The Development of a Single-Payer Universal Healthcare Delivery System

By

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The development of a comprehensive Single-Payer Universal Healthcare Delivery System is a necessary and urgent task. It will constitute a health and healthcare service model that works for all citizens to eliminate continual racial and ethnic discrimination in Oregon and across the nation. To effect this method, we must contemplate a broad framework that is sustainable, strong, and serviceable. The current national healthcare delivery system structures operate using challenging principles guided by how we finance, organize, practice, distribute, and deliver healthcare services. These principled foundations are admirable and necessary; nevertheless, I see them as being unequal, inequitable, grossly mismanaged, exclusionary, profit-driven, and life-threatening. As a result, this approach has not been socioeconomically, equitably, or equally beneficial for all healthcare consumers. Therefore, it is ineffective, inefficient, and unsustainable.

Strong qualitative and quantitative evidence exists about historical and contemporary institutional and environmental structures of our social, cultural, political, and economic policies and practices that contribute to disproportionate minority impacts. Other crucial elements impacting minority behaviors, attitudes, health, and well-being are low quality of care services and health providers' implicit racial bias (unconscious stereotypical thinking). These social elements and their structural features add to the ongoing significant and negative influences on Black, Hispanic, Asian, and Native Americans' poor health status and health outcomes. These factors also contribute to other social determinants of health circumstances, including rural residence, concentration in low-income (and often racially segregated), urban residence, and other manifestations of socio-economic inequalities, health inequities, and health differences. These significant issues, among other discriminatory factors, stem from inadequate health insurance, due to either underemployment or unemployment and inferior healthcare plans. These associated components magnify insufficient access to healthcare and quality of care services that result in financial distress, unequal treatments, poor health outcomes, increased health disparities, and reduced

preventative care services. These situations add to the importance, necessity, and urgency of creating a robust healthcare system that is conducive to all society and its citizens.

Therefore, the primary purpose of developing a Single-payer Universal Healthcare Delivery System is to identify appropriate strategies to eradicate long-term racial-ethnic health inequalities, health disparities, and health inequities. In so doing, it will rid us of other racial and ethnic discrimination, such as classism, ageism, and gender inequality associated with socio-economic, social determinants of health inequities, and cultural issues. The primary benefit is that it will address the unmet health and healthcare needs of the poor and racial-ethnic populations in Oregon and throughout the United States. Meeting both health and healthcare needs that reflect sufficient access to health services and the quality of care services received will include timely scheduling, emotional support, diagnostic testing, preventative services, appropriate medication, and adequate nutrition. It must address provisions for equal and equitable access to social determinants of health impacts by ensuring adequate, affordable, and impartial housing and educational services. Other factors it will provide for that affect access to care and self-maintenance practices are employment, reliable non-emergency medical transportation services, and facility locations.

A Single-Payer Universal Healthcare Delivery System possesses the most significant potential and power to reduce administrative healthcare costs and simultaneously achieve the highest standard of quality of care services. This unique system's approach will ease the burden and concerns of increased healthcare costs, and poor quality of care, as it meets Oregon's triple aim of attaining better health, better quality, and lower cost. This approach is most reflective when we consider the anticipated healthcare costs involved with the public health crises of the Coronavirus (COVID-19) pandemic and the long-standing Black minority disproportionate health impacts and outcomes. Since the enactment of the 2010 Affordable Care Act—Patient Protection Clause—and its 2013 implementation and expansion of healthcare coverage nationwide, Blacks are still experiencing unresolved health inequities and inequalities. These acknowledged observations are in the ongoing poor health outcomes in death rates, poor quality of care, and limited access to healthcare services and treatments, and other issues. The

emotional and economic health of our state and country, especially the Black community, is at unprecedented high risk.

Considering these critical circumstances, we can no longer ignore these historical and current issues and health impacts in silence while individuals are prematurely and disproportionately dying from preventable conditions, which is no fault of their own. The unprecedented COVID-19 virus has revealed astounding and significant mortality rates among various racial and ethnic minorities compared to the White population. In Chicago Illinois, 42% of the Black community has succumbed to COVID-19, a rate that is 3.4 times higher than their White counterparts[1]. This occurrence is despite Blacks constituting only 14% of Illinois' total population[1]. These and other differentiated racial outcomes make it imperative to change the way our current healthcare model practices, finances, delivers, and distributes healthcare services in the United States (U.S.).

In developing the Single-payer Healthcare Delivery System, the focus must not only be on the previous failed efforts, health interventions, and unequal and disparaging outcomes of the current system. We must focus on the processes of the existing healthcare systems fragmented, complex, and multi-payer structures and their impacts. We must also consider how services are aligned and distributed as well as who and who does not benefit. In analyzing our present model, it is essential to understand its underlying power and structures. In the United States, the tri-economy structures—non-profit, private, and public entities—comprise our economic system that governs our communal affairs. These structures function within the financial policy guidelines to produce goods and services, all of which encompass providing health insurance coverage, upon which we heavily rely. However, our economic system comprises several types of government-sponsored healthcare coverage for the unemployed, the disabled, the elderly, the military, and the federally defined poor populations.

These health plans are known as Medicaid, Medicare, and Tricare, which provide limited medical services. Each serves a specific community. Each has its own set of internal and external challenges built into its policies and practices, which influences the delivery of services, patient outcomes, health status,

and patient satisfaction levels. Military Tricare plans are exclusive memberships designed only for military individuals and their families and managed by veteran administrators. Its challenges present themselves as patient grievances involving untimely services, long waiting periods, misleading information, administrative errors, and patient delays in processing authorization referrals. Patients also complain about problems and concerns around the poor quality of care services, reflecting staff and providers' behavior and attitudes, patient safety, improper care, insufficient care, and poor results.

The federally defined poverty populations for Medicaid eligibility include the working poor, the poor, the unemployed, the elderly, and the developmentally and physically challenged. Both state and federal governments fund this health plan. The states incorporate partnerships by contracting out administrative responsibilities to non-profit private coordinated care organizations that distribute and manage healthcare services to the eligible recipients. This approach also comes with internal and external threats, weaknesses, and challenges. It presents itself with poor quality of care, delayed scheduling, prolonged waiting periods, required referral authorizations, medication approvals, and complaints about cultural insensitivities, health providers, and staff's implicit racial bias.

The government also provides the 1965 Medicare, Title XVIII of the Social Security Act health insurance plan. This plan's policy eligibility requirements are that individuals must be of retirement, age 65, have particular disabilities, and end-stage renal disease. This plan is an entitlement model that revolves around earned waged benefits and premium amounts. It consists of four troubling parts; A, which pays for hospital stays, skilled nursing and hospice care, and limited home healthcare services[4]. Part B reimburses for services such as doctors' visits, necessary medical supplies, outpatient services, emergency transport, and preventive care, and durable medical equipment[4]. These two parts, A and B, are reflective of the traditional fee-for-service (FFS) program, representing additional difficulties with services rendered. This feature requires whether or not the providers choose to accept the assignment—amount reimbursed by Medicare or reject the assignment—the patient pays the remaining 20% for services provided.

Third, Part C is an alternative way of receiving Medicare benefits[4]. It requires the beneficiary to opt-in a Medicare Advantage Plan, which is a subsidiary plan that has provider and facility network restraints[4]. However, one will still be responsible for paying both A and B premiums[4]. This plan's policy also challenges the insured with its different rules, costs, and restrictions that impact the manner and timeliness of care received. An individual needs to have a clear understanding of how to choose coverage benefits. This knowledge is vital because it can result in having to pay increased out-of-pocket costs and also determine the provider or facility that provides the care. The advantage of this type of plan will provide coverage benefits to both vision and dental care services, which are not offered through the traditional Medicare plan[4].

Lastly, Part D covers prescription listed drugs (formulary); however, these medications are tiered and affordable based on the different types of drug plans[4]. Also, it requires annual deductibles and co-pays for specialty acute and referral services[4]. Private non-profit managed care or coordinated care organizations garner contracts with insurance industries to administer medical assistance. These services include the management and distribution of healthcare needs and reimbursements to control healthcare costs. To effect this outcome requires dictating predetermined medicinal formularies, limited treatments, prior authorizations and approvals, patient referrals, and specified diagnostic and procedural coding. With these bureaucratic health plan objectives come untimely access delays, and often denials for treatments, testing, and other preventative services. These complicated procedures and dissected parts make it difficult for the elderly, health illiterate, and disabled patients to analyze, interpret, and understand the consequences of their actions.

The U.S. working population is granted healthcare coverage through their employers known as "employer-sponsored coverage." The private health insurance industry is the primary supplier of employer-sponsored health coverage plans of different types. These plans consist of coordinated care organizations (CCOs), health maintenance organizations (HMOs), preferred provider organizations (PPOs), and exclusive provider organizations (EPOs). Other privately managed insurance plans are the point of service plans (POS), and High-deductible health plans (HDHPs). Employer organizations and

corporations purchase these insurance plans through predetermined amounts paid to the insurance provider. Employers select their health plan types according to premium costs, deductibles, number of employees, type of business, and state law requirements. These private corporations and coordinated care organizations control and manage all healthcare plans as their primary focus is on profits. Their procedures, policies, practices, prices, and segmented services revolve around benefits that promote and sustain competition in the private healthcare exchange market. Such profitable primary focus results in both expensive and substandard health coverage plans, thereby offering restrictive services that are often limited, inadequate, unpredictable, and that require prior authorizations and approvals. The non-medically trained administrative leadership in the human resources department enforces the policies. Therefore, the insurer's policies dictate and determine what diagnostic tests, treatment, the healthcare facility, and the administering health network that will provide these services. The covered services received depend on the type of employer-contracted health plan.

However, the more costly, inclusive, and comprehensive plans that exist are beyond many essential and non-essential employees' budgets or income, and therefore better serves the one to two percent of the wealthy population. Employees are allowed various health plan options from which to choose and are selected based on personal and or wage income affordability. Reimbursement funds are accessed when needed by individuals filing eligibility claims based on the type of plan, insured approved benefits, and services rendered. This practice is unsustainable in achieving and maintaining a healthy economy and health status for the 98% population. The traditional and discriminatory private market employer-based insurance plan model has not served the workforce population well, and it is buckling under massive profit-taking. This situation is likely due to spare capacity. This metric reflects the gap in the non-employment rate and the low employee productivity rate connected to continued employment.

These situations disproportionately and negatively impact the working poor and racial and ethnic groups. To prevent these systematic unequal, health plan choices requires a robust intervention healthcare system change. Addressing these preventative measures would help to sustain and maintain comparable

quality of life, longevity, and improved overall health status among the disenfranchised and marginalized racial and ethnic minorities and the poor populations.

A Single-payer Universal Healthcare Delivery System will provide effective and efficient leadership by lowering the overhead costs associated with the private administrative and providers' claim expenditures. This reform system will show that the private for-profit system cannot meet catastrophic or pandemic emergencies. It will yield a good model for the private health insurance market; if it becomes an ongoing player in the healthcare system reform effort following the 2020 presidential election. Such developmental measures require analyzing the policies and practices of the private market's high administrative costs and their multiple healthcare service plans.

In the United States, the financial, administrative cost is 34% of total healthcare expenditures[2]. Yet, we spend almost five times more per individual on administrative expenses than our neighboring country, Canada[3]. In 2017, we spent $2,497 per person compared to Canada's $551 per capita[3]. A comprehensive single-payer universal health policy is the best way to end racial and ethnic poor quality care and to ensure adequate access to all healthcare services. This development will do so by addressing the current structured systems' health insurance industry methods in how it delivers, distributes, reimburses, and sponsors the various segmented healthcare plans and services, including the metrics used.

As we look to rebuilding this system, we must purposefully address inequalities, racial and ethnic differences, and inequities across the board and at all levels of design, construction, and policy. This system's approach would include comprehensive engagement of all citizens and society, including the private, non-profit, and the public sectors, to participate in developing and sharing responsibility and accountability in designing a purposeful holistic healthcare system. It is, therefore, necessary to advocate for a single-payer universal healthcare delivery system. Supporting this system ensures that all citizens have equal and adequate access to equitable, affordable, and quality healthcare services at lowered healthcare administrative costs. When developing this system, the focus must emphasize the delivery system's healthcare coverage plans and practices, institutional policies, and healthcare providers' implicit racial bias, geographies, environmental living conditions, equal healthcare access, and equitable

distribution of medical services. It must address living wage employment, nutritional value, fair housing, and educational opportunities.

If we allow our current healthcare delivery system to remain unchallenged or unimproved, we risk not only financial, medical challenges, and shortened life minority expectancies. We will also risk repeating another historical social and economic demise. Such as we observed in the Great Economic Depression of 1929-1939, that brought our country to the brink of no financial return. If we fail to plan for an equal, equitable healthcare system that serves everyone right now, then we can anticipate unprecedented human suffering, and perhaps even longer dire socio-economic and political consequences. This purposeful strategic health systems' approach is one from which all Oregonians will benefit.

In conclusion, a holistic single-payer universal healthcare delivery system's model would forge inclusionary partnerships with the citizens, charitable non-profits, the public, and private sectors of our community. This kind of all in buy-in healthcare system reform is needed to eliminate the ongoing racial and ethnic health disparities, inequities, inequalities, and poor health outcomes. For these reasons, our Governor and legislators should purposefully design, propose, adopt, approve, finance, and implement a single-payer unlimited universal healthcare delivery system. This kind of system would eradicate racial-ethnic discrimination. And it would work for all healthcare consumers throughout the state of Oregon and the nation.

References

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