

Universal Health Care and Homelessness

Policy Recommendations

1. **Establish a national health care plan with a single-payer financing mechanism guaranteeing access to comprehensive, affordable health services of high quality for everyone in the U.S.**
2. **Adopt House Joint Resolution 30 to institute the universal right to health care in the Constitution of the United States**
3. **Ratify the International Covenant on Economic, Social and Cultural Rights (ICESCR)**

The central focus of the National Health Care for the Homeless Council is to reduce the incidence of homelessness by bringing about comprehensive health care reform and ensuring universal accessibility of essential health services.

The vast majority of homeless Americans lack health insurance, primarily because they do not qualify for public insurance and cannot afford private insurance. Among those served by Health Care for the Homeless (HCH) projects, 70% are uninsured. Most remain uninsured, often because they cannot afford non-group coverage or do not qualify for public insurance programs. Poor health and lack of access to health care are among the causes of homelessness. For people struggling to pay for rent, food, and other basic needs, the onset of a serious illness or disability can result in homelessness as financial resources are depleted. In 2007, sixty-two percent of personal bankruptcies were attributed to an unexpected medical illness, and more than three-fourths of those filing for bankruptcy are actually insured at time of their emergency or onset of illness.¹ Timely access to affordable health care of high quality would alleviate health problems and reduce the incidence of homelessness.

The vast majority of homeless Americans lack health insurance, primarily because they do not qualify for public insurance and cannot afford private insurance. The uninsured population has steadily increased by approximately one million individuals per year since 2000. To fill the gaps in health coverage and health care access—incremental expansions of public insurance programs have targeted vulnerable populations such as the elderly and children. Despite these initiatives, 46.3 million people (15.4% of the US population) were uninsured in FY 2008. Although the increase in number of uninsured from 45.7 million in 2007 to 46.3 million in 2008, is statistically insignificant; between 2007 and 2008 the number of people covered by government health insurance climbed from 83.0 million to 87.4 million, which is likely a result of the rising unemployment caused by the Great Recession and indicates a growing need for safety net health services. Since 1999, premiums for employer sponsored insurance have increased 119 percent.² Between 2007 and 2008, the number of people covered by employment-based health insurance declined from 177.4 million to 176.3 million.³ As insurance premiums rise—

¹ Himmelstein DU, Thorne D, Warren E, , Woolhandler S. "Medical Bankruptcy in the United States, 2007: Results of a National Study." *The American Journal of Medicine*. Feb. 2009.

² The Henry Kaiser Family Foundation. *HRET Survey of Employer-Sponsored Health Benefits*. September 2009.

³ United States Census Bureau. *Income, Poverty, and Health Insurance Coverage in the United States: 2008*. September 2009.

making health care more unaffordable—the decline in the number of people covered by employer-sponsored health insurance expected to continue.

Uninsurance and underinsurance increase costs for every American. Out-of-pocket expenses deter people—particularly those who are poor and uninsured—from seeking early intervention and preventive services. Emergency departments are overused and in many cases uncompensated. Unpaid bills undermine credit ratings of uninsured patients and pressure medical institutions to raise prices to replace lost revenue. In response to these rising costs, insurers increase premiums or scale back benefits, pricing many people out of the market and leaving others with inadequate coverage. It is estimated that 25 million people (14% of non-elderly adults in 2007) are underinsured—lacking sufficient health coverage to protect them from catastrophic health care expenses. Underinsured individuals are almost as likely as those who are uninsured to have difficulty paying for medical care and forego necessary services; 53% of the underinsured and 68% of the uninsured report going without needed care.⁴

Health care should cost less and provide more. The United States pays twice as much as other industrialized nations for health care (\$7,129 per capita in FY 2008) but performs poorly in comparison on major health indicators such as life expectancy, infant mortality, and immunization rates. (The World Health Organization ranks the U.S. 37th in health outcomes.) It is estimated that lack of health insurance causes 45,000 unnecessary deaths a year.⁵ The rapid growth of our health spending (about twice the rate of inflation) is untenable, unproductive, and unnecessary. For every dollar spent on health care, 30 cents is utilized for administrative costs, such as paperwork, overhead, underwriting, billing, sales and marketing departments, as well as investor profits and excessive executive pay. For comparison, Medicare (the federal government’s health insurance program for the elderly and disabled) spends just three percent on administration. Wasteful and inefficient administration consumes resources that could instead be directed toward the actual delivery of care. A publicly financed and privately delivered national health care system structured around a “single payer” financing mechanism is the most effective and efficient way to provide comprehensive, high quality, affordable, and accessible health care to everybody in the United States—even and especially the most vulnerable. Establishing a Medicare for All health care system would eliminate financial barriers to quality care, improve public health, protect the freedom of provider choice (maintaining competition), and provide a stimulus for the U.S. economy by creating 2.6 billion new jobs and infusing \$317 billion in new business and public revenues into the economy, while saving thousands of lives and billions of dollars each year.⁶

Universal Health Care Recommendations in Detail

1. Establish a national health care plan with a “single payer” financing mechanism.

We urge Congress to codify a right to health care by guaranteeing insurance – universally and continuously – for all medically necessary services. The most efficient way to attain this goal is through a single payer mechanism financed by a progressive tax system. This would be realized by House Resolution 676, the *Expanded and Improved Medicare for All Act*. Until this goal is accomplished, we support State efforts to ensure universal health coverage for their residents and incremental efforts to expand access to health insurance for vulnerable populations.

2. Adopt House Joint Resolution 30.

All persons benefit from the human right to health care. Congress has reintroduced H.J. Res. 30 proposing that the Constitution should be amended to articulate and defend the right of citizens of the United States to equal, high quality health care.

⁴ Schoen C, Collins SR, Kriss JL, et al. How many are underinsured? Trends among U.S. adults, 2003 and 2007. *Health Affairs* 2008; 27(4): w298-w309. <http://www.commonwealthfund.org>

⁵ Wilper A., Woolhandler S., et al. Health Insurance and Mortality in U.S. Adults. *American Journal of Public Health* 99 (12). December 2009.

⁶ Institute for Health & Socio-Economic Policy (IHSP). *Single Payer/Medicare for All: An Economic Stimulus Plan for the Nation*. January 2009.

3. Ratify the International Covenant on Economic, Social and Cultural Rights.

The ICESCR and the International Covenant on Civil and Political Rights (ICCPR) were drafted by the United Nations in 1966 to codify the rights enumerated in its Universal Declaration of Human Rights (UDHR) in 1948. Member States typically endorse a treaty to signal their intent to ratify it at a later time; signing a treaty or covenant is a non-binding act of goodwill, whereas ratification is the process by which a national government agrees to be subject to the international law detailed in the document thus ratified. The United States signed both the ICESCR and the ICCPR in 1977, and the ICCPR was subsequently ratified in 1992; but there has been no progress toward ratification of the ICESCR, which includes the right to “the highest attainable standard of physical and mental health.” The United States’ ratification of this document would advance the campaign for global human rights and direct the Covenant’s ratifying parties into a discussion of international health standards and concerns. We urge the Administration and Congress to proceed with the ratification of the ICESCR and the full employment of the rights specified therein.