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PERSPECTIVE

The Equity Effect of Universal Health Care

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For well over a century, the politics of universal health care have shaped the development of modern welfare states and their ability to manage economic inequality. Whether governments adopt universal health care in response to workers' struggles, capitalist labor demand, or other factors, universal health care tends to advance economic redistribution.[1] This equity effect of universal health care is often overlooked, including in the human rights field.[2] Although right to health standards are clear on states' obligation to finance health care equitably, along with providing universal access to quality health facilities, goods, and services, the distributional impact of a universal system has received less consideration.[3] I propose that right to health advocates embrace universal health care as a redistributive project that can help advance not only the right to health but also economic equality. Both are deeply intertwined.

The United States presents a prime example. It is one of the most unequal wealthy countries, where resources are concentrated in the hands of a few while millions struggle to access basic economic and social rights. The top 10% of US households own approximately 70% of the total wealth, and the typical white family is about ten times wealthier than the typical Black family.[4] Life expectancy and health outcomes are below average, compared to other OECD countries, yet health expenditure is the highest.[5] Despite spending twice as much per capita on health as Canada or France, the pre-COVID-19 mortality rate from treatable causes was over a third higher in the United States than in Canada and twice as high as in France.[6] While poor and unequal health outcomes point to health system failures, economic and social structures are key underlying factors. The pandemic brought this into sharp focus: COVID-19 mortality has been positively associated with country-level income inequality.[7] The United States has among the highest COVID-19 mortality rate in the world, disproportionately affecting Black, Indigenous, and low-income populations.[8] Economic and social inequalities drive much of this unconscionable toll on human lives. A large body of research confirms that societies with greater income inequality have poorer health outcomes.[9]

But if economic inequality is at the root of poor health outcomes, does the health care system matter? It does. Inequalities are maintained and reproduced by the systems and institutions that organize

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our lives. In the United States, these are racialized, commodified systems that control access to human rights according to factors such as income, wealth, race, and gender. The largest of these systems is market-based health care, controlled by a powerful medical industrial complex. At 18.3% of GDP in 2021, the US health sector has a greater share of the economy than in comparable countries, whose average is less than 12% of GDP.[10] Shifting the US health care system out of the market and toward universal public provision and public financing would catalyze structural economic changes and facilitate the decommodification of other economic and social rights.

Fifteen years ago, at the beginning of the Obama presidency, I wrote in these pages about emerging US advocacy efforts to treat health care as a right and a public good, rather than a commodity.[11] A growing number of right to health advocates had been pushing for free and equal access to care for all. Our vision centered the right of everyone to get the health care they need, when and where needed, financed publicly through progressive taxation. The focus on the right to care, rather than a right to coverage, revealed and responded to the layers of inequity and control produced by intermediaries, from insurance companies to employers. Unfortunately, Obama's signature reform, the Affordable Care Act of 2010, took a different approach. It established private insurance "marketplaces," thereby entrenching the hold of insurance companies on people's access to care. An increase in households covered by insurance was nullified by deductibles, user fees, and claim denials, leaving two-thirds of insured people struggling to access care.[12]

As advocates shifted their attention to state-level reforms, I shared Vermont's "Healthcare Is a Human Right" campaign's financing proposal, a progressive tax mix that would have reduced wage disparities and raised the incomes of all but the wealthiest households.[13] The campaign spearheaded a narrative shift, subsequently popularized by Senator Bernie Sanders. His two presential runs centered on health care as a human right and a lever for advancing economic equality.

When the COVID-19 pandemic exposed shocking gaps in preventive and primary care, and stark inequities in access and outcomes, the days of market-based health care seemed to be numbered. Universal health care, it was estimated, could have saved 212,000 lives in 2020 alone.[14] Today, however, market-based US health care continues to be a global flagship for the neoliberal economic model and its entrenched inequities.

The tentacles of economic neoliberalism reach deep into health systems around the world. While the United States is unique among its peers in refusing to provide universal access to health care, many universal health systems, conceived at the height of the welfare state era, are under intense pressure from privatization and prolonged resource deprivation.

Where do human rights advocates go from here? Below, I offer three guiding questions, addressing health care financing, delivery, and governance, to promote a shift in approach. While I focus on US conditions, these questions can be applied to any system exposed to capitalist market imperatives.

1. Who pays?

The concept of "single payer" has long served as a stand-in for the goal of universal health coverage in the United States. It describes the consolidation of all payers—private, public, and employers—into one government payer, primarily to increase efficiency and generate savings for coverage expansion. Hence, the key question for single-payer advocates is "How much does it cost?" While countless studies have confirmed that a universal health system will cost less than the fragmented, exorbitantly expensive market-based system, neither aggregate nor average savings are particularly meaningful to lower-income families that are disproportionately

burdened by health care costs.[15] By shifting the question to "who pays," we can identify and prioritize the distributional effects of various financing models.

Market-based health care, anchored by the for-profit insurance industry, is financed regressively, primarily through premiums and user fees. This produces an inverse correlation between household income and household health care expenditure, resulting in lower-income people spending a greater income share on health care than the wealthy. This is not merely a reflection of existing income disparities but a regressive effect of the financing design and payment mechanisms. Although much of US health care is already publicly subsidized, the flow of public funds is largely obscured. For-profit companies have all but taken over the two main public programs, Medicaid and Medicare, which primarily serve poor people and those aged 65 or older, respectively. The majority of Medicaid recipients are enrolled in so-called managed care organizations, with five publicly traded for-profit companies accounting for half of all enrollment.[16] Similarly, over half of all Medicare beneficiaries have bought private "Medicare Advantage" plans, which generate the highest profit margins in the industry through strategies such as limiting provider networks and requiring prior authorization for accessing certain types of care.[17] In addition to public programs, the single largest federal tax expenditure is the tax exclusion for employer-sponsored health insurance, which costs more than US$300 billion annually.[18] It benefits high-earning taxpayers the most, providing them with a net subsidy for their insurance coverage.[19] Additionally, the effect of financial risk protection generated by the insurance model is regressive, as it is of greater value to wealthier households.

In contrast, a universal, publicly financed health care system that provides free access at the point of care generates both aggregate savings and redistributive impacts. It flips who pays for health care: those who make more pay more. How big this equity effect is depends on the progressivity of the financing design. For example, the Medicare for All Act, introduced by Senator Sanders in 2017, could sharply reduce health care payments for families in the bottom 80% of income, while removing subsidies for the top 20% of earners.[20] This would also narrow racial and gender income gaps, since people of color and women are overrepresented among lower-income groups. According to a set of financing proposals—not entailed in the bill—middle-income families would pay, on average, an estimated 2.6% to 14% less for health care than in the current system, while high-income households would pay 3.9% to 5.6% more (depending on their current insurance status).[21] Several state-level universal health care proposals, introduced in the past decade, illustrate similar redistributive effects. By ensuring that top earners contribute according to their means, publicly financed systems can deliver significant financial relief to low- and middle-income families and narrow the income gap. Questioning "who pays" will allow right to health advocates to achieve the maximum redistributive effect within a framework of adequate and equitable revenue generation.

2. Who has ownership?

The ownership of hospitals, specialist clinics, physicians' practices, pharmaceutical companies, and other health care facilities has rarely been questioned in the United States—until the recent wave of corporate mergers, private equity takeovers, and hospital closures. Private equity firms have spent around US$750 billion over the last decade acquiring and consolidating health care facilities, leading to higher prices and worse health outcomes.[22] The pharmaceutical industry is failing to produce essential medicines, prioritizing more profitable drugs. Amid the rapid corporatization of

both for-profit and nonprofit health facilities, the longtime advocacy demand of "publicly financed, privately delivered" health care has been overtaken by the dynamics of advanced capitalism. Insurance companies are no longer the only profiteers jeopardizing people's access to care. By raising the question of public ownership alongside public financing, we can begin to talk about a national health service, with public hospitals, publicly employed doctors, and publicly owned pharmaceutical facilities.

In a country built on a racialized system of property ownership, nationalizing health care is not going to be an easy feat. The logic of private ownership drives economic, racial, and gender inequities and substitutes for the missing welfare state. When government fails to provide public goods to meet everyone's needs, private property becomes the route to economic security, albeit a route largely blocked for many, especially people of color and women. Those identifying as property owners and consumers, not rights holders, tend to limit their expectations of government to the maintenance of functioning markets.

What would it take to transform market-based health care, undergirded by the private property regime, into a publicly owned and operated system that provides health care as a public good? Some US advocates are looking to the Veterans Affairs health system as a model, a publicly funded, owned, and operated system that is lauded for its quality health outcomes.[23] They have crunched the numbers on a federal buy-out of investor-owned health facilities.[24] The question of "how we seize ownership of health care assets from the corporations that have come to dominate them" is bold but necessary.[25] It underscores the need for a broad-based popular movement, united through human rights.

3. Who governs?

In an era of concentrated corporate power and democratic decline, the governance question takes on new urgency. It is not acceptable that corporate actors make decisions about health care affordability, accessibility, availability, and quality. Although dependent on public funding, these corporations use their market power to circumvent regulations and evade accountability. Limited consumer and patient rights cannot counterbalance the rights of shareholders to reap profits from what should be an essential public service.

But the system, at least in the United States, may be eroding from within. The extreme pressures of market-driven health care are pushing both health care workers and "consumers" to question the legitimacy of corporate rule. The financial bottom line determines care provision even in nonprofit facilities.[26] Across the system, doctors and nurses are flagging their "moral injury" as they are forced to put profits over patients.[27] People are encountering the limits of their consumer rights when high-level decisions cause them to lose access to vital services, such as reproductive care. At the same time that faceless investors and stock market algorithms tighten their grip on health governance, health care reemerges as a moral claim—and a human right.

The human rights framework empowers all of us to participate in the decisions that affect our lives. But to exercise this power, we will need to reshape democratic governance to become both inclusive and meaningful. People systematically excluded from decision-making must gain a seat at the table. The right to participation must extend to co-creation, co-governance, and co-ownership of public services and infrastructure. This propels us into the realm of economic democracy, the rebalancing of power in the economic sphere. In health care, which depends on a centralized funding pool to cross-subsidize different levels of need, new governance models may have to strike a balance between system-wide and community-level decision-making, mindful that all decisions have racialized and gendered impacts. If we elevate hu-

man rights principles as guardrails for governance, we obtain a basic framework for the democratization of health care.

Human rights advocates may point out that international right to health standards do not prescribe redistribution, public ownership, or co-governance. But these standards do obligate us to make progress toward a clear and compelling outcome. Change starts with the desired result: if everyone—not just the wealthy and otherwise privileged—is to enjoy the highest attainable standard of health, the pursuit of economic equality must be at the heart of our efforts.

References

1. World Health Organization, *The World Health Report 2010: Health Systems Financing; The Path to Universal Coverage* (Geneva: World Health Organization, 2010).

2. I use the concept of equity/inequity to emphasize the dynamics of difference (e.g., differential needs or inputs necessary to achieve a just distribution) and equality/inequality when describing a status of outcomes.

3. Human Rights Council, Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Interim Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, UN Doc. A/67/150 (2012), paras. 1, 5, 9.

4. A. Hernández Kent and L. R. Ricketts, "The State of U.S. Wealth Inequality," Federal Reserve Bank of St Louis (July 31, 2023), https://www.stlouisfed.org/institute-for-economic-equity/the-state-of-us-wealth-inequality.

5. Organisation for Economic Co-operation and Development, *Health at a Glance 2021: OECD Indicators* (Paris: OECD Publishing, 2021).

6. Ibid.

7. E. R. Sepulveda and A.-S. Brooker, "Income Inequality and COVID-19 Mortality: Age-Stratified Analysis of 22 OECD Countries," *SSM - Population Health* 16 (2021).

8. Johns Hopkins Coronavirus Resource Center, "Mortality Analysis" (March 2023), https://coronavirus.jhu.edu/data/mortality; N. Ndugga, L. Hill, and S. Artiga, "COVID-19 Cases and Deaths, Vaccinations, and Treatments by Race/Ethnicity as of Fall 2022," KFF (November 2022).

9. See, e.g., K. E. Pickett and R. G. Wilkinson, "Income Inequality and Health: A Causal Review," *Social Science and Medicine* 128 (2015); P. Matthew and D. M. Brodersen, "Income Inequality and Health Outcomes in the United States: An Empirical Analysis," *Social Science Journal* 55/4 (2018).

10. M. McGough, I. Telesford, S. Rakshit, et al., "How Does Health Spending in the U.S. Compare to Other Countries?," Peterson-KFF Health System Tracker (February 2023), https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/.

11. A. Rudiger, "From Market Competition to Solidarity? Assessing the Prospects of US Health Care Reform Plans from a Human Rights Perspective," *Health and Human Rights Journal* 10/1 (2008).

12. K. Pollitz, K. Pestaina, A. Montero, et al., "KFF Survey of Consumer Experiences with Health Insurance," KFF (June 2023).

13. A. Rudiger, "Human Rights and the Political Economy of Universal Health Care: Designing Equitable Financing," *Health and Human Rights Journal* 18/2 (2016).

14. A. P. Galvani, A. S. Parpia, A. Pandey, et al., "Universal Healthcare as Pandemic Preparedness: The Lives and Costs That Could Have Been Saved during the COVID-19 Pandemic," *Proceedings of the National Academy of Sciences* 119/25 (2022).

15. For cost savings of universal health care, see, e.g., R. Pollin, J. Heintz, P. Arno, et al., *Economic Analysis of Medicare for All* (Amherst: Political Economy Research Institute, University of Massachusetts, 2018), p. 91; A. P. Galvani, A. S. Parpia, E. M. Foster, et al., "Improving the Prognosis of Health Care in the USA," *Lancet* 395/10223 (2020).

16. J. Ortaliza, A. Krutika, C. Cox, et al., "Health Insurer Financial Performance in 2021," KFF (February 2023).

17. A. Cottril, J. F. Biniek, T. Neuman, et al., "What to Know about the Medicare Open Enrollment Period and Medicare Coverage Options," KFF (September 2023).

18. Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under 65: 2022 to 2032* (June 2022).

19. Pollin et al. (see note 15), p. 90.

20. Ibid., p. 91.

21. Ibid., pp. 89–90.

22. R. M. Scheffler, L. M. Alexander, J. R. Goodwin, *Soaring Private Equity Investment in the Healthcare Sector: Consolidation Accelerated, Competition Undermined, and Patients at Risk* (University of California, Berkeley: 2021).

23. D. U. Himmelstein, S. Woolhandler, A. Gaffney, et al., "Medicare for All Is Not Enough. Communities, Not Corporations, Should Own Our Most Vital Health Care assets," *Nation* (March 31, 2022), https://www.

thenation.com/article/economy/healthcare-corporations-private-equity.

24. S. Woolhandler and D. Himmelstein, "Aligning House and Senate Single-Payer Bills: Removing Medicare's Profiteering Incentives Is Key," *Health Affairs* (November 19, 2018).

25. Himmelstein et al. (see note 23).

26. D. Jenkins and V. Ho, "Nonprofit Hospitals: Profits and Cash Reserves Grow, Charity Care Does Not," *Health Affairs* 42/6 (June 2023).

27. E. Press, "The Moral Crisis of America's Doctors," *New York Times* (June 15, 2023), https://www.nytimes.com/2023/06/15/magazine/doctors-moral-crises.html; National Nurses United, *Deadly Shame. Redressing the Devaluation of Registered Nurse Labor Through Pandemic Equity* (December 2020).