

Single-Payer Health Reform: A Step Toward Reducing Structural Racism in Health Care

Dominic F. Caruso, MD/MPH Candidate; David U. Himmelstein, MD; Steffie Woolhandler, MD

Racial and income equality are too often absent from conversations about health care financing. Research continually exposes alarming health disparities in the United States, particularly impacting African Americans and Native Americans. These groups have lower life expectancies than non-Hispanic white Americans, and

experience higher rates of most major causes of death including infant mortality, trauma, heart disease, and diabetes.^{1,2,3,4,5,6,7} Yet despite their greater need, access to care is worse for minority populations by most measures.⁸

Unequal medical care is often viewed as a consequence of broader social inequalities, but the current health financing system also

¹ QuickStats: Life expectancy at birth, by sex and race/ethnicity — United States, 2011. (2014, September 5). Retrieved February 28, 2015, from the Centers for Disease Control and Prevention: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6335a8.htm>

² Indian health disparities. (2015, January). Retrieved February 28, 2015, from the Indian Health Service: http://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/factsheets/Disparities.pdf.

³ QuickStats: Infant mortality rates,* by race and Hispanic ethnicity of mother — United States, 2000, 2005, and 2009. (2013, February 8). Retrieved February 28, 2015, from the Centers for Disease Control and Prevention: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6205a6.htm>.

⁴ MacDorman, M. F., & Mathews, T. J. (2011). *Understanding racial and ethnic disparities in U.S. infant mortality rates*. Hyattsville, MD: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. Retrieved February 28, 2015,

from the Centers for Disease Control and Prevention: <http://www.cdc.gov/nchs/data/databriefs/db74.pdf>

⁵ Wong, M. D., Shapiro, M. F., Boscardin, W. J., & Ettner, S. L. (2002). Contribution of major diseases to disparities in mortality. *New England Journal of Medicine*, *347*(20), 1585-1592.

⁶ Murphy, S. L., Xu, J., & Kochanek, K. D. (2013). Deaths: final data for 2010. *National Vital Statistics Reports*, *61*(4), 1-117

⁷ Veazie, M., Ayala, C., Schieb, L., Dai, S., Henderson, J. A., & Cho, P. (2014). Trends and disparities in heart disease mortality among American Indians/Alaska Natives, 1990–2009. *American Journal of Public Health*, *104*(S3), S359-S367.

⁸ Mead, H., Lara, C., Jones, K., Ramos, C., Woods, K., & Siegel, B. (2008). *Racial and Ethnic Disparities in U.S. Health Care: A Chartbook*. New York and Washington DC: The Commonwealth Fund. Retrieved February 28, 2015, from The Commonwealth

Fund: http://www.commonwealthfund.org/usr_doc/mead_raceethnicdisparities_chartbook_1111.pdf

reinforces and institutionalizes inequality; unequal care may be viewed as a form of structural racism.

While most Americans rely on private insurance, rates of private coverage are much lower for minorities and the poor.⁹

The Patient Protection and Affordable Care Act (ACA) offered subsidies to expand private coverage, making insurance more affordable for many families. However, many of these new private plans carry high deductibles and co-payments. Deductibles for the ACA's bronze and silver plans average over \$5000 and \$2900, respectively, for single coverage, and over \$10,000 and \$6,000, for family coverage.¹⁰

Deductibles have also soared in employer-sponsored plans; in 2014, more than 40% of such plans carried a deductible of more than \$999, up from just 10% in 2006.¹¹ Moreover, while Medicaid traditionally imposed virtually no cost-sharing, several conservative state governors have extracted

waivers from the Centers for Medicare and Medicaid Services allowing the imposition of cost-sharing on recipients as a condition for implementing the ACA's Medicaid expansion.^{12, 13}

High cost-sharing particularly impacts minority families, whose average incomes are far lower than those of non-Hispanic whites. Yet even figures on income disparities understate minorities' disadvantage when confronted with high out-of-pocket costs. With medical bills often reaching into the thousands for even routine care such as childbirth and appendectomy, many families must tap savings or other assets like housing equity, and racial/ethnic disparities in assets dwarf the differences in income.¹⁴ African American and Hispanic median household income was 58 percent and 70 percent, respectively, that of non-Hispanic whites in 2011.¹⁵ In contrast, the median net worth of black and Hispanic householders was \$6,314 and \$7,683, respectively, vs. \$110,500 for non-Hispanic

⁹ Todd, S. R., & Sommers, B. D. (2012). *Overview of the uninsured in the United States: a summary of the 2012 Current Population Survey report*. Retrieved February 28, 2015, from the U.S. Department of Health and Human Services: <http://aspe.hhs.gov/health/reports/2012/uninsuredintheus/ib.cfm>

¹⁰ Goodnough, A., & Pear, R. (2014, October 17). Unable to meet the deductible or the doctor. *The New York Times*. Retrieved February 28, 2015, from The New York

Times: http://www.nytimes.com/2014/10/18/us/unable-to-meet-the-deductible-or-the-doctor.html?_r=0

¹¹ Claxton, G., Rae, M., Panchal, N., Damico, A., Bostick, N., Kenward, K., & Whitmore, H. (2014). *Employer health benefits 2014 annual survey*. Retrieved February 28, 2015, from The Henry J. Kaiser Family

Foundation: <http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report>.

¹² Dickson, V. (2015, January 5). CMS gives Arkansas, Iowa more leeway in Medicaid expansion

waivers. Retrieved February 28, 2015, from Modern Healthcare: <http://www.modernhealthcare.com/article/20150105/NEWS/301059960/cms-gives-arkansas-iowa-more-leeway-in-medicaid-expansion-waivers>

¹³ Erb, R. (2013, December 31). Michigan wins ok for Medicaid expansion that requires sharing of costs. *Detroit Free Press*. Retrieved February 28, 2015, from Detroit Free Press: <http://archive.freep.com/article/20131230/NEWS06/312310022/Medicaid-Healthy-Michigan-approval>

¹⁴ Hsia, R. Y., Kothari, A. H., Srebotnjak, T., & Maselli, J. (2012). Health care as a "market good"? Appendicitis as a case study. *Archives of Internal Medicine*, 172(10), 818-819.

¹⁵ Race and Hispanic origin of householder—households by median and mean income. (2014, September 16). Retrieved February 28, 2015, from United States Census

Bureau: <https://www.census.gov/hhes/www/income/data/historical/household/>

whites, a 15-fold difference.¹⁶ Hence, the average family deductibles for bronze and silver plans would bring financial ruin to most African American and Hispanic households. Even the lower cost-sharing now increasingly common under Medicaid may be prohibitive for poor families, many of whom have zero or negative net worth.

The ACA's drafters erred in relying on private, for-profit insurers to fund health care. Health insurance's social purpose is to pay for care in order to promote access to health services and prevent financial hardship. For-profit insurers' purpose is to maximize shareholders' profits, a goal that provides strong incentives to maximize premiums and minimize the health care they pay for. Historically, this incentive led to such practices as denying coverage for pre-existing conditions and canceling policies for expensive enrollees. Although the ACA prohibits these tactics, recent evidence indicates that insurers are finding ways to subvert these regulations, e.g. through tiered pharmacy benefits that discriminate against enrollees with potentially expensive illnesses such as HIV, Parkinson's, seizures, psychosis and diabetes.^{17,18}

The persistence of our corrupt and irrational insurance system may stem in part from the way Americans (and particularly health professional students) are taught to think about health care. In a recent conversation with a Canadian student at Harvard's school of public health, he expressed surprise that many of his U.S. classmates perceive health care interactions as business transactions, and reflected that Canadians, who have a publicly-funded universal coverage system, view health care as a fundamental right to be provided for all.

Should we in the U.S. continue to treat health care as a commodity distributed according to financial ability, or shift to a financing system that assures it as a right equally available to all without regard to income, health status, race or ethnicity? While market theorists might claim that a commodity-based approach to care breeds efficiency, facts on the ground argue otherwise. At present, we have the world's highest per-capita health care expenditures, yet tens of millions remain un- and under-insured, and our health outcomes trail most other wealthy nations.^{[9]19,20,21}

This isn't just an indication of failed policy, it's a national embarrassment. We have the

¹⁶ Net worth and asset ownership of households: 2011. (2014, August 20). Retrieved February 28, 2015, from United States Census

Bureau: <http://www.census.gov/people/wealth/>

¹⁷ Jacobs, D. B., & Sommers, B. D. (2015). Using drugs to discriminate—adverse selection in the insurance marketplace. *New England Journal of Medicine*, 372(5), 399-402.

¹⁸ Oster, G., & Fendrick, A. M. (2014). Is all "skin in the game" fair game? The problem with "non-preferred" generics. *The American Journal of Managed Care*, 20(9), 693-695

¹⁹ Himmelstein, D. U., Thorne, D., Warren, E., & Woolhandler, S. (2009). Medical bankruptcy in the

United States, 2007: results of a national study. *The American Journal of Medicine*, 122(8), 741-746.

²⁰ Davis, K., Stremikis, K., Squires, D., & Schoen, C. (2014). *Mirror, mirror on the wall, 2014 update: How the US health care system compares internationally*. New York and Washington DC: The Commonwealth Fund. Retrieved February 28, 2015 from The Commonwealth

Fund: http://www.commonwealthfund.org/~media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf.

²¹ U.S. Burden of Disease Collaborators. (2013). The state of US health, 1990-2010: burden of diseases, injuries, and risk factors. *The Journal of the American Medical Association*, 310(6), 591-606

resources to provide everyone in the U.S. with access to health care. And Canada provides a working model for how to put those resources to good use: a public, single-payer, national health insurance program, similar to an expanded and improved Medicare for all.

In our view a national single-payer health insurance program offers the best possibility for equitable financing of U.S. health care. It would eliminate the motive to deny needed care or discriminate against the expensively ill for the sake of profit. A national public insurance system would provide coverage based on residence in the U.S., not employment status, income level or ability to pay, as in the current regime. A program that abolished co-payments and deductibles would level the playing field for minorities and the poor who generally lack the assets to surmount these barriers.²²

A single-payer system would also offer economic benefits. A federally-run financing system would have far lower administrative costs than private insurance, as the Medicare program consistently demonstrates. A universal public model would lift a significant financial burden from businesses that currently fund health insurance for their employees. Finally, a single-payer program would largely eliminate the financial burden of illness, a leading cause of bankruptcy and debts sent to collection.^{19],23}

Perhaps most importantly, a single-payer system would make a clear statement that

health care is a human right. This framework recognizes health care as a universal necessity, not a commodity reserved for those lucky enough to have won the economic lottery, and most definitely not a scheme for denial and discrimination. While implementing a single-payer insurance program will not solve all of our nation's health, racial or social inequities, it is clearly a step in that direction.

²² Physicians' Working Group for Single-Payer National Health Insurance. (2003). Proposal of the physicians' working group for single-payer national health insurance. *The Journal of the American Medical Association*, 290(6), 798-80

²³ Khazan, O. (2014, October 8). Why Americans are drowning in medical debt. Retrieved February 28, 2015, from The Atlantic: <http://www.theatlantic.com/health/archive/2014/10/why-americans-are-drowning-in-medical-debt/381163/>