

Universal Health Care and Homelessness

Summary of Recommendations

- **Guarantee access to comprehensive, high quality, affordable health services for all Americans** through a national health insurance program with a single payer financing mechanism. Enact House Resolution 676 to this end. Support State initiatives to ensure universal health coverage.
- **Declare the universal right to health care in the Constitution of the United States.** Enact House Joint Resolution 30 to this end.
- **Ratify the International Covenant on Economic, Social and Cultural Rights (ICESCR).** Pronounce unequivocally our national commitment to human rights both at home and abroad, as it has been previously expressed through the United States' endorsement of this document and the Universal Declaration of Human Rights.

Poor health and lack of access to health care are among the causes of homelessness. At the center of the National Health Care for the Homeless Council's mission is the goal of ending homelessness, and ensuring the universal accessibility of essential health services is as important in that pursuit as growing the supply of affordable housing and providing for a livable income. For people struggling to pay for rent, food, and other needs of daily living, the onset of a serious illness or disability can easily result in homelessness as financial resources are quickly depleted. Timely access to quality, affordable health care would ostensibly alleviate health problems that might otherwise precipitate homelessness and increase risk for premature mortality. Homeless persons are 3–4 times more likely to die than the general population.¹

The number of people in the United States without access to health care is overwhelming. According to the Census Bureau, 45.8 million Americans – 15.7% of the population – lacked health insurance coverage of any kind for all of 2004.² A separate study by Families USA found that 81.8 million Americans – one third of the U.S. population younger than 65 – were uninsured at some point during 2002 and 2003, most for periods longer than nine months.³ Included in this cohort are 70% of people served by Health Care for the Homeless (HCH) projects. People without insurance face significant financial barriers to health services and are less likely to seek primary and preventive care than insured people. More than one third of uninsured adults said they neglected to fill a prescription in 2003 due to cost, and more than one third went without a recommended medical test or treatment for the same reason.⁴ It is unsurprising then that the uninsured are 30% to 50% more likely to be hospitalized for an avoidable condition, at an average cost of \$3,300 per stay.⁵ Despite myriad efforts to patch the current health care framework in the United States – including the valuable yet insufficient expansion of the Community Health Center and HCH programs – the uninsured population has steadily increased by approximately one million per year since 2000. The Institute of Medicine attributes 18,000 deaths per year to the unrelenting, uniquely American epidemic of uninsurance.⁶

The absence of a universal health care system increases costs for every American. Out-of-pocket expenses deter people – particularly the poor and the uninsured – from seeking early intervention and preventive services. Emergency room care is thus overused and in many cases uncompensated. Unpaid bills cripple the credit of the uninsured patient and pressure medical institutions to raise prices to replace the lost revenue. In response to these rising costs, insurers in turn increase premiums or scale back benefits, pricing many people out of the market and leaving others with inadequate coverage, or underinsurance. As it is not concretely defined, the breadth of underinsurance is unclear. Harvard

¹ O'Connell JJ. Premature Mortality in Homeless Populations: A Review of the Literature. National Health Care for the Homeless Council, Dec 2005. <http://www.nhchc.org/PrematureMortalityFinal.pdf>

² DeNavas-Walt, Carmen, Proctor, Bernadette D. and Lee, Cheryl Hill. "Income, Poverty, and Health Insurance Coverage in the United States: 2004." *US Census Bureau (Department of Commerce)*. Aug 2005.

³ "One in Three: Non-Elderly Americans Without Health Insurance, 2002-2003." *Families USA*. June 2004.

⁴ "Facts on Health Insurance Coverage." *National Coalition on Health Care*. 2004.

⁵ "Hidden Costs, Values Lost: Uninsurance in America." *Institute of Medicine*. June 2003.

⁶ "Insuring America's Health – Principles and Recommendations." *Institute of Medicine*. 2004.

researchers have found, however, that among personal bankruptcies in the U.S. that are the result of medical bills (nearly half), more than three fourths of those filing were actually insured at time of their emergency or the onset of their illness. “Covering the uninsured isn’t enough,” says Dr. Steffie Woolhandler, co-author of the study. “We must also upgrade and guarantee continuous coverage for those who have insurance.” The Harvard report illustrates the disastrous impact of a medical emergency upon the uninsured and underinsured and exemplifies the dire need for a system of coverage that is both universal and comprehensive.⁷

Health care should cost less and provide more. The World Health Organization ranks the U.S. 37th in health outcomes.⁸ Despite the highest health expenditures in the world by every measure (projected \$6,830 per capita in FY 2006), the United States is the only developed nation that does not guarantee health care to its citizens.⁹ The rapid growth of our health spending (about twice the rate of inflation) is untenable, unproductive, and unnecessary. Investor profits and excess administration consume money that could instead be directed toward the actual delivery of care. We are in need of systemic reform to ensure that health care dollars are efficiently used and that patients are the rightful beneficiaries of our investments. 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. Numerous organizations – including the Government Accountability Office, the Congressional Budget Office, and the National Coalition on Health Care – have determined that a single payer system would cost substantially less than our current system. Congress and the Administration should act swiftly to achieve these savings and to realize the equal right of all people to health care.

Recommendations

1. **Guarantee health care for all Americans.** 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 taxes. Such 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.
2. **Adopt House Joint Resolution 30.** We urge the Administration to endorse and the Congress to enact HJR 30 in recognition of the right of all people to “health care of equal high quality.” The Constitution should articulate and defend this right against violations such as uninsurance, underinsurance, and discrimination.
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 the 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.

⁷ Woolhandler, Steffie, et al. “Illness and injury as contributors to bankruptcy.” *Health Affairs* W5.63 (2005): <http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.63/DC1>

⁸ “The World Health Report 2000 – Health Systems: Improving Performance.” *World Health Organization*. 2000.

⁹ “National Health Care Expenditures Projections: 2004-2014.” *Centers for Medicare & Medicaid Services*. 2005.