Endorsing Component Template Letter

Note: to be considered in the review process, this letter must be completed by the Chair and submitted by the primary author with the proposal.

Date: October 15, 2020

Chair: Renae Moch, MBA, FACMPE
President, NDPHA

APHA Component: Policy Statement Endorsement

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To the Joint Policy Committee:

With this letter I acknowledge that the component has reviewed and endorses proposal The Importance of Universal Health Care in improving our Nation's Response to Pandemics and Health Disparities.

Signed,

Renae Moch, MBA, FACMPE

Chair: Renae Moch, MBA, FACMPE,
President, NDPHA

I. **Title:** The Importance of Universal Health Care in Improving our Nation's Response to Pandemics and Health Disparities

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III. Sponsorship/co-sponsorship

This statement does not have a sponsoring unit.

IV. Collaborating units

This statement does not have collaborating units.

V. Endorsement

We are in the process of obtaining endorsements for this policy statement.

VI. Summary

The COVID-19 pandemic adds a new sense of urgency to establish a universal health care system in the United States. Our current system is inequitable, does not adequately cover vulnerable groups, is cost-prohibitive, and lacks the flexibility to respond to periods of economic and health downturns. During economic declines, our employer-supported insurance system results in millions of Americans losing access to care. While the Affordable Care Act (ACA) significantly increased Americans' coverage, it remains expensive and is under constant legal threat, making the ACA an unreliable conduit of care. Relying on Medicaid as a safety net is untenable because, although enrollment has increased, states are making significant Medicaid cuts to balance budgets. During the COVID-19 pandemic, countries with universal health care

leveraged their systems to mobilize resources and ensure testing and care for their citizens. Additionally, research shows that expanding health coverage decreases health disparities and supports vulnerable populations' access to care. This policy statement advocates for universal healthcare as adopted by the United Nations General Assembly in October 2019 where "universal health coverage implies that all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative, rehabilitative and palliative essential health services, and essential, safe, affordable, effective and quality medicines and vaccines, while ensuring that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor, vulnerable and marginalized segments of the population."[1]

Relationship to existing APHA policy statements

The following APHA policy statements support the purpose of this statement by advocating for health reform:

- APHA Policy Statement 200911: Public Health's Critical Role in Health Reform in the United States
- APHA Policy Statement 200007: Support for a new Campaign for Universal Health Care

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

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

VII. Rationale for consideration

This policy statement is relevant as a late-breaker due to the ongoing COVID-19 pandemic. COVID has wreaked havoc on the health and economy of the U.S. One particular consequence is that many Americans have lost their jobs and, as a consequence, their employer-sponsored

insurance. Without proper healthcare for all Americans, controlling the pandemic and stemming its spread becomes nearly impossible.

While the discussion of universal healthcare in the United States is not new, the COVID-19 pandemic adds a new urgency by focusing on the inaccessibility, inflexibility, and inequity in our current health system. The abnormally high demand for health care during the pandemic makes this late-breaker policy statement particularly relevant for this year's meeting.

Rather than preclude adopting universal healthcare, economic and state crises can act as a catalyst to develop more inclusive and comprehensive systems. For instance, France, Japan, and the United Kingdom moved toward universal healthcare in their recoveries after World War II and Rwanda after the 1994 genocide. Both poor and rich countries have established universal healthcare. While the COVID pandemic brings economic and public health challenges, it also provides the opportunity to reconstruct our health care system by making it more resilient, equitable, and accessible for all Americans.

VIII. Problem Statement

Background.

Discussions surrounding universal healthcare started in the 1910's in the United States and resurfaced periodically.[2] President Franklin D. Roosevelt tried twice in the 1940's to establish universal healthcare and failed both times.[2] Eventually, the U.S. Congress passed Medicare and Medicaid in the 1960's. Universal healthcare more recently gained attention during debates and eventual passage of the Affordable Care Act (ACA).[3]

To date, the U.S. government remains the largest payer of healthcare in the U.S., covering nearly 90 million Americans through Medicare, Medicaid, TRICARE, and the State Children's Health Insurance Program (SCHIP).[4] However, this coverage is not universal, and many Americans were uninsured[5] or underinsured[6] before the pandemic. The COVID pandemic has exacerbated underlying issues in our current healthcare system and highlighted the urgent need for universal healthcare for all Americans.

Health care is inaccessible for many individuals in the United States.

For many Americans, accessing health care is cost-prohibitive.[7] Coverage under employer-based insurance is vulnerable to fluctuations in the economy. During the COVID pandemic, an estimated 5.4 million Americans lost their employer-sponsored health insurance due to job loss.[8] The number could reach 10 million by December 2020.[9] When uninsured or underinsured people refrain from seeking care secondary to cost issues, this leads to delayed diagnosis and treatment, promotes the spread of COVID, and increases overall healthcare system costs.

The 2010 ACA reformed healthcare by, for instance, eliminating exclusions for pre-existing conditions, requiring coverage of ten standardized essential health care services, capping out-of-pocket expenses, and significantly increasing the number of insured Americans. However, many benefits remain uncovered. For example, The ACA did not cover optometry or dental services for adults, thereby, inhibiting access to care even among the insured population.[10]

Out-of-pocket costs can vary considerably. For example, an ACA average deductible ($3,064) is twice the rate of a private health plan average deductible ($1,478).[5] Those living with a disability or chronic illness are likely to use more health services and pay more. For example, for someone living with multiple sclerosis (MS) who requires prescription biologics to manage MS symptoms, the average out-of-pocket costs skyrocketed 12.8% per year over ten years from $372 per month to $2,673.[11]

Our current healthcare system cannot adequately respond to the pandemic and supply the care it demands.

As in other economic downturns where people lost their employer-based insurance, more people enrolled in Medicaid during the pandemic. State efforts to cover their population, such as expanding eligibility, allowing self-attestation of eligibility criteria, and simplifying the application process, also increased enrollment numbers in Medicaid.[12] The federal "maintenance of eligibility" requirements further increased the number of people on Medicaid by postponing eligibility redeterminations. While resuming eligibility redeterminations will cause some to lose coverage, many will remain eligible due to incomes continuing to fall below Medicaid income thresholds.[12]

A need for coverage during the pandemic exists. Virginia's enrollment increased by 20% since mid-March. Seventy-eight thousand people in Arizona enrolled in Medicaid and the Children's Health Insurance Program in two months.[13] In New Mexico, where 42% of the population was already enrolled in Medicaid, 10,000 more people signed up in the first two weeks of April than expected before the pandemic.[13] Nearly 17 million people who lost their jobs during the pandemic could be eligible for Medicaid by January 2021.[14]

While increasing Medicaid enrollment can cover individuals who otherwise cannot afford care, it further strains state budgets, already expecting budget shortfalls of over 20%.[15] Medicaid spending represents a significant portion of states' budgets, making it a prime target for cuts. Ohio announced $210 million in cuts to Medicaid, a significant part of Colorado's $229 million in spending cuts came from Medicaid, Alaska cut $31 million in Medicaid, and Georgia anticipates 14% reductions overall.[13]

While Congress authorized a 6.2% increase in federal Medicaid matching, this increase is set to expire at the end of the public health emergency declaration (currently set for October 23, 2020)[16] and is unlikely to sufficiently make up the gap caused by increased spending and decreased revenu.[17] Given the severity and projected longevity of the pandemic's economic consequences, many people will remain enrolled in Medicaid throughout state and federal funding cuts. This piecemeal funding strategy is unsustainable and will strain Medicaid, making accessibility even more difficult for patients.

Our health care system is inequitable.

Racial disparities are embedded in our health care system and lead to worse COVID health outcomes in minority groups. After the Civil War, a smallpox epidemic affected newly emancipated slaves. To ensure that they were healthy enough to return to plantations and prevent smallpox from spreading to white communities, Congress established the medical division of the Freedmen's Bureau.[18] This division became the first federal health care program, but it was understaffed, poorly equipped, and hospitals closed prematurely. When our nation's hospital system expanded in 1945 under the Hill-Burton Act, states gained control over federal funds' disbursement and the right to segregate facilities.[18] Similar to today, health insurance was employer-based, making it difficult to obtain for Black Americans.

Although the 1964 Civil Rights Act outlawed segregation of healthcare facilities receiving federal funding and the 2010 ACA significantly benefited people of color, racial disparities persist today in our health care system. For example, under a distribution formula set by the Department of Health and Human Services (HHS), hospitals reimbursed mostly by Medicaid and Medicare received far less federal funding from the March 2020 Coronavirus Aid, Relief, and Economic Security (CARES) and the Paycheck Protection Program and Health Care Enhancement Acts than hospitals mostly reimbursed by private insurance.[19] Hospitals in the bottom 10% based on private insurance revenue received less than half of what hospitals in the top 10% received. Medicare reimburses hospitals, on average, at half the rate of private insurers. Therefore, hospitals that low-income patients rely on received a disproportionately smaller share of total federal funding.[19]

Additional barriers for these communities include fewer and farther testing sites, longer wait times,[20] prohibitive costs, and lack of a usual source of care.[21] Black Americans diagnosed with COVID-19 are more likely to live in lower-income ZIP codes, are more likely to receive tests in the emergency department or as inpatients, and are more likely to be hospitalized and require ICU care than their white counterpart.[22] Nationally, only 20% of U.S. counties are disproportionately black but account for 52% of COVID diagnoses and 58% of deaths.[23] The pre-pandemic racial gaps in health care catalyzed the pandemic disparities and will continue to widen them in the future.

Our health care system insufficiently covers vulnerable groups.

About 14 million U.S. adults needed long-term care (LTC) in 2018.[24] Medicare, employer-based insurance, and the ACA do not cover home and community-based services long-term care (HCBS LTC). Only private long-term care insurance or a patchwork system for Medicaid-eligible recipients covers such assistance. Some states offer Medicaid buy-in HCB LTC support for adults with disabilities to help them work, though income eligibility and benefits vary by state.[25] For those paying out-of-pocket, estimated home care services average $51,480 - $52,624 per year, with adult day services at over $19,500 per year.[26] Assisted living costs an average of $48,612, and skilled nursing care is an average of $102,200 per year.

Problem Statement Summary

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

IX. Evidence-based Strategies to Address the Problem

Evidence supporting universal healthcare is mostly limited to natural experiments and examples from other countries. Countries with universal healthcare systems also struggle with containing

the COVID pandemic, however, their response and mortality outcomes are better due to a robust universal healthcare system.

Universal healthcare can increase accessibility to care.

While individuals in the United States lost health care coverage during the pandemic, those in countries with universal healthcare maintained access to care. Some European and East Asian countries continue to offer comprehensive, continuous care to their citizens during the pandemic.

Taiwan's single-payer national health insurance (NHI) covers more than 99% of its population, allowing easy access to care with co-payments at $14 for physician visits and $7 for prescriptions. On average, people in Taiwan see their physician 15 times per year.[27] They also enjoyed free Coronavirus tests and sufficient hospital isolation rooms for confirmed and suspected cases of COVID-19.[28]

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

In the United States, natural experiments comparing states that expanded adult Medicaid eligibility with states that did not associate the expansion with improved access to care, coverage, and self-reported health.[30]

Universal healthcare is a more cohesive system that can better respond to health care demands during the pandemic and in future routine care.

Leveraging its universal healthcare system, Norway began aggressively tracking and testing known contacts of individuals infected with COVID as early as February. Public health officials identified community spread and quickly shut down areas of contagion. By April 30, Norway had administered 172,586 tests and recorded 7,667 positive cases of COVID-19. Experts attribute Norway's success, in part, to its universal healthcare system.[31] Norway's early comprehensive response and relentless testing and tracing benefited their case counts and mortality outcomes.

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

Italy's universal health care system allowed them to quickly perform millions of free diagnostic tests, increase ICU bed capacity, and quickly recruit additional medical staff to avoid a shortage of health workers.[32]

Although these countries' success containing COVID varied, their universal healthcare systems allowed comprehensive responses.

Universal health care can help decrease disparities and inequities in health.

Several factors point to decreased racial and ethnic disparities under a universal healthcare model. The State Children's Health Insurance Program (CHIP) creation in 1997 covered children in low-income families who did not qualify for Medicaid; this coverage is associated with increased access to care and reduced racial disparities.[33] Similarly, differences in diabetes and cardiovascular disease outcomes by race, ethnicity, and socioeconomic status declined for previously uninsured adults once they become eligible for Medicare coverage.[34] While universal access to medical care can reduce health disparities, it does not eliminate them; health inequity is a much larger systemic issue that society needs to address.

Universal healthcare better supports the needs of vulnerable groups.

The United States can adopt strategies from existing models in other countries with LTC policies already in place. For example, Germany offers mandatory long-term disability and illness coverage as part of their national social insurance system, operated since 2014 by 131 non-profit Sickness Funds. German citizens can receive an array of subsidized LTC services without age

restrictions.[35] LTC services are also part of the publicly provided healthcare system in Sweden.[36] Korea's national long-term care program serves adults 65 and older or younger if diagnosed with dementia. 91% of those eligible use LTC services.[37] In France, citizens 60 and older receive LTC support through an income-adjusted universal program.[38]

X. Opposing Arguments/Evidence

Universal healthcare is more expensive.

Counterpoint: Modeling of single-payer universal healthcare systems estimate savings of $450 billion annually.[39] Other models estimate $1.8 trillion in savings over a ten-year period (51). Countries with universal healthcare spend between 28% - 47% per capita of what the U.S. spends (129). While modeling of universal healthcare systems in a post-pandemic U.S. is prudent prior to making any conclusions, decreased healthcare spending is a possibility.

Counterpoint: Health care services in the U.S. are more expensive than other economically comparable countries. For example, per capita spending on inpatient and outpatient care (the biggest driver of healthcare cost in the U.S.) is over two times greater even though hospital stays are shorter and physician visits fewer.[40] Overall, the U.S. spends over $5,000 more per person in health costs relative to countries of similar size and wealth.[40] 17% of the U.S. G.D.P. in 2019 was spent on healthcare; comparable countries with universal healthcare spent, on average, only 8.8%.[41]

Counterpoint: Administrative costs are lower in countries with universal healthcare.

The U.S. spends four times more per capita on administrative costs compared to similar countries with universal healthcare.[42] 9% of healthcare spending goes toward administrative costs, while others average only 3.6%. Additionally, the U.S. has the highest growth rate in administrative costs and, at 5.4%, is currently double that of other countries.[42]

Universal healthcare will lead to rationing of medical services, increases wait times, and offers inferior care to the U.S. healthcare system.

Counterpoint: The Unites States already rations health care services by excluding patients who are unable to pay for care. This entrenched rationing leads to widening health disparities. It also

increases the prevalence of chronic conditions in low-income and minority groups and, in turn, predisposes these groups to disproportionately worse outcomes during the pandemic. These issues played out to their natural end during the pandemic when limited life-sustaining resources forced doctors to ration care and scramble to develop equitable crisis standards of care.[43] The allocation of resources should be an open and public discussion, as in other countries,[44] and should not be determined by what patients can and cannot afford. This policy statement calls for high-value, evidence-based health care, which will reduce waste and decrease rationing.

Counterpoint: Opponents of universal healthcare note that Medicaid patients endure longer wait times to obtain care compare compared to privately insured patients[45] and that countries with universal healthcare have longer wait times relative to the U.S.[46] Although the U.S. enjoys shorter wait times, this does not translate into better health outcomes. For instance, the U.S. has a higher mortality rate for respiratory disease, higher maternal mortality rate, a higher premature death rate, and carries a higher disease burden than comparable wealthy countries.[47]

Counterpoint: The U.S. ranks last in measures of healthcare access and quality.[47] We also have higher rates of medical errors than countries with universal healthcare. A review of over 100 countries' healthcare systems suggests that broader coverage increases access to care and improves population health.[48]

XI. Alternative Strategies

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

State Strategies

The remaining 14 states can adopt the Medicaid expansions in the ACA, and states that previously expanded can open new enrollment periods for their state ACA marketplaces to encourage enrollment.[49] While this is a strategy, frequent legal challenges to the ACA and

Medicaid cuts make it an unreliable source of coverage in the future. Additionally, although many people gained insurance, access to care remained challenging due to prohibitive costs.

Before the pandemic, the New York state legislature began exploring universal single-payer coverage, and the New Mexico legislature started considering a Medicaid buy-in option.[50] These systems would only cover residents of a particular state and remain susceptible to fluctuations in Medicaid cuts.

Federal Government Strategies

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

An additional option for the federal government is to cover the full costs of Medicaid expansion in the 14 states yet to expand coverage. If states increased expansion and enforced existing ACA regulations, nearly all Americans could gain health insurance.[51] This alternative is risky, however, due to frequent legal challenges to the ACA. Furthermore, high costs to access care would continue to exist.

XII. Action Steps

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

1. Urges Congress and the President to recognize universal healthcare as a right
2. Urges Congress and the President to enact a comprehensive universal healthcare system accessible and affordable for all residents; is not dependent on employment, health status,

or income; emphasizes high-value, evidence-based care; includes automatic and mandatory enrollment; minimizes administrative burden.

3. Urges the Department of Health and Human Services (HHS), the Agency for Healthcare Research and Quality (AHRQ), the National Institutes of Health (NIH), academic institutions, researchers, and think tanks to examine equitable access to health care, including the provision of long-term care, dental care, and vision care
4. Urges Congress, national health care leaders, academic institutions, hospitals, and each person living in the United States to recognize the harms caused by institutionalized racism in our health care system and collaborate to build one that is equitable and just.
5. Urges Congress to mandate Federal Register "Standards for Accessible Medical Diagnostic Equipment" to meet the everyday health care physical access challenges of children and adults with disabilities.
6. Urges national healthcare leaders to design a transition strategy that communicates the impact of a universal healthcare system on individuals, hospitals, healthcare companies, healthcare workers, and communities.

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