

Universal Health Care and Homelessness

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.

Summary of Recommendations

- **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.**
- **Adopt House Joint Resolution 30 to institute the universal right to health care in the Constitution of the United States**
- **Ratify the International Covenant on Economic, Social and Cultural Rights (ICESCR)**

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. Half of personal bankruptcies can be 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. 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. Only 45% of surveyed homeless people nationwide and 30% of clients receiving services through the Health Care for the Homeless program (223,980 individuals in 2007) have any health insurance coverage.²

The number of uninsured Americans continues to grow. One in 5 adults under age 65 and nearly one in 10 children are uninsured.³ To close the gap between health care needs and access to needed services, incremental expansions of public insurance programs have targeted vulnerable populations such as the elderly and children. Despite these initiatives, 45.7 million people (15.3% of the US population) were uninsured in FY 2007; and an estimated 86.7 million people—one out of every three Americans under the age of 65—was uninsured for some period during 2007 and 2008.⁴ Although the number of uninsured declined from 47 million in 2006 to 45.7 million in 2007, analysts remind us that the drop is statistically insignificant and that uninsurance is likely to increase due to the rising unemployment rate, since most Americans still receive health insurance through their employer. Employers are not required to provide health insurance, however, and more than 80% of the uninsured live in working families. Only 7% of Americans under age 65 purchase health insurance for themselves or their families without the financial advantage of group coverage through employer-sponsored health plans. Despite myriad efforts to fill the gaps in health coverage and health care access—including valuable yet insufficient expansions of the Community Health Center program—the uninsured population has steadily increased by approximately one million individuals per year since 2000.

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

¹ Himmelstein DU, Warren E, Thorne D, Woolhandler S. "Illness and Injury as Contributors to Bankruptcy." *Health Affairs: The Policy Journal of the Health Sphere*. Feb. 2005. <http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.63/DC1>

² Health Resources and Services Administration, DHHS. Health Care for the Homeless Rollup Report for CY 2007. <http://www.bphc.hrsa.gov/uds/2007data/National/homeless/NationalTable4ho.htm>

³ Institute of Medicine. *America's Uninsured Crisis: Consequences for Health and Health Care*. February, 2009. <http://www.iom.edu/CMS/3809/54070/63118.aspx>

¹⁴ Families USA and The Lewin Group. *Americans at Risk: One in Three Uninsured*. <http://www.familiesusa.org/assets/pdfs/americans-at-risk.pdf>

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.⁵

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 2007) 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 22,000 unnecessary deaths a year.⁶ The rapid growth of our health spending (about twice the rate of inflation) is untenable, unproductive, and unnecessary. Investor profits and excessive administration consume resources that could instead be directed toward the actual delivery of care. For every dollar spent on health care, 30 cents is utilized for administration. In 2007, employer-sponsored health insurance premiums increased by 6.1%—far ahead of the 3.7% increase in employee wages and the 2.6% inflation rate.⁷ Additionally, U.S. tax-financed health spending—59.8% of taxes—is the highest in the world.⁸ Approximately one-third of these tax dollars is spent on private insurers to cover government employees; meanwhile, uninsured Americans pay thousands of dollars in taxes to fund the health care of others. Comprehensive national health insurance with a single-payer financing mechanism would reduce administrative costs and waste, eliminate financial barriers to quality care, improve public health, protect the freedom of provider choice (maintaining competition), and save thousands of lives and billions of dollars each year.⁹

Recommendations

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 so that 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.

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.

⁵ 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>

⁶ Institute of Medicine. *Knowing What Works in Health Care: A Roadmap for the Nation*. January 2008. <http://www.iom.edu/CMS/3809/34261/50718.aspx>

⁷ The Kaiser Family Foundation. Employer-Sponsored Health Insurance Premiums Increased by 6.1% in 2007....*Kaiser Daily Health Report*, Sep 12, 2007. http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=47450

⁸ Woolhandler S, Himmelstein DU. “Paying for National Health Insurance--and Not Getting It.” *Health Affairs*, 2002 Jul-Aug;21(4):88-98. <http://www.pnhp.org/publications/payingnotgetting.pdf>

⁹ Physicians for a National Health Program. http://www.pnhp.org/facts/single_payer_resources.php; American Medical Student Association. Single Payer 101. <http://www.amsa.org/uhc/SinglePayer101.pdf>; Krugman P. The Health Reform Imperative. *The Conscience of a Liberal*. New York: W.W.Norton & Company, 2007, 214–243.