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.

References

"6 Reasons Healthcare Is So Expensive in the U.S." *Investopedia*, Investopedia, 29 Aug. 2020, www.investopedia.com/articles/personal-finance/080615/6-reasons-healthcare-so-expensive-us.asp.

Beaumont, Hilary. “Universal Healthcare 'Critical' in COVID-19 Pandemic: Experts.” *Coronavirus Pandemic News | Al Jazeera*, Al Jazeera, 14 Nov. 2020, www.aljazeera.com/news/2020/11/14/universal-healthcare-critical-covid-19-pandemic.

Carlson, Rosemary. “The Racial Life Expectancy Gap in the U.S.” *The Balance*, 15 Oct. 2020, www.thebalance.com/the-racial-life-expectancy-gap-in-the-u-s-4588898.

Chait, Nadia, and Sherry Glied. “Promoting Prevention Under the Affordable Care Act.” *Annual Reviews*, Apr. 2018, www.annualreviews.org/doi/full/10.1146/annurev-publhealth-040617-013534#_i5.

Chetty, Raj, et al. “The Association Between Income and Life Expectancy in the United States, 2001-2014.”

Cohn, Jonathan. *“Does Universal Health Care Suppress Innovation?” PNHP*, 21 Aug. 2017, pnhp.org/news/does-universal-health-care-suppress-innovation/.

JAMA, U.S. National Library of Medicine, 26 Apr. 2016, www.ncbi.nlm.nih.gov/pmc/articles/PMC4866586/.

“Coronavirus in the U.S.: Latest Map and Case Count.” *The New York Times*, The New York Times, 06 Mar. 2021, www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html.

“Department of Health.” *Foreign Countries with Universal Health Care*, 2011, www.health.ny.gov/regulations/hcra/univ_hlth_care.htm.

“E-16. Unemployment Rates by Age, Sex, Race, and Hispanic or Latino Ethnicity.” *U.S. Bureau of Labor Statistics*, U.S. Bureau of Labor Statistics, 08 Jan. 2021, www.bls.gov/web/empsit/cpsee_e16.htm.

Gelles, David. “The Husband-and-Wife Team Behind the Leading Vaccine to Solve Covid-19.” The New York Times, The New York Times, 10 Nov. 2020, www.nytimes.com/2020/11/10/business/biontech-covid-vaccine.html.

Horn, Chris. “COVID-19 Highlights Underlying Racial Health Disparities.” *University of South Carolina*, June 2020, www.sc.edu/uofsc/posts/2020/06/covid_health_disparities.php.

Horn, Tim. “Universal Health Care and Prescription Drug Pricing.” *Treatment Action Group*, 12 Oct. 2019, www.treatmentactiongroup.org/resources/tagline/tagline-fall-2017/universal-health-care-and-prescription-drug-pricing/.

Kamal, Rabah. “How Does Health Spending in the U.S. Compare to Other Countries?” *Peterson-KFF Health System Tracker*, 04 Jan. 2021, www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#item-spendingcomparison_health-consumption-expenditures-per-capita-2019.

King, Jaime S. “Covid-19 and the Need for Health Care Reform: NEJM.” *New England Journal of Medicine*, 24 Feb. 2021, www.nejm.org/doi/full/10.1056/NEJMp2000821.

Santhanam, Laura. “How Canada Got Universal Health Care and What the U.S. Could Learn.” *PBS*, Public Broadcasting Service, 31 Aug. 2020, www.pbs.org/newshour/health/how-canada-got-universal-health-care-and-what-the-u-s-could-learn.

Wohl, Charles I. “Letter: COVID Demonstrates Time Has Come for Single-Payer Health Care.” *The Berkshire Eagle*, 22 Dec. 2020, www.berkshireeagle.com/opinion/letters_to_editor/letter-covid-demonstrates-time-has-come-for-single-payer-health-care/article_4279b342-43aa-11eb-b997-5f3d74a6af27.html.