I. Title: Adopting a Single-Payer Health System

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III. Sponsorship

This proposed policy statement was co-sponsored and submitted on behalf of the Medical Care and Pharmacy sections.

IV. Endorsements:

Caucus on Homelessness
Occupational Health and Safety
Oral Health

V. Summary

Healthcare is a human right. Achieving universal health coverage for all US residents requires significant system-wide changes to financing healthcare. The best, most efficient, equitable health system is a public, single-payer (SP). The rapid growth in national health expenditures can be addressed through a system that yields net savings over projected trends by eliminating profit and waste.

With universal coverage, providers can focus on optimizing triage of services, rather than working within a system covered by payers who have incentives to limit costs regardless of benefit. Rather with SP, the people act as their own insurer through a partnership with provider organizations where tax dollars work for everyone. Consumer choice is then based on best care to meet needs with no out-of-pocket payments. SP is the best option to ensure equity, fairness, and priorities aligned with medical needs, providing incentives for wellness. Consumer choice will drive market forces, not provider network profits or insurer restrictions. This approach benefits public health, as everyone will have universal access to needed care, with treatment plans developed by providers based on what works best for the patient. Clinics and hospitals will be free to provide appropriate treatments based on need. Hospitals will accept all patients, with all care reimbursed equally for all. Resolving the great discrepancy in coverage for mental health and substance use disorders compared with medical and surgical services is more likely in a SP model where equity rather than profitability is a core principle.

Patients will partner in their care, receiving diagnosis, treatment, and prevention without facing cost barriers. We will build a healthier nation, saving lives and reducing financial burdens while addressing inequities rooted in social, demographic, mental health, economic, and political conditions.

VI. Relationship to existing American Public Health Association (APHA) policy statements

The proposed policy is an update and extension to the following statements by APHA:

- APHA Policy Statement 20007: Support for a New Campaign for Universal Health Care
- APHA Policy Statement 200911: Public Health's Critical Role in Health Reform in the United States
- APHA Policy Statement LB7 2020: Universal Health Care in Response to Pandemics and Health Disparities

The proposed policy is supported by the following previous statements by APHA:

- Archived APHA Policy Statement 6922: A Medical Care Program for the Nation
- Archived APHA Policy Statement 7018: A National Program for Personal Health Services

- Archived APHA Policy Statement 7107: National Health Insurance - A Choice Between Imperfect Alternatives
- Archived APHA Policy Statement 7124(PP): Health Maintenance Organizations
- Archived APHA Policy Statement 7405: Long Term Care Under National Health Insurance
- Archived APHA Policy Statement 7601: Committee for a National Health Service
- Archived APHA Policy Statement 7602: Health Insurance for Preventive Services
- Archived APHA Policy Statement 7605: Establishment of a National Health Service
- Archived APHA Policy Statement 7609: A Sound Basis for a National Health Program
- Archived APHA Policy Statement 7628(PP): Improving the Organization and Financing of Ambulatory Preventive and Primary Health Services in Today's Economy
- Archived APHA Policy Statement 7734(PP): Criteria for Assessing National Health Service Proposals
- Archived APHA Policy Statement 7809: National Health Insurance
- Archived APHA Policy Statement 7901: Vision Care in a National Health Program
- Archived APHA Policy Statement 8804: State Health Care Initiatives for the Medically Uninsured
- Archived APHA Policy Statement 9418: Children with Special Health Care Needs under Health Care Reform
- Archived APHA Policy Statement 9502: Toward a Comprehensive Universal National Health Program
- Archived APHA Policy Statement 9702: Protecting Health Care Accessibility and Quality in a Profit-Oriented Marketplace
- Archived APHA Policy Statement 9716(PP): The Issue of Profit in Health Care
- APHA Policy Statement 9934(PP): Protecting and Strengthening Medicare: Financing and Prescription Drug Issues (Position Paper)
- APHA Policy Statement 20006: Making Medicines Affordable: the Price Factor (Position Paper)
- APHA Policy Statement 201013: American Public Health Association Child Health Policy for the United States
- APHA Policy Statement 20111: Improving Access to Over the Counter Contraception by Expanding Insurance Coverage
- APHA Policy Statement 20153: Universal Access to Contraception
- APHA Policy Statement 20189: Achieving Health Equity in the United States

VII. Rationale for Consideration

APHA has a long history of support for a single payer (SP) universal healthcare system. In both policies and practice, its members, leaders, and statements have recognized this approach as the best model for advancing public health principles. This policy aims to reinforce that position with up-to-date context and an urgent call to action. The passing of the Patient Protection and Affordable Care Act (ACA) in 2010 represented a critical step toward increasing insurance coverage, particularly in states that agreed to expand Medicaid coverage. However, opportunities remain to integrate payment mechanisms or rein in administrative waste, instead offering incentives for private payers to provide eligible low-cost plans through state-level marketplaces.

Now, the need for SP is more relevant and pressing than ever. The proportion of those without health insurance spiked during the economic hardship associated with the SARS-CoV-2 pandemic; the degree of health disparities and the income gap continue to widen further in the United States (US). Our reliance on an employer-based coverage strategy must be seriously reconsidered, in light of the economic and demographic disparities in coverage that result. Private payer employment-based insurance and private for-profit insurance must be abandoned, given the inefficient scale of administrative costs associated with the current system. SP is the single best approach to address the problems in the US healthcare industry. Further incremental steps are not an acceptable alternative, but rather a major source of the problems in the system. Therefore, this statement reaffirms the unity of the APHA members and leadership around the principals of universal coverage and single-payer payment reform.

VIII. Problem Statement

A. Rising Per Capita Costs of Healthcare in the US

National Health Expenditure (NHE) in the US grew by 4.6% in 2018, to US$ 3.65 trillion, or US$ 11,172 per capita.[1] This accounted for 17.7% of the Gross Domestic Product (GDP) at the time.[1,2] The US spends the most by far on healthcare among all 36 countries in the Organization for Economic Cooperation and Development (OECD), both as a proportion of GDP and per capita.[3,4] Despite using fewer healthcare resources, the US spends US$ 2,000 more per person than the next highest-spending country, Switzerland, and nearly twice as much per capita on healthcare as the median for OECD countries.[3,5] The pricing system is inherently the single greatest driver of healthcare costs, while providing fewer key health resources.[3] There is also a large and widening gap in the prices which public and private payers are charged for identical services, which indicates that the rising total NHE is primarily driven by private healthcare insurers[3] and pharmaceutical expenditures in particular.[6]

B. US Pharmaceutical Expenditures

US prescription drug expenditures reached US$ 335 billion in 2018, a 28% increase in a decade.[6] The growth is expected to continue and is projected to increase 67.3% to US$ 560 billion by 2028.[6] In 2018, annual per capita US prescription drug spending was US$ 1221, well above that of the United Kingdom (US$ 526), Sweden (US$ 534), and Germany (US$ 884).[7] Prescription drug expenditures alone will represent 19.7% of the US GDP by 2028.[6] Increased prescription drug expenditures will be largely driven by manufacturers' increase in drug prices.[8]

One of the distinctions in US prescription policy is the burden of drug costs borne by patients as out-of-pocket costs. For instance, Medicare Part D prescription drug benefit has no cap on out-of-pocket costs for beneficiaries.[9] Drug prices are significantly higher in the US than in any other OECD country. By contrast, the UK requires little or no cost sharing by patients. Countries that have implemented SP financing systems offer multiple examples of ways to reduce drug prices, including harmonization of pharmaceutical coverage, pricing over a single formulary or across formularies, exclusion of the added administrative costs from pharmacy benefit managers (PBMs) used in the US, and the leveraging of scale to negotiate prices with suppliers.

C. Efficiency in the US Compared to Single-Payer Countries

While the US spends more per capita on healthcare than any other OECD country, the additional spending contributes little value from either an economic or a health outcomes perspective.[3,5,10] Countries with SP spend less while their populations live longer, healthier lives.[11] The average life expectancy and burden of adverse health outcomes for almost all major chronic illnesses, apart from cancer treatments, in the US also falls short of the OECD median.[7,10,11]

Administrative Costs

As far back as 2003, administrative costs of healthcare (including insurance, reimbursement, and other administrative tasks) accounted for nearly a third (31%) of the US NHE.[12,13] By 2011, the US still spent more of its NHE on the administrative costs of the reimbursement system than any other country, 8-18% of healthcare spending.[4,5,14] Analysis between countries with a variety of health insurance systems showed that both SP (most optimal) and "two-tiered" systems, such as those in France and Japan, operated with lower administrative costs than the insurance-mandated systems of the US or Switzerland.[5] A two-tiered system has a public insurance-and-delivery system, and another based on private health insurance. Notably, the Swiss system (2nd highest NHE per capita of OECD countries) demonstrated significantly lower administrative costs than the US, indicating that there is room for correction even within public-private systems.[5] By one analysis updating the 2003 analysis through 2017, excess administrative costs in the US compared with Canada (SP) have persisted and still account for 17% of NHE.[15]

Private insurance pricing inefficiency

Excess US spending is driven by the availability (not utilization) of medical technology and broad service pricing, as opposed to a higher rate of healthcare consumption.[3] Healthcare services are provided at a less efficient cost for equivalent levels of care.[3] Neither the quantity nor quality of care is improved by the increase in US spending, either per capita or as a percentage of the GDP.[3] The US funded 50.9% of its NHE through private payers in 2016, compared with the OECD median of 25.0%. While public spending on healthcare is also higher than in most OECD countries that have a majority (>80%) public payer system in place, private insurers drive the largest segment of excess cost in the US healthcare system. Furthermore, the gap between publicly and privately funded healthcare prices in the US has widened from 2000 to 2016, with the Medicare Payment Advisory Commission estimating that private insurers pay prices 50% higher than Medicare payments for identical services.[16] Reducing fractionalization through consolidation of private insurers into fewer, larger, private payer organizations does not necessarily lower plan costs, either for individuals (premiums, copayments, deductibles) or to the overall system.[17] Instead, these mergers tend to shift profits away from the delivery system, providing cost savings to insurers without generating cost savings to society.[17]

D. Access & Equity Issues

Lack of insurance is the primary systemic barrier to healthcare access in the US, demonstrating that the multiple financing systems fall short of universal coverage. Universal health coverage means that all people have access to the health services they need, when and where they need them, without financial hardship.[18] It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.

In addition, the high cost of healthcare in the US exacerbates existing healthcare disparities that result in premature morbidity and mortality and intersects with race, social and socio-economic status (SES), age, and disability. One feature of the United States healthcare system is the prevalence of high deductible healthcare plans. These plans, intended to incentivize patients to not over-utilize healthcare, disproportionately affect individuals with low income. In the period from 2003 to 2014 when high-deductible health plans proliferated and overall increases in US healthcare spending slowed down, healthcare expenditures for the wealthiest quintile grew by 20% while it fell by 3.7% in the lowest quintile group, despite this group having the worst health outcomes.[19] Additionally, since healthcare expenses are not proportional to personal income, individuals with low income pay a larger percentage of their household income towards healthcare costs. Thus, the private health insurance market exacerbates wealth inequality by acting like a regressive tax. A survey of healthcare expenditure data found that this system effectively redistributes 1.7% of total income from individuals lower incomes to higher.[20]

These plans have devastating financial and health outcomes for Americans with low income. One American study found that, among patients with cardiovascular disease, almost 60% of patients with low income faced financial hardship or were unable to pay their medical bills, resulting in food insecurity and inability to take prescribed medications.[21] Even among the insured, close to 40% of patients with insurance still faced financial hardship due to the out-of-pocket expenses associated with their plans.[21] One study found that high deductible plans lead to a delay in diagnosis and treatment of breast cancer in women with both high and low income, although the effect was more pronounced in those with low income.[22] Another study found that high deductible plans reduce utilization in potentially high value care such as preventive and outpatient medical visits.[23]

Despite the passage of the ACA, there are also persistent racial health disparities in the US uninsured population.[24,25] In 2019, the rate of uninsurance among adults not qualified for Medicare was 7.8% for White, 11.4% for Black, and 20.0% for Hispanic individuals.[24] This leads to racial and ethnic disparities in receiving recommended care, for example one study found that Black, Hispanic and Asian individuals with diabetes were 23-53% less likely to receive annual hemoglobin A1c tests.[26] Lack of universal healthcare also exacerbates health inequities based on citizenship and immigration status, for example one study found that 40 of 50 states withhold coverage of dialysis for patients with End Stage Renal Disease (ESRD) who are undocumented immigrants.[27] In these states ESRD patients can only access dialysis on an emergency basis, subsequently this study found that in states that did cover dialysis there was a 14% absolute reduction in mortality and a $5678 reduction per-patient in total healthcare costs associated with providing this coverage to people with ESRD who are undocumented.[27] High out of pocket expenses and lack of universal coverage exacerbate health disparities among people with disabilities, one study found that older adults with disabilities were more likely to delay seeing a doctor due to financial reasons despite having insurance, because of out of pocket expenses.[28] A multi-payer insurance system exacerbates segregation along economic, racial, immigration status, and disability in the medical system by creating financial incentives to take care of particular patients based on their insurance status. For example, one study found that academic medical centers, which are widely regarded as providing the highest quality of care, were much less likely to treat racial minorities, Medicaid, and uninsured patients in New York City.[29]

Moreover, an examination of the current state of behavioral healthcare in the US reveals even larger gaps.[30] This is an area that has suffered from lack of financial support historically, and also from the compounded cumulative negative behavioral and primary health effects from COVID-19 since 2020. Making Single-Payer reform work for behavioral health is possible by revisiting the lessons learned from Canada and other countries that have adopted SP systems.[15,31]

IX. Evidence-Based Strategies to Address the Problem

The American Public Health Association (APHA) has called for universal coverage of healthcare for all US residents for decades.[32] This has included calls for a unified, nationally-coordinated and -funded approach (i.e., SP) to healthcare expenditure since the late 1970s. This goal for coverage, met by the majority of other developed countries in the world, is no longer in question, but the best approach is still being debated in policy and political spheres. In this debate, the evidence in support of SP has grown rapidly in the past decade. In addition, recent polls conducted of broad clinician samples have shown that a majority of doctors 'strongly support' policy reform to implement SP.[33] The American College of Physicians (ACP), the second largest provider organization in the US, has also recommended that US policy initiate a transition to a system of universal coverage, through either an SP or a public payer choice capable of supporting universal coverage.[34]

A. Single-Payer Health System

In 1993, the APHA leadership and Executive Board developed 14 Points on Health Reform in order to organize and guide the essential criteria for reform for public health.[35] These points continue to guide the principles of the public health field in developing proposals for national health reform.[36] Overall, the evidence clearly demonstrates that SP is the most optimal structure for health reform in order to support these principles.

Designing, implementing, and transitioning to a single-payer system may entail significant changes in the sources and extent of coverage, provider payment mechanisms, and financing of healthcare services in the current US healthcare system.[37] The federal government could administer some functions of the single-payer health plan at the national level and delegate other functions to state and local governments. Alternatively, state governments could administer the single-payer health plan with broad federal oversight.[37] single-payer system implementation can be done in incremental stages starting with people who have health insurance coverage through various public sources (Medicare, Medicaid/ Children's Health Insurance Program, Veterans Administration) who could continue to have such coverage under a single-payer system, although covered benefits and cost-sharing agreements might change.[38] People who have private insurance (primarily employer-based insurance) may enroll in the public plan and might retain private coverage that supplements the coverage under the public plan preserving public financing and redistributing revenues among the pools to attenuate risk selection.[39] With regards to health insurance several countries progressively transitioned from multiple large insurance pools to single-payer system while building the financial and administrative capacity to establish a single insurance pool. An alternative approach would be to first standardize the health plans that can be offered in the market.[38] All of these approaches may be slowed by legal challenges by states or business interests, but they each

reflect a lower risk as changes to taxation and federal program reimbursement does not involve constitutional rights issues posed by individual mandates to purchase private plans.

Overall, a single-payer system will significantly simplify the revenue collection and benefit payouts to a single agency.[40] Countries with single-payer systems experience significant cost-savings over their multi-payer counterparts through the streamlining of billing and insurance procedures, the creation of a more equitable and predictable spread of risk throughout an entire populace, and the leveraging of bargaining power to control costs.[40]

B. International Evidence of Quality and Cost with Single-Payer

Taiwan: The National Health Insurance (NHI) system was introduced in 1994, modeled in part on the US Medicare program, although it was created to cover all citizens and foreign residents in Taiwan, boasting a 99.9% enrollment rate.[41] Benefits are uniform and comprehensive, covering hospital care, physician care, pharmaceuticals, and other services. Subsequent to 1994, the health system in Taiwan has adopted both pay-for-performance measures and a global budget mechanism to improve quality while reducing cost of care.[41]

Patients in Taiwan can choose their doctors or hospitals freely instead of being limited to a certain network of providers like in the US.[42] This enhances the access to care for disadvantaged populations but also encourages providers to improve the quality, and thereby the value, of care to attract patients. Also, government sets the rates; thus, collaborating with other providers increases every provider's market share and simultaneously mitigates the consequences of fragmentation. Beneficiaries with low incomes under the single-payer health system in Taiwan can either receive exemptions from cost sharing or directly receive their medical care.[37] Enrolling individuals with low income and providing them with public health services may prevent them from using costly and unnecessary emergency care, which affects both provider and patient more heavily. It may also discourage private insurance companies and providers from securing profits through reducing coverage or even rejecting beneficiaries with low incomes.[43]

Canada: The Canadian health system, administered by the provinces, is a funding partnership between the provincial and federal governments (similar to the shared state and federal funding in the US). Provider, diagnostic, and hospital costs are covered based on a federally-negotiated fee schedule and providers are not allowed to receive private payments at or above those costs for any covered services. Private insurance exists only to cover services not already covered by the national system. Provinces administer billing and reimbursement services, but these must be comprehensive (defined by the province), universal (citizens and legal residents), portable across provinces, and accessible (which means no co-pays or other user fees). Comparative analyses of physician utilization in Canada and the US demonstrate higher

utilization rates among populations that are sicker and lower income in Canada, suggesting that more equitable allocation of resources in the US could lead to improved public health.[44]

Australia: Australia provides coverage through a hybrid, SP, universal health system (Medicare), available to all citizens and permanent residents. The costs of publicly funded primary and other basic health services (67% of all health spending) are shared by national, state, and local governments, with the remainder paid through individual and employer contributions. Australia, and other countries using a hybrid approach, mandate co-pays or deductibles for additional, private plans in order to manage utilization of specialist and other high-cost services and use an Electronic Medical Records systems to track patient utilization patterns.[37,45,46]

C. Financial Feasibility

The economic benefits of a SP system are rapidly realized by reducing the high administrative costs, primarily billing and insurance related costs, in the current US health delivery systems, even when accounting for expanded coverage to all those currently uninsured and residing in the US.[5,47] These costs emanate from the use of multiple differing insurance companies, allowable charges, reasons to deny care, coding, provider network negotiations and care restrictions, deductibles and co-pays.[37,47] Further, system-wide cost savings are realized by eliminating the processes for collecting co-pays and out-of-pocket expenses from patients.[37,48] One review estimated a mean of US$ 556 billion in potential annual savings.[48] Within the estimated increased federal expenditures required to support universal coverage through a public SP is the offsetting cost transfer from fewer private sector charges and projections of further increases in costs under the status quo.[37] In a review published by RAND Corporation, SP plans offering universal and comprehensive coverage models were projected to generate a total net savings of US$ 121 billion annually to NHE.[48] Certain models with supplemental insurance options demonstrated reductions in annual NHE by US$ 211 billion and federal expenditure by US$ 40 billion, even without the theorized savings from administrative efficiency.[48] A more recent economic review showed that 20 of 22 SP proposals from the past 30 years would provide net savings within the first several years if implemented in 2020.[47] Relative to the projected growth in healthcare costs under current (2020) conditions and trends, all of these proposals would offer longer-term net savings.[47]

As seen during the time of the COVID-19 pandemic, the health of the nation relies on creating a universal, efficiently coordinated system that improves access, eliminates disincentives to preventative care, and fosters access with a streamlined approach to universal coverage. Indeed, a single-payer health system is not only financially feasible, but also the most fiscally viable approach for all.

D. Reducing National Pharmaceutical Expenditures

A national drug formulary is an important tool of universal single-payer healthcare systems, e.g. the 2013 Medicare for All Act[49,50], intended to rein in ever-increasing U.S. drug expenditures.[49] A national

formulary can achieve reduced drug expenditures in two ways. First, it restricts duplicative and unnecessary medications within a class of drugs while allowing waivers to provide access for the occasional exception.[49,51] Second, by supporting price negotiation at the national level, manufacturers will have substantial incentives to be included as formulary drugs.[51] The Veterans Administration Health system exemplifies a national formulary system with a public health perspective that been shown to change physician behavior favorably while providing substantial cost savings through price reductions from manufacturers.[49-51]

E. Access and Equity Strategies

A SP system creates new opportunities to improve racial health disparities beyond the impact of eliminating differences in rates of insurance. A SP that includes coverage for workplace injuries and illnesses could eliminate cost shifting within the workers' compensation system that currently burdens workers with 50% of the costs, adding inequality to injury. SP would also address the socioeconomic disparities that have been described in our healthcare system. People who are uninsured and underinsured are more likely to have delays in medical care. Medical debt is also associated with housing instability and homelessness.[52] Because a single-payer health system would create healthcare savings by creating a more efficient administrative system, as a matter of health equity, some of these savings can and should be used to address additional ways to tackle health disparities outside of insurance.

A single-payer healthcare system would also address the socioeconomic disparities that have been described in the US. An SP that breaks down financial barriers to care would help resolve the rationing of medical care based on SES. A study of healthcare expenditures and finance in Canada found that their SP reduced income inequality between income groups by 16%, solely through more equitable healthcare utilization.[53]

Clinical factors are also a source of inequities in healthcare services in insured populations. For example, coverage of mental health and behavioral services have not been on an equal footing with medical and surgical services in the US for-profit health insurance environment. Since 2008, federal law (Mental Health Parity and Addition Equity Act) mandates insurers to provide mental health coverage equivalent to medical surgical coverage. While substantial gains in parity were made since passage of the Affordable Care Act, the challenge of real mental health parity in regulating managed care for mental health remains. Publicly financed healthcare is far more likely to achieve real parity than a for-profit insurance industry.[4,54]

While a SP universal healthcare system would not immediately eliminate all the health disparities outlined above, it would address many of them caused by lack of insurance and out of pocket expenses, which also leads to reduced utilization of high-value, lower-cost care.[3,27,55] Additionally, it would

incentivize a public health response focused on reducing disparities in order to reduce the costly care that results from the acute and chronic diseases related to health disparities.[3,4,27,55]

F. Improving the Value of Care

SP healthcare systems have the ability to emphasize chronic and preventative care. As discussed above in Taiwan, enrolling individuals with low income in comprehensive health benefits decreases the need for costly emergency care.[32] Providing comprehensive health benefits can direct patients towards less expensive scheduled care, as discussed above in the example of coverage of dialysis being associated with lower healthcare costs due to less emergency dialysis visits.[27] A SP system should include funding for strategies to improve access to primary care across the country, in order to shift care to low-cost higher value primary care. As discussed above under the current system with high out of pocket expenses even among the insured, some patients are less likely to fill prescriptions or obtain needed preventative care, deferring costs.[20] A SP system aligns the interests of the national insurer to cover preventative care upfront in order to avoid the need for costly care later.

Along with improving access to higher value care, SP has the potential to reduce health care costs by altering payment structures to incentivize high value care. There have been many proposals for alternative payment structures to healthcare providers to improve value of care delivery. Although the payment structure for hospitals and physicians is not synonymous with an insurance system these questions are closely entwined. Single Payer Health Insurance Systems in other countries have utilized both Fee For Service (FFS) and capitation models for healthcare provider reimbursement. For example, Taiwan initially implemented an FFS reimbursement model when they first transitioned to a single payer health insurance system but introduced capitation to reduce the volume of care being provided as problems arose.[56]

Evidence for the ability of capitation alone to make healthcare more efficient is mixed. Some studies have found the providers in an FFS method do tend to induce more demand, for example increasing elective hospital admissions[57] whereas other studies did not find an effect.[58] Many capitation models try to adjust payment for baseline health characteristics of patients or populations to minimize physician "cherry picking" healthier patients who need less healthcare and thus are less likely to reach their capitation rate. Within the current US system, the evidence for the benefit of capitation in some of the Accountable Care Organizations (ACOs) that have adopted this payment model is mixed.[59] There has been some concern that despite efforts to avoid negative selection of unhealthier patients or of communities that traditionally suffer from healthcare disparities, ACOs might still be less likely to profit from accepting these patients.[60] In the absence of strong evidence alternative, value-driven payment models can and should continue to be studied after the implementation of universal healthcare through a SP financing model, recognizing that any payment structure to physicians and hospitals might operate differently under a new insurance

system. The competitive disincentives that undermine capitation models in the current US system are expected to be alleviated when all providers are held to the same reimbursement schedules and risk pools.

G. Education and Advocacy

The scientific and economic (typically peer-reviewed) debate on SP reform is characterized by caveats[55,61] or political rationalizations[55,62] against the larger, generally overwhelming economic evidence. However, the public debate on SP reform is both more wide-ranging and more divisive in tone, taking on partisan political rhetoric.[63,64] Providing clear information from the economic to the public debate about the actual scientific evidence, including the caveats and political complexity of reform, is a vital step toward successful SP system transformation.

Education and advocacy campaigns directed toward the public[65,66] and representatives of the legislative and executive branches of government,[67,68] using multiple communication media and forums, have successfully demonstrated that communicating facts about policy effectiveness from trusted sources can produce shifts in public and political opinion toward the evidence over time. This can anchor the public and political debate around SP reform on the details of how best to implement such change and move the focus away from the unfounded arguments and rhetoric[61,63] that are used to manipulate public opinion away from the evidence.

X. Opposing Arguments/Evidence

A. Political Barriers

Calls for universal healthcare in the US have been made since the beginning of the 20th century and the legislative beginnings of the SP movement have their origin in the Wagner-Murray-Dingall bills of the 1940s to create a national health insurance system.[55,69] The fact that decades later the US still does not have SP is a testament to the significant political barriers to implementing such a system.[55] Lessons from history can be illustrative. The national health insurance bills of the 1940s and 1950s faced significant opposition from the American Medical Association (AMA), which launched widescale public opinion campaigns against nationalized healthcare using the language of the Red Scare.[55,69] However, the opposition from medical provider groups such as the AMA and ACP has reversed course in recent years.[33,34,70]

Despite this reversal, significant opposition to SP remains among some physician groups, which represent important stakeholders in health policy reform. Although polls show support for an SP among the general population, that support might not withstand the scrutiny the policy would receive if it were to have serious chance of passage. For instance, one survey found that support for the ACA decreased across many different polls after it was initially passed but before many of the provisions took effect, suggesting that the increased scrutiny of the bill in that period increased opposition.[71]

B. Market Forces and Barriers

It is a common justification for the higher spending in the US healthcare system that the outsized costs paid to pharmaceutical and medical technology industries in the US market incentivize the greatest innovation and highest quality of care for US citizens. Vested interests will also propose that market forces between private payers and providers create the best source of innovation in care delivery models through competitive pressures.[55,61,63] However, those same innovations drive the annual rise in excessive spending rates year after year. High inputs, such as material costs, only widen the disparate impact of healthcare-related debts in low- and high-income strata. Further, government-administered healthcare financing can still direct the system through statutes and payment models incentivizing innovation, based on value-based metrics to achieve the most cost-effective care. The competition between provider organizations is not diminished by a level playing field in reimbursement and incentive models. In fact, SP financing will only improve the quality of competition. There are other driving forces that affect pharmaceutical prices, such as regulatory costs. In fact, the general disadvantage of US pharmaceutical pricing is that the prices are higher due to the lack of regulation that surrounds the process.[15,47] SP provides the opportunity for pricing negotiation by federal regulators, which is currently not permitted, for both pharmaceuticals and other medical technologies. It also places the greatest possible leverage in the hands of the consolidated payment system, which will inherently improve market competition, pricing strategies, and simultaneously shift the cost share of research and development operations to other large economies around the world.

In addition, critics point to the threat of rationing of healthcare, long wait times, and a lack of choice in healthcare providers.[55,61,63] These voices sometimes point to anticipated increases in healthcare demand from individuals newly insured and the lower reimbursement rates from CMS programs relative to private insurance providers as evidence that healthcare providers will constrict program availability.[61,64] However, in international comparisons or economic model projections there is no evidence that adopting SP financing will lead to rationing or wait times for time-sensitive services.[3,4,15,55] Countries with SP systems do not ration primary care services, require wait-times outside of elective procedures and types of care.[3,15,41] These countries also have high-functioning economies that are not made less wealthy through their support of accessible, efficient healthcare.[4,7] Currently, the US system rations healthcare by withholding care from those without sufficient economic resources to access the system. Ironically, provider choice is a hallmark of the current, siloed system with many risk pools and individualized contracts between payers and providers which would be remedied by a SP financing system.[3,14,55]

C. Infeasibility of a Single Payer Health System Due to Cost

The primary argument in political circles is often that an SP will cost the federal government more money, increasing the federal mandatory budget leading to higher taxation or deficit spending or

both.[55,61,63] Estimates for expanding Medicare to provide universal coverage range widely, but often cite a cumulative cost of US$ 32.6 trillion in the first 10 years after implementation (2022-2031).[72] Although there are likely to be increased federal expenditures associated with the adoption of an SP,[72] projections must also incorporate the significant reduction in costs generated by private sector payers and clients and the continued growth in healthcare spending trends under the status quo (See Section IX. Evidence Based Strategies: Financial Feasibility). Adoption of an SP system is actually projected to both reduce annual net healthcare expenditure and improve the progressive level of the healthcare cost burden by income level,[48] improving inequities in access. This impact is reflected in the lower per capita costs of coverage in every country with an SP.[7]

It is also suggested that the transition to an SP system will have negative impacts on the medical insurance and pharmaceutical industries. While the transition may lead to reduced positions in medical insurance organizations in the short term, these organizations are already developing plans to redirect their business models toward supplemental insurance plans and roles that assist with tasks such as innovating care delivery models, care navigation, and managing care for high-risk patient pools, roles in which those organizations already excel. The pharmaceutical market will naturally balance the costs of innovation across more economies if the US negotiates prices and implements regulatory reforms.

D. Sufficiency of Incrementalism

Historically, incremental expansion of existing coverage mechanisms is the traditional approach to policy development in the US. This approach has been advocated by some in the fields of medicine, health policy, and public health as a more feasible means of making asymptotic progress toward universal coverage.[32] In particular, the argument has been made that SP reform legislation has not succeeded so far because it is not a realistic or achievable goal, and that smaller reforms with greater likelihood of adoption are preferable.[32] However, the evidence shows that other countries have had successful transitions to systems that provide universal coverage or have nationalized healthcare financing through single, large, coordinated legislative efforts.[36,,73] What's more, a recent US survey found that similar levels of debtors (a majority) before and after the implementation of the ACA had medical expenses contribute to or cause their debt, suggesting that incremental reforms have not fixed this problem of social and economic disparities in access.[74]

XI. Alternative Strategies

Affordable Care Act (ACA)

Since the passage of the ACA in 2010, the landscape of healthcare reform has been fundamentally altered. The ACA was ambitious in its goal of increasing rates of insurance coverage, attempting to bend the curve of rising healthcare costs and improve the quality of healthcare. Under the ACA, the rates of

uninsured reached a historic low of 8.8% in 2016, largely due to expanding Medicaid to include an additional 12 million people who receive insurance through Medicaid.[75] After adjusting for inflation, annual NHE (all sources) grew at a rate of 2.7% from 2003-2010 and 2.8% from 2010-2018, indicating that the ACA has not made substantial inroads into improving healthcare spending.[76]

We also know that the scope of coverage with regards to in-network behavioral health services grew more comprehensive from 2013 to 2014. This reflects the positive change that occurred when the ACA and the parity requirements went into effect. Coverage appeared to improve when the insurance companies reduced their exclusion list for behavioral health conditions.[77] In addition, knowledge of the benefits returned from enhanced coverage of behavioral health conditions remains a key piece of the puzzle for optimization of the existing ACA coverage mandate.[31]

As far as improving quality of care, the ACA also launched the Hospital Readmission Reduction Program, which incentivizes higher quality care in order to reduce readmission rates at hospitals.[76] However, some studies have questioned whether these programs reduce readmissions at all, let alone improve quality of care.[78] Thus it would suggest many of the successes of the ACA have come from increasing access to insurance.

However, at the same time that Medicaid has expanded, the proliferation of high-cost insurance plans has grown as well. Health insurance premiums increased 4.6% in 2017 and 2018 compared to a 2.6% median increase among OECD countries.[1,2,75] In 2016, among uninsured persons 45% of survey respondents identified cost of care as the reason for not having coverage.[74] Additionally, 44% of people with marketplace plans are considered underinsured due to the high cost of out-of-pocket expenses like deductibles.[75] In fact, the average deductible for a silver plan on Healthcare.gov has gone from US$ 2425 in 2014 to US$ 4500 in 2020.[76]

Waiting for future incremental gains based on the ACA provides an insufficient path towards universal health coverage. Prior to the ACA, studies estimated that almost 45,000 Americans died each year due to lack of insurance.[79] Although a more recent review of available evidence concluded that the odds of death for persons with insurance was between 0.71 and 0.97 relative to those without insurance.[80] With the number of uninsured expected to reach 31 million in 2020, any delay in achieving universal coverage will cause unnecessary and unacceptable mortality (Keith, 2020).

Not only are incremental approaches to universal healthcare too slow but they are also politically vulnerable, as exemplified by the ACA. There have been over 50 attempts to repeal the ACA in the House of Representatives since the passage of the law.[81] Additionally, many of the potential gains of the ACA have been undermined by states using work requirements to reduce Medicaid eligibility.[81] There have also been many legal challenges to the law that have gone to the Supreme Court, which could potentially overturn the ACA.

XII. Action Steps

APHA joins other national and international organizations in declaring that healthcare is a human right. Furthermore, APHA holds that a national SP plan is the optimal design for simultaneously improving health and lowering the cost of care in the US. Therefore, the APHA joins Physicians for a National Health Program, Public Citizen, Congressional Black Caucus, American College of Physicians, American Medical Association – Medical Student Section, American Medical Student Association, American Medical Women's Association, American Nurses Association, and other national and international organizations in calling for legislation and administrative policy reforms to implement a national SP system.

To this end, APHA will establish an intersectional working group to:

1. Educate members of the organization and public,
2. Develop advocacy strategies, materials, and actions for contemporary SP reforms in partnership with the Action Board, Science Board, and Education Board, and
3. Deepen, debate, disseminate our understanding of the intersections of SP and public health, particularly as it applies to APHA and the sections' core missions and strategic aims.

And the APHA urges:

1. Congress to enact policies directing:
    i. The Centers for Medicare and Medicaid Services (CMS) expand Medicare and Medicaid to provide universal coverage to a harmonized package of healthcare services (including vision, hearing aids, behavioral health, dental and long term care) and pharmaceuticals without exception — regardless of race, sexual orientation and gender identity, citizenship, residency, carceral system or institutional status — to include all those living in the US;
    ii. The Centers for Medicare and Medicaid Services (CMS) expand Medicare and Medicaid to provide reimbursement financing using a whole health focus on parity between medical, surgical, dental care, and especially treatment for mental health and substance use disorders;
    iii. The removal of any and all statutes, laws, rules, regulations, policies or practices inconsistent or in conflict with universal coverage by CMS programs, including the elimination of all deductibles and co-payments – so that there are no financial barriers in accessing healthcare;
    iv. Appropriate budgetary and revenue collection reforms of federal healthcare financing and CMS administration policies to create and sustain a single funding mechanism to support a whole health focus on comprehensive, universal coverage by US healthcare providers;
    v. The Department of Health and Human Services (HHS) and CMS to regulate, monitor, and report on health disparities as an accountability mechanism;
    vi. State and local healthcare system reimbursement policies become tied to measurable patient-centered outcomes and health equity targets;

vii. Funding and technical assistance be provided to state and local jurisdictions and individual healthcare provider organizations to:
    a) reform their reimbursement practices to adjust for billing practices under a SP system,
    b) implement health disparity screening and reporting systems at all levels;
viii. The creation of standards, timelines, and milestones for progress toward full interoperability of healthcare provider data systems across the US;
ix. Funding for HHS and CMS to provide technical assistance and direct support to underserved or under-resourced healthcare providers (FQHCs, CHCs, HCH, low-resource tertiary care centers, etc.) to implement interoperability standards;
x. HHS to update and strengthen privacy practices and the data security infrastructure for CMS, while supporting interoperability goals for healthcare providers;
xi. Funding for HHS to modernize and update CMS data and data security infrastructure to facilitate the transition to single-payer health system and expansion of coverage to everyone in the US.

2. State legislatures, agencies, and other public servants, to:
    i. Work with the full Federal administration and State agencies to adopt reforms to transition their healthcare financing and reimbursement procedures to an SP system.
3. Community partners to engage in:
    i. Legislative advocacy and educational campaigns to inform legislative and executive branch representatives and staff on the short-term and long-term benefits of SP reform, in coalition and partnership with APHA;
    ii. Public education campaigns;
    iii. Community outreach and engagement, to facilitate collaboration on the design and implementation of SP reform.

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