healthcare spending could free up money for Americans to spend on other basic needs like food and shelter. Finally, preventative measures and a healthier populace would mean fewer Americans would have pre-existing conditions that increase people's dispositions to more severe COVID-19 cases. All in all, from a cost standpoint, universal healthcare is a better option than the US's current system.

### *B. Equity*

Next, a universal healthcare system will ensure the equitable distribution of healthcare. Currently, Americans rely on private health insurers to help cover their healthcare costs, and most Americans rely on employer-provided healthcare. High costs and insurance tied to employment disproportionately harm lower-income individuals, who also happen to more often be uninsured and be people of color — healthcare accessibility is an intersectional problem.

First, the intertwined nature of health insurance and employment in the US system is a deep flaw since it guarantees that the unemployed are disproportionately likely to be uninsured. A person laid off during a recession (like the current COVID-19 recession). A discouraged worker. A stay-at-home parent. All are at severe risk of not having access to healthcare. In 2020, approximately 12 million Americans lost employer-sponsored health insurance, so the number of uninsured Americans is now approximately 27 million (Wohl). Unfortunately, the unemployed are also the most likely to face financial difficulties, meaning the US healthcare system disproportionately lacks support for lower-income individuals. As well, in 2020, the unemployment rates for people of color were higher than those for white Americans—the unemployment rates for African Americans, Hispanics/Latinos, and Asian Americans were 9.9, 8.7, and 6.7 percent, respectively, compared to 5.8 percent for white Americans ("E-16, Unemployment Rates"). Thus, people of color are also disproportionately likely to lack healthcare. The difference between the healths of the uninsured and the insured is stark. For example, a Michigan doctor observed that between uninsured and insured diabetic COVID-19 patients, the uninsured patients were more likely to have uncontrolled diabetes and die quicker (Beaumont). While universal healthcare ensures that everyone has access to healthcare, the US system creates a stark dichotomy between the lives of the uninsured and insured, poor and rich, white and not.

Even if people are insured, high costs still serve as a barrier for lower-income individuals. While insurance often covers a sizable portion of people's medical bills, co-pays can still be significant. Furthermore, people can receive surprise bills if they unwittingly receive treatment from an out-of-network (not covered by insurance) doctor at an in-network (covered by insurance) medical center. Many, deterred by the costs, may avoid seeking care, causing their conditions to worsen. In 2020, half of lower-income US adults skipped out on doctor visits, recommended tests, treatment, follow-up care, or prescription medications due to cost (Wohl). Compare that to 12 and 15 percent of lower-income adults in Germany, the UK, Norway, and France (all countries that have universal healthcare) (Wohl). As discussed above, universal healthcare can help regulate healthcare prices, making healthcare more accessible to lower-income individuals.

Even without COVID-19, the inequities in the American healthcare system were already evident: in 2014, long before COVID-19, the life expectancy for African Americans was 3.58 years less than that for white Americans and the life expectancy gap between the richest one percent and the poorest one percent was 14.6 years for men and 10.1 years for women (Carlson; Chetty et al.). COVID-19 only compounded these health inequities. More low-wage workers became unemployed and lost their health insurance. People of color face higher mortality rates from COVID-19—African Americans are 2.2 times as likely to die from COVID-19 compared to white Americans (Horn). The disparities in the number of people who have pre-existing conditions among people of color and white Americans are largely responsible for these COVID-19 mortality rate disparities. Diabetes is 60 percent more common in African Americans than in white Americans, and African Americans develop high blood pressure with much higher levels earlier on in their lives than white Americans do (Horn). Ultimately, these issues all trace back to the disparities in healthcare access, and a universal healthcare system would go a long way toward solving these problems by ensuring that everyone has equal access to healthcare.

## Criticisms

Of course, any healthcare system comes with tradeoffs, and a universal healthcare system should not be seen as a panacea for all of America's healthcare-related problems. Indeed, while a universal healthcare system may solve some of our problems, new problems may arise, so the debate really becomes a question of which costs are more palatable.

One of the most common criticisms of universal healthcare is that patients in a universal healthcare system face longer wait times. Critics often point to Canada, where patients may face extended wait times for surgeries such as a hip or knee replacement. First, a clarification: the long wait times that critics refer to are primarily for non-essential elective procedures; that is, in cases where not receiving the procedure immediately is not life-threatening, but the patient would likely live more comfortably if they received the procedure. Indeed, if the US transitioned to a universal healthcare system, some patients may face longer wait times. However, it is crucial to emphasize that in a universal healthcare system, everyone receives care. For a person who needs emergency care, they will receive it without fretting about hospital bills, insurance plans, or co-pays. For a person who needs a non-essential elective procedure, although they may have to wait a little bit longer, they will receive care (still without cost and insurance plans as burdens). Compare that to the US's current system, where the uninsured and under-insured often are not receiving necessary care and there is no incentive to provide it to them. Finally, despite sometimes facing longer wait times, Canadians still have lower infant mortality and higher life expectancy rates, indicating that in the grand scheme of things, universal healthcare better serves the population than the US's multi-payer system (Santhanam).

Next, critics often claim that universal healthcare will stymie medical innovation. Their reasoning is that with universal healthcare, the government will reduce pay for doctors and pharmaceutical companies to keep costs low, which will decrease the incentive for innovation. There are two flaws in this argument. First, the argument assumes that the primary source of funding for medical research is the profit that pharmaceutical companies receive from selling drugs and the money that doctors receive from patients. In reality, the single biggest source of funding for medical research is the National Institutes of Health (NIH) (Cohn). The NIH is a government entity that is entirely separate from health insurance companies, and changing who pays for healthcare will not negatively affect the NIH's funding. Second, the argument assumes that the primary driving force for medical researchers is profit. Sure, firms in the private sector want profit, but at the same time, many medical researchers enter their professions to serve a higher purpose: they wish to advance science and improve people's lives. Take Dr. Ughur Sahin, one of the leading scientists behind Pfizer's COVID-19 vaccine. Albert Bourla, Pfizer's chief executive was quoted saying "[Dr. Sahin] only cares about science. Discussing business is not his cup of tea. He doesn't like it at all. He's a scientist and a man of principles" (Gelles). The claim that medical researchers will be less innovative with universal healthcare is based on a rather narrow-minded assumption that medical researchers are only working for the pay. It also

requires several logical leaps to establish the causal link chain from doctors receiving less pay to researchers, say, being less motivated to develop a cure for cancer.

Finally, critics claim that universal healthcare will be very expensive, especially with large upfront costs, and cause people's tax rates to rise. Indeed, any systemic change will require large upfront costs; however, that initial investment is worthwhile in the long run. Each year, the average American spends about twice as much on healthcare as people in comparable countries (Kamal). Those costs add up quickly. Without a major change to the US's healthcare system, Americans will continue to pay exorbitant prices for healthcare. However, with a transition to universal healthcare, in the long run, Americans will save on healthcare. In terms of taxes, the costs for universal healthcare will likely be incorporated into the progressive income tax. In the current system, healthcare costs are regressive, as the average $10,966 per capita spending on healthcare accounts for a larger proportion of a poorer person's income than it does of a wealthier person's income. However, with progressive taxation, wealthier Americans will pay a larger proportion of their incomes on healthcare, and the cost burden will no longer unequally fall on the sick and poor. While Americans may be paying more in taxes, they will be paying less out-of-pocket. Ultimately, a universal healthcare system will result in long-term savings on healthcare and more equitable distribution of healthcare costs.

## Conclusion

Even before the COVID-19 pandemic, it was becoming abundantly clear that the US healthcare system needed an overhaul: sky-high costs and inequities in healthcare access simply were not benefitting Americans' health. COVID-19, however, has made the problems with the US healthcare system even more salient as more people face financial hardship, more people are unemployed and uninsured, and people of color are disproportionately dying from COVID-19. While universal healthcare is not a panacea for all of the US's healthcare problems and some trade-offs will be necessary, looking at the bigger picture, those trade-offs are worth it. With a universal healthcare system, Americans will be healthier on the whole. Now—with Americans' attention focused on healthcare and a global pandemic revealing the American healthcare system's ugly truths—is as good of a time as any for the US to transition to a more cost-effective and equitable healthcare system: universal healthcare.

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# Correcting Delusions and Providing Free-Market Solutions in American Healthcare


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*The American healthcare system is in desperate need of medicine. It is plagued by ever-increasing costs of treatment and a lack of overall transparency, with the majority of Americans demanding reforms. While free-market capitalism seems to be the fashionable scapegoat for such problems, market-based solutions are, in fact, the best way for Americans to get the affordable, high-quality care that they deserve.*


One of the most common misconceptions regarding America's current healthcare system is that it is guided by the forces of free and unobstructed markets. While certain components of the system are indeed privatized, almost none of the fruitful trademarks of a free and fair enterprise are actually visible. The abject falsehood that the imperfections — of which there are plenty — in the current system are the product of capitalism has distorted the debate on healthcare reform for decades. Through this misconception's stranglehold on public opinion, it is one the most significant obstacles currently standing in the path towards affordable and high-quality care for Americans and, thus, presents a clear and present danger to the financial and physical well-being of every citizen. It is only upon the correction of this delusion that America's path to a prosperous market-based system can be uncovered.

Interestingly, the origins of much of the modern U.S. healthcare system are largely fortuitous; the system is the product of the creativity of employers attempting to circumvent government intervention, not in the market for healthcare, but in the market for labor (Roy; "How Employer-Sponsored Insurance Drives Up Health Costs"). New Deal wage controls

instituted by President Roosevelt significantly curtailed the ability of employers to attract new workers. To remain competitive, they began offering generous healthcare plans to prospective employees, taking advantage of the exclusion of health insurance from the scope of the regulations. In the following years, the Internal Revenue Service permanently baked this accident into the tax code. It exempted employer-sponsored health insurance purchases from income and payroll taxation; however, it notably did not extend this privilege to insurance purchased by individuals with their own money (Roy; "United States: #4 in the World Index of Healthcare Innovation"). This created a major disincentive for healthcare to be purchased directly from providers, where each party would be more responsive to the needs of the other.

It is a basic principle of economics that, for markets to work, the consumer who makes demands must be sensitive to the cost of having those demands met. This is why the government so easily succumbs to price gouging by federal contractors: it has little stake in the matter because it is spending other peoples' tax dollars. By creating a four-tier system wherein employers and insurers act as middlemen, the government has completely divorced the consumer from the supplier. The patient rarely negotiates directly with his healthcare provider; instead, he goes to the employer who pays the insurer who, finally, pays the provider. Each additional tier of this system distances the original consumer from the cost of fulfilling his needs, thus allowing insurers and providers to charge unfair prices (Heath Manning). In other words, the sole balancing force powerful enough to bring the market to equilibrium — informed and direct consumers — is simply not present. For instance, take a recent study conducted by the University of Iowa College of Medicine where a researcher called 100 hospitals and asked for the price of a stand coronary artery bypass grafting (CABG), a very common procedure. Just half of the hospitals were able to provide an upfront price, and for those who could, the range of estimates was $456,000 (Giacomino et al.). This is, as explained, due to an excess of government involvement. It should be no surprise that an opaque market composed of price-insensitive consumers and monopolistic suppliers fails to deliver affordable care. Capitalism, therefore, is not at fault for the problems with the current state of healthcare in America, as supporters of increased central planning would claim. On the contrary, there is not enough of it.

Where a free market in healthcare has managed to emerge from the shackles of government, the results have been overwhelmingly positive. The United States ranks fourth in the World Index of Healthcare Innovation (Roy; "United States: #4 in the World Index of Healthcare Innovation"). It ranks first in the subscores of both Choice and Science & Technology, with the second-highest rated country trailing by a whopping twenty-three points

in the latter of these categories — the highest margin of any dimension on the index (Roy; "United States: #4 in the World Index of Healthcare Innovation"). It should be of no surprise that the pharmaceutical and biotechnology industries are some of the freest components of the healthcare supply chain, where innovators can pursue research, gain access to markets, and reap the benefits of their hard work. Entrepreneurs are not forced to navigate the thick web of red tape that would be commonplace in other (worse-performing) healthcare sectors. Instead, clear-cut profit motives propel the country's talent to the frontiers of medical ingenuity. The safe yet efficient regulatory process allows for America to be the world's number one producer of new drugs and medical devices that gain approval, as well as the home of the most Nobel prizes in chemistry and medicine per capita (Roy; "United States: #4 in the World Index of Healthcare Innovation"). Regular citizens benefit from this free market and the unparalleled access to world-leading treatments it provides. And, for the record, the only reason why America is not ranked first overall on the index is due to its Fiscal Sustainability subscore. It has the highest levels of per capita government healthcare spending in the entire world (Roy; "United States: #4 in the World Index of Healthcare Innovation"). Once again, government intervention is no friend to regular people.

For an example of what could be expected if markets were left to do their job, LASIK eye surgery — a non-emergency medical procedure — can serve as a roadmap for the future. It was created as a revolutionary technology to improve visual acuity, often providing an alternative to cumbersome eyeglasses and contact lenses. It was approved by the FDA in the 1990s, and, as one would expect, demand immediately skyrocketed (Tolbert). Now, in the American healthcare system, surging demand generally spells disaster; long wait times and rising costs instantaneously become the norm. However, two anomalies of LASIK make it unique: it is (1) seldom covered by insurance companies and (2) relatively unregulated (Tolbert). The latter of these irregularities created a profit motive, which, in turn, drew competing suppliers into the newly lucrative business, drastically lowering prices and improving quality along the way. This increased competition was supported by price-sensitive consumers targeted directly by suppliers who could now provide transparent and reliable prices upfront, rather than having to deal with an opaque insurance company acting as a middle-man (Hoffmans). Patients were then able to compare prices and values from different providers and make an informed, rational decision on how to best care for themselves and their pocketbooks.

Of course, not all situations are suitable for comparison shopping. In times of emergency, when a patient is being rushed to a hospital in an ambulance or when human life is on the line, people are naturally insensitive to the cost of treatment. This is where health

insurance makes sense; after all, insurance is, by definition, there to provide a safeguard against the unexpected. For this type of critical care, there is *perhaps* even room to consider interventionist policies in an effort to keep life-saving treatment affordable. However, nearly 60% of healthcare in the United States is shoppable, falling under the categories of elective surgery, medical tests, or diagnostic exams (Lee). A free market — composed of direct transactions between patients and providers — can, therefore, easily satisfy a significant portion of the national demand in a high quality and cost-effective manner. All that is required from the government is a foundation upon which entrepreneurs can innovate and people can have access to the information they need in order to make their own health decisions.

Free-market solutions such as price transparency will level the playing field between patients and providers, and this new era of accountability will make healthcare more affordable without compromising the country's already impressive quality of treatment. If the federal government can overcome its inclination to involve itself in the work of the private enterprise, markets will always get the job done.

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# POLICY MEMOS

# National Electronic Health Records with Health*E*Pin


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### Executive Summary

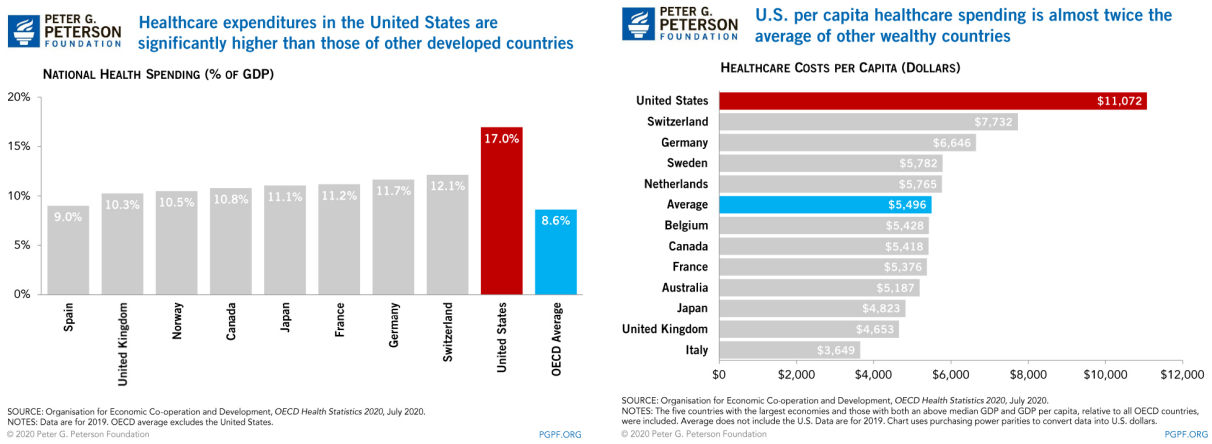

National EHR with HealthEPin is a policy proposal that can reduce healthcare costs and increase access to healthcare diagnostics. To elaborate, EHR are electronic health records. Currently, different organizations use different EHR systems, which drives up administrative costs. US healthcare is costly primarily due to administration. So, a national EHR can reduce expenses. Additionally, a medical ID app with a QR code will connect patients, providers, and responders to medical records. This medical ID app is referred to as Health*E*Pin. Effectively, it allows patients and medical professionals to read and update data from a central repository without needing to pull them up, carry them around, or transfer them from one provider to

another. The more efficient system provides both patients and medical professionals a single source of truth in accessing up-to-date health information of a patient as a whole. This comprehensive 360-degree view of a patient's records will facilitate easier diagnosis, the cross-impact of various drugs, as well as the communication between patients and healthcare workers everywhere, not just in specific systems. Combined, national EHR and Health*E*Pin can create more affordable, transparent healthcare.

## Electronic Health Records in Their Current Form

Electronic health records are a digital collection of patient health information ("What is an Electronic…"). These records compile medical history, diagnoses, medications, treatment plans, and other such information. EHRs allow data to be available instantly and securely to authorized users and are most commonly used by clinicians to make diagnoses and prescriptions. Currently, electronic health records serve first to document the care provided to patients. They are legal documents used to establish medical necessity, support quality measures, and support claims for reimbursement ("Electronic Medical Records Standards"). Nevertheless, EHR can be modified to assuage other problems.

## A Two-Fold Problem: Healthcare Costs and Information Access




Source: Peter G. Peterson Foundation

A national, unified EHR with a personal medical ID addresses two issues at once. First,

reduced administration costs alleviate healthcare costs as a whole by removing the need to invest in decentralized, provider-based IT systems and infrastructure. The US currently has the most expensive healthcare system with an annual cost of $11,072 per capita, which far outpaces the country with the next highest expenditure — Switzerland, at $7,732 per capita. US healthcare is an outlier in another way — administrative costs. At $937 per capita, the US spends 4 times as much as the OECD average ("Health Expenditure and…"). Hence, reducing administrative expenses is an excellent way of reducing expenditure writ large and alleviating the burden on the average healthcare consumer.

Second, if paired with HealthEPin, an accessible medical ID, unified EHR can reduce administrative burden and makes access to healthcare data easy. Currently, access to information for both patients and providers is a major healthcare issue. The lack of access to medical notes in New Zealand conveyed that. Only 52% of polled New Zealand patients answered that they understood their medications. Said issues have been estimated to cost New Zealand $222.5 million NZD per year. This may be because medical records are directed toward clinicians, not patients. On the whole, lack of knowledge and non-adherence costs $317 billion globally ("National Health Information…"). Not to mention, opaque medical info has indirect consequences for patients. Case in point, fragmented EHR systems make it difficult to collect data for studies (Franzén). In another scenario, medical ID affects emergency care. Responders require rapid access to healthcare information (Blaney-Koen).

## A Two-Fold Solution: National EHR with Personal Medical IDs

The US should create a national EHR and Health*E*Pin to reduce costs and increase access. Primarily, national EHR decreases administrative costs, as it does not require information transfers (Sninsky). Administrative burden could be further reduced because of decreased education requirements. To put it simply, healthcare workers will not need to learn about different EHRs. In practice, employees often needed EHR system-specific training when implementing an EHR and when new staff is hired. Finally, the EHR can be pre-adapted to regulations (Fennelly). The cost reduction has been shown in other countries as well. Australia's HealthConnect system shares patient data with participating and authorized providers. Because it reduced errors and excess effort, they estimated $300 million AUD per year in savings (Gunter).

Moreover, the national EHR and Health*E*Pin will improve information access and hence,

decrease costs. In Sweden, the national eHealth system collected large, reliable, and consistent data sets (Franzén). New Zealand used a similar system to Sweden, and access to said data improved patient adherence and medication knowledge. Health*E*Pin also has other benefits. Medical ID bracelets, a similar solution, assist emergency responders in faster, more effective responses, and Health*E*Pin would have a similar effect. Correspondingly, there are other inefficiencies this solution could address. Foraging for the patient's information requires valuable time and effort, but Health*E*Pin would streamline the process. Overall, this would reduce labor costs by cutting on time while allowing first responders to obtain the information they need quickly (Blaney-Koen). Ensuring that there is only one EHR and one medical app is, on the whole, simpler and more efficient. These two components must be implemented in conjunction. Hence, national EHR and Health*E*Pin can both cut costs and improve outcomes.

## Implementation and Limitations

The government would be responsible for implementing the national EHR and Health*E*Pin. Then, authorized providers will have access to read the info and add to it. Currently, an American EHR only contains information from a single hospital or medical center (Fennelly). Without a unified system, each healthcare provider and organization will differ. As a result, the end result will be like the current problem: incompatibility (Sninsky). Adopting a national EHR system will be no easy feat. Many steps must be taken to ensure that this system runs efficiently.

Chiefly, several critical steps include funding and development. To implement the EHR, Congress must develop a designated universal EHR system. Similarly, the government must ban EHR advertising and levy taxes. This is to prevent competing EHRs that would increase administrative burden while also funding the national EHR ("Strategy on Reducing…").

Another step is the transfer of medical information into the new national system. As of 2019, it was estimated that there are 500 EHR vendors ("Who Are the Largest…"). Correspondingly, it will take much time and effort to transfer it. Additionally, transitioning into the use of a national unified EHR system requires training. Healthcare professionals are trained in using their organization's EHR. This must take into account their goals and learning style ("5 Important Areas…"). Additionally during the transfer steps must be taken to ensure the security of this confidential information. As recent hacks such as Solar Wind have demonstrated, it is paramount that the security of such information is safeguarded. Proper

training will ensure that all possible advantages will be derived, but will admittedly require a significant initial investment.

Another aspect of implementing a new EHR system is financially incentivizing quality training. The Centers for Medicare & Medicaid Services (CMS) already incentivizes providers who demonstrate "meaningful use" of EHR (Rosiak), and this can be done for providers using national EHR as well. Not to mention, the government must facilitate the elimination of private EHR vendors. National EHR would eliminate such vendors, so the government must compensate these private companies for the elimination of their products. These incentives are to prevent lobbying against a unified, national EHR.

## Conclusion

Therefore, a national EHR combined with a personal medical QR ID is an effective solution to both healthcare costs and access. Both of those components are major issues within American healthcare, for which reform has been discussed for long periods of time. This solution serves as an incremental change that benefits patients, providers, and the government by reducing administrative burden, increasing transparency, improving efficiency, and advancing research. In exchange for implementation costs, patients and providers can obtain cheaper, more efficient care. Said benefits can result in improved outcomes, but this requires commitment and cooperation from all parties in healthcare.

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# Against Drug Testing TANF Welfare Recipients: An Overview


## Tarun Ramesh

*Tarun Ramesh is an Economics and Genetics major at the University of Georgia, interested in substance use disorder prevention and the disparate impacts of addiction epidemics on vulnerable populations. His work on opioid use disorder and rural hospital closures have been published by the Center for American Progress, the Roosevelt Institute, the Georgia Political Review, and the Undergraduate Economic Review, and his policy recommendations have been used by congressional campaigns, rural hospital boards, legislators, and correctional facilities. Tarun hopes to pursue a joint Masters in Health Economics and Medical Degree to help end the criminalization of addiction.*


Under the Personal Responsibility and Work Opportunity Act, Congress and President Bill Clinton devolved federal welfare assistance and granted states a wide latitude to implement the Temporary Assistance for Needy Families (TANF) program. The means-tested program offers states block grants to provide financial assistance and support services to eligible families. The stated goals of the program are to assist economically insecure families, end welfare dependence, reduce unmarried pregnancies, and encourage two-parent families. In 2018, states spent $31.3 billion on TANF programs, a majority ($16.6 billion) of which came from federal appropriations.

However, states are authorized to distribute funds from their block grants based on state law, highlighting heterogeneous treatment for economically insecure families. The fixed monetary formulation of block grants leads to a large variation in the assistance provided to families. For example, families receive $318 per child in Texas, but a similar family would receive $3,220 per child in Vermont. Recipients must also meet inflexible work requirements laid out by state laws. Generally, a single parent must engage in 30 hours of work-related activities per week to remain beneficiaries of the program.

Furthermore, state-led efforts to weaken the safety net have continued to exclude beneficiaries from receiving critical aid. Since the implementation of TANF, 15 states have passed legislation for drug testing or other screening for public assistance. For some of these states (e.g. Tennessee), 'reasonable suspicion' of a substance use disorder triggers a mandatory drug test,

while other states (e.g. Georgia, Oklahoma) universally drug test recipients of public assistance prior to a 2014 court ruling that deemed universal drug testing unconstitutional. Strict eligibility criteria, including the use of drug testing or crime restrictions, for TANF exclude marginalized populations and prevents funds from reaching families.

### 1. Drug testing TANF is costly with little benefit to state governments

A 2019 analysis by Think Progress found that of the 263,000 TANF applicants drug tested, only 338 people tested positive. In total, 13 states that codified drug testing for public assistance spent $200,000 for drug screening. Drug tests can cost from $35 to more than $200 each, while repeat testing and false positives can drive costs even higher. After the implementation of a universal testing law, Florida spent $118,140 in four months with a net cost of $45,780. Oklahoma's 'reasonable suspicion' law cost $74,000 in the same time period, and an Idaho Department of Health and Welfare investigation found that a drug testing program to exclude recipients would not reduce state costs by an amount equal to the cost of administering drug testing requirements.

### 2. Drug testing TANF stigmatizes individuals with substance use disorders

Excluding TANF recipients based on substance use disorders reinforces barriers to care for individuals with addiction. The American Society for Addiction Medicine has published extensive reports on how addiction is, and should be treated as, a chronic, psychiatric illness. Preventing individuals with a chronic disease from receiving public funds not only prevents individuals from receiving evidence-based treatment for their addiction but also criminalizes a public health issue.

### 3. Drug testing confused drug use with drug dependence

Using the Women's Employment Study and the National Household Survey of Drug Abuse, University of Michigan researchers found that while one-fifth surveyed reported illicit drug use only 5% had drug dependence diagnostic criteria. Considering that heroin and cocaine

metabolites can be flushed out of the system within 72 hours, a positive drug test might divert necessary and finite resources away from individuals with addiction to infrequent drug users.

### 4. Universal drug testing for public assistance is unconstitutional

In multiple cases, federal courts have found that universal, mandatory drug testing for public assistance violates the Fourth amendment. In 2011, a US District Court in *Lebron v. Wilkins* vacated Georgia and Florida laws regarding universal drug testing citing that the "state has made no showing that it would be 'impracticable' to meet these prerequisites [reasonable suspicion or probable cause] in the context of TANF recipients." District Courts in Florida and Michigan also vacated state laws that codified universal, mandatory drug testing for TANF recipients.

### 5. Drug testing TANF disproportionately impacts families of color

Drug testing TANF recipients reinforces racist stereotypes for Black and Brown families, which are deeply rooted in institutional and systemic white supremacy. Strict policing of communities of color translates to the criminalization of individuals with addiction in marginalized populations. Furthermore, racially charged dog whistle terminology such as 'welfare queen,' represents institutional justification for excluding vulnerable communities from public goods and cutting funding to welfare programs such as TANF. Policies that exclude beneficiaries rather than improving aid to families should be unconditionally rejected.

# COMMENTARY

# The Battle Over Reproductive and Women's Healthcare


## Talia Wilcox

*Talia Wilcox is a Staff Writer at the Journal of Interdisciplinary Public Policy. She is a senior at Ventura High School and will be attending Tufts University in the fall of 2021. At VHS, she plays violin in the honors orchestra and varsity tennis. Talia is a passionate social activist and is president of her school's Model United Nations Club and co-president of her school's chapter of the National Association of Students Against Gun Violence. Talia's dream job is to be the Press Coordinator to the U.S. Secretary of State.*


Contrary to popular belief, Planned Parenthood is not, as publicized by conservative media, an "abortion factory" (Carpenter). In fact, abortion services make up only 3% of Planned Parenthood's total provided services. Testing and treatment of sexually transmitted diseases (42%) and prescription of contraception (34%) comprise the bulk of its offered services (Ross). Until April 19th, 2019, Planned Parenthood was a part of Title X, the national family planning program that provided affordable and comprehensive reproductive healthcare information and services to low-income patients or those otherwise unable to afford these healthcare services.

Established as part of the Public Health Service Act in 1970, the intent of Title X was to address inequalities in access within the healthcare system to contraception and related services ("Title X") as well as to help patients advocate for themselves and their reproductive rights and decisions. Over 4 million patients rely on the healthcare services provided by Title X. Although Planned Parenthood centers comprise only 13% of the 4000 Title X-funded centers, they are responsible for servicing 41% of all Title X patients ("Title X …"). In addition to providing patient education, the Title X Family Planning Program is responsible for services such as "wellness exams, life-saving cervical and breast cancer screenings, birth control, contraception education, testing and treatment for sexually transmitted diseases (STDs) and HIV testing" ("Title X …" ). Also, due to the Hyde Amendment, passed in 1976, government funds allocated to federally funded clinics cannot be used to perform abortions (Kliff).

Despite the fact that millions of Americans rely on federally funded clinics for care, the Trump administration had taken several steps to limit their funding, curtailing reproductive healthcare rights for those who need it the most.

First, the Trump administration restored the global gag rule, also known as the Mexico City Policy. First implemented by the Reagan Administration in 1984, the policy barred "foreign organizations that receive U.S. family planning assistance from providing information, referrals or services for abortions " (Atkins). This rule has been intermittently rescinded by Democratic presidents but was restored by President Trump and renamed "Protecting Life in Global Health Assistance" in 2017; it expands the restrictions to almost all federal global health assistance programs. For example, the global gag rule gives employers the option to deny free contraceptive coverage for their employees. Failure to comply results in complete loss of funding, leaving thousands, if not millions of critical reproductive healthcare facilities to choose between continued operation and transparency on abortion procedures ("The Mexico City Policy: An Explainer"). As of late January 2021, President Biden has rescinded the Mexico City Policy (Sciubba).

Trump also implemented the Title X Gag Rule in 2019, which "bans doctors in the Title X program across the country from telling women how they can safely and legally access abortion" ("ProtectX: …"). The gag rule makes it impossible for patients under the Title X program to receive birth control at clinics such as Planned Parenthood as long as those clinics receive federal funding. Perhaps even more devastating, the gag rule "prohibits doctors from giving women full information about all of their sexual and reproductive health care options" ("ProtectX: …").

Before 2019, the vast majority of funding for Planned Parenthood came from the government, with non-governmental sources and private donors/foundations providing the rest (Ross). However, when Planned Parenthood officially pulled out of Title X in April of 2019 because of these restrictions, the resultant loss of funding was substantial—about $60 million per year (Schwiegershausen). A boon to anti-abortion groups, who have been lobbying for years about "defunding Planned Parenthood," the Title X Gag Rule and its Conservative backers rob millions of Americans of necessary reproductive health services, including general healthcare resources as well as abortions. With the loss of these services, which affects low-income patients disproportionately, the health of millions of Americans is at risk. Due to withdrawing from Title X, Planned Parenthood patients are likely to see longer wait times and be forced to pay higher prices for reproductive healthcare services, as well as significantly reduced access to birth

control (McCammon; Schwiegershausen). Also, data from the Office of Population Affairs 2019 Family Planning Annual Report showed that the number of women receiving healthcare maintenance screenings, such as for sexually transmitted infections and breast and cervical cancer, significantly decreased after Planned Parenthood left Title X (Brittni).

The Trump administration has taken several other actions that chip away at reproductive rights. In addition to the Gag Rule, Republicans expedited judicial hearings and proceedings to ensure a conservative anti-abortion majority on the Supreme Court, culminating in Justice Amy Coney Barret's confirmation in October of 2020 ("Senate Confirms Amy Coney Barrett for Supreme Court"). The death of Justice Ruth Bader Ginsberg, a champion of women's rights and the right to choose, and Coney Barrett's ascension to the court likely puts the Roe v. Wade ruling at risk (Svokos). Foreshadowing that concern, on January 12, 2021, the Supreme Court ruled 6-3, along ideological lines, to reinstate a federal requirement that requires women seeking abortion-inducing drugs to do so in person, even during the COVID-19 pandemic (Zimmermann). In response, the American College of Obstetricians and Gynecologists instituted a policy advocating for equal access to healthcare free from political intervention. In addition, U.S. District Judge Theodore Chuang of Maryland ruled that removing the mail option for these pills during a pandemic violated a woman's Constitutional right to an abortion. Despite this opposition, the FDA won the case before the U.S. Supreme Court, arguing that "in-person requirement does not impose a substantial obstacle for a woman seeking to obtain an abortion" (Zimmermann; "Title X"). Liberal Justices Sotomayor and Kagan highlighted the impact on reproductive rights in a joint opinion expressing how this new policy is "unnecessary, unjustifiable, irrational and [an] undue burden on women seeking abortion during the current pandemic" (Sotomayor).

With movements on both sides from March for Life, an anti-abortion organization, to NARAL Pro-Choice America, an organization that fights for reproductive freedom, Americans remain extremely divided over the issue of legal abortion ("About the March for Life;" "About"). According to the Pew Research Center, "a majority of Americans (61%) continue to say that abortion should be legal in all (27%) or most (34%) cases" ("U.S. Public …"). With the election of Joe Biden, the balance of power may have tipped. President Biden has eliminated the Mexico City Policy; although, analysts suggest that the reversal's full effects will take time. (Abrams) He also supports eliminating the Hyde Amendment, though that remains up to the legislature. Planned Parenthood president Alexis McGill Johnson has asked him to issue an executive order on day one rolling back the Title X Gag Rule to return the right of healthcare to millions of Americans. Abortion rights advocates have gone further, calling upon Congress to pass the

Global HER Act, which would permanently remove the rule (Lowey).

As Biden hits the ground running in his first year as President, he will need to address abortion policy within his first months as President to preserve the integrity of a woman's right to chose. Biden has promised his voters to appoint Supreme Court justices who support the landmark abortion rights case Roe v Wade. Still, only time will tell if this long-term endeavor will be as successful as former President Trump's slew of judicial appointments (Groppe). While the battle over reproductive rights and healthcare for all women, particularly low-income women, will likely continue beyond President Biden's presidency, with a Democratic President, Senate majority, and House majority, abortion advocates are hopeful for real change moving forward, protecting women's rights both now and in the future.

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# Healthcare Beyond The Binary: In Conversation with Professor and Activist Pau Crego Walters


## Gabrielle Beck

*Gabrielle Beck is a high school student at Tenafly High School in New Jersey. She is an avid analog photographer and hopes to combine her love for activism with photography. She started a research initiative with the City College of San Francisco studying trans-affirming and non-binary inclusive care needs and plans to pursue public health and public policy.*


Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) populations are disproportionately affected by limited health care access, poor health outcomes, and mistreatment in health care settings. Despite these disparities, comprehensive approaches to improve the quality of health care of LGBTQ patient populations are currently lacking. In addition, numerous states have passed a series of unprecedented legislation aimed at the trans community, such as Arkansas which has banned critical, gender-affirming medical care for transgender children, and Tennessee which has prohibited hormone treatments for transgender youth.

Publication fellow Gabrielle Beck (she/her/hers) recently sat down with Professor Pau Crego Walters (he/him/his), Deputy Director & Director of Policy and Program at the Office of Transgender Initiatives at City and County of San Francisco, Professor at the City College of San Francisco, former Lecturer at UC Berkeley School of Public Health, and trans/queer activist based in San Francisco, California, to discuss the state of healthcare for LGBTQ communities and the future for reform.

### What are the current disparities for LGBTQ communities in healthcare?

There are too many to list exhaustively, but the main point I want to make is that there's a lot of health inequities experienced by LGBTQ communities as a whole compared to the general population. In addition, there are also a lot of inequities within the LGBTQ community. For instance, it's not the same to be a Black LGBTQ person and a white LGBTQ person. There's a lot of inequities between the trans community and the rest of the LGBTQ community, or even

women who are LGBTQ versus men who are LGBTQ. It is very different based on the sub-population, but we know that if we look at LGBTQ communities as a whole, we experienced higher rates of mental health issues, substance use, including tobacco use, HIV, sexually transmitted infections, cancer, hepatitis C, and many more.

The reason for that, at least in part, has to do with social determinants of health, which are the economic and social conditions that influence differences in health status. While there are some disparities in health status for LGBTQ people compared to the general population that may have to do with different kinds of practices, the inequities we see are really about the history of oppression and the current oppression that the LGBTQ community experiences, such as barriers around immigration, the criminal justice, racism, trauma, poverty, homelessness, lack of family, and community acceptance, etc. It's a really important piece to highlight because the common misconception is that LGBTQ people are just more unhealthy, but it really is all these factors that can lead members of the LGBTQ community to sometimes engage in coping mechanisms that can be harmful to health like smoking, using substances, or engaging in behaviors that may put someone at higher risk for HIV and STIs.

**According to the Trevor Project, 42% of LGBTQ youth seriously considered attempting suicide in the past year, including more than half of transgender and nonbinary youth. In addition, more than 80% of LGBTQ youth stated that COVID-19 made their living situation more stressful — and only 1 in 3 LGBTQ youth found their home to be LGBTQ-affirming. How has the pandemic exacerbated health disparities for the LGBTQ community?**

For LGBTQ youth, a big source of stress and negative mental health issues can be a lack of acceptance in their families. I could see how COVID-19 has made young people's living situations more stressful because often families of origin, or birth families, are not accepting of LGBTQ identities, or at least not at first, but it's hard to be in a space when families are not accepting. When it's not a global pandemic and we don't have to be stuck at home, we can find other communities that feel more validating and safe. For young people as a whole, isolation and loss of community has been detrimental, but it's really key for communities like LGBTQ communities because we sometimes don't have those family-of-origin relationships to fall back on.

There are other ways in which the pandemic has exacerbated health disparities. For example, many LGBTQ people work in industries that have been affected by COVID-19, like retail, restaurants, healthcare, or education, which can lead to more exposure to COVID-19. We also know that LGBTQ people are poorer than the general population, especially Black, Indigenous, Latinx, immigrants, and trans people. COVID-19 has impacted these vulnerable sub-populations significantly because the landscape of the economy has completely changed, and folks who did not have a safety net financially before were left with even less of a safety net due to COVID-19. Not having the minimum resources to survive significantly affects your mental and physical health. There's a lot of research showing how our mental health changes the chemistry of our body, making us more vulnerable to physical health problems. Moreover, if someone has fewer economic resources, then they have fewer resources to go and get health care, even if they overcome distrust towards the system, which is particularly prominent among LGBTQ sub-populations.

**On April 6, the Arkansas state legislature passed HB 1570, the first bill in the U.S. that effectively bans trans youth from transitioning. Specifically, it bans gender-affirming care for trans youth, making it illegal for clinicians to provide hormone therapy and puberty blockers. In addition, The Human Rights Campaign has called 2021 the worst year for anti-LGBTQ legislation in recent history. What are the repercussions of the current political climate hostile to gender-affirming healthcare for the trans community?**

The repercussions are devastating. Accessing gender-affirming health care for trans people is a medical necessity. For a lot of us, it really is a life or death situation, not only for mental health reasons but also in terms of our ability to navigate spaces like school, work, and our daily lives. Sometimes people are just outright violent towards us if they perceive us as trans, but even when people have good intentions when they just don't see us for who we are, that has a devastating effect on mental health and our ability to be resilient.

The current legislation, like the one that you mentioned that has passed, but also all the proposed bills that have been popping up throughout the country, are devastating for trans people everywhere in terms of mental health to see that so many places are actually considering and wanting to take away our basic health care. It adds to our lack of safety and sense of alienation in the world. It demonstrates how tenuous trans people's basic rights are. If we think

about what would happen to communities that have dominant cultural power — this would never happen to cis, white, straight men since they would never get their rights taken away. It just speaks to the transphobia that is still present in our legal and healthcare system.

**What is the future of policy reform for the health system to provide better gender-affirming and adequate care?**

My ideal future policy reform for the healthcare system would be universal health care, because we know that when we live in communities where there is inequity, it actually impacts the entire health of the community, not just the people who have the worst outcomes. For example, we know that when there's a huge economic imbalance within a community that affects the health of everyone in that community, even the rich people. Universal healthcare is a way to equalize the current state of health to also make sure that everyone's basic needs are met.

But beyond that, the future of gender-affirming care would be mandatory training for medical providers on trans and LGBTQ health issues and needs, as well as cultural humility on how to actually provide that care. In addition, our healthcare system is deeply infused with assumptions about bodies, gender, and sexuality. For example, why do we call certain types of services women's health when not all women have those body parts and people who are not women also have those body parts, or how we talk about how babies develop in utero, in terms of sex assigned at birth and gender identity. In addition, the current healthcare system makes assumptions about people's sexualities, not just in terms of sexual orientation, but also sexual practices that could actually be related to what care somebody needs. This is all to say that there needs to be a revamping of the health system addressing those assumptions from the ground up.

In terms of gender-affirming transition level treatment, the US still has a long way to go in terms of making transition-related treatment based on self-determination and not based on gatekeeping. Currently, most places in the US have a system that requires trans people to get letters from therapists to get medical transition care to show that we are truly trans. Even after that, there are still a lot of assumptions in the process of accessing gender-affirming treatment. For example, you have to *first* take hormones, then *have* to have surgery, but there's no research to back that rigid process up. It really is about how cis people who control our healthcare system have designed it in a way that makes them feel comfortable. The last piece I'll say about transition-related treatment is there's still a lot of rhetoric around medical transition being about

"fixing" something or addressing suffering. I know that some trans people do suffer with the ways in which they want to have gender-affirming care and can't access that, but I wish that it were more based on self-determination and what someone wants and needs versus having to prove that they're suffering in order to receive treatment.

**What are the benefits and drawbacks of different policy reforms at the local, state, or federal level?**

The US is very piecemeal in terms of policy. In some ways this has some benefits because policy reform can happen at the local level where it's easier to pass legislation, and then it can go to the state level, then it can go to other states and eventually federal level. That's a really cool avenue for change, but it also has some drawbacks because individual experiences of people vary a lot based on where they live, for example, a trans person's experience in San Francisco is not the same compared to a trans person's experience in Arkansas. That is a result of the patchwork of policy differences. I wish there was a standard of basic humanity, safety, and social justice for everyone and not imply that if you're trans in this place, you're worth more than if you're trans in another place.

**How do you see change taking place in San Francisco specifically?**

San Francisco has a really inspiring and rich history of LGBTQ organizing and advocacy. Some of that developed during the HIV epidemic when San Francisco became a leader in health care for HIV and guided a lot of other parts of the country and in the world. It wasn't just the medical community, the communities who lived here also advocated for that care. That is the case with a lot of our history; we have a really strong trans organizing history here, which shines in our current work. For example, we're lucky to have the first trans cultural district in the world, and it was founded by some of our local Black trans heroes.

We have a lot of inspirational and innovative programs and policies like our sexual orientation and gender identity collection policy, all gender restroom policy, the trans housing program, and the guaranteed income pilot program for trans people, which my own office has worked to establish and continue. It's also important to note that the things that we do in San Francisco can have ramifications beyond San Francisco. We have the ability to set a precedent for other parts of California and other states, especially when our policies are successful.

There's still a lot of work to do, though. In San Francisco, we still see really high rates of homelessness, mental health issues, substance use, and poverty for LGBTQ communities, especially Black, immigrant, Latinx, and trans folks. There are also inequities for young LGBTQ people. A high proportion of our young homeless people in San Francisco identify as LGBTQ. In addition, we know that there's still a lot of work to do around older LGBTQ people and addressing their isolation, poverty, and lack of health access. I'm super grateful to see that there's a lot of change that happens here and it can be a source of hope for many other places, but I still think we need to do better. It's just an ongoing, ever-evolving process.