

Healthcare Is a Human Right Campaign
January 2013



From Coverage to Care: Re-envisioning Our Healthcare System
Statement on the healthcare “benefits” discussion

Vermont is in the process of implementing Act 48, the United States’ first universal healthcare law, which envisions a universal, publicly financed healthcare system for the people of Vermont by 2017. Although the State does not have flexibility to provide true universal healthcare during the Exchange phase of Act 48, planning is ongoing for transitioning to a system that will fulfill that goal. The Green Mountain Care Board will soon take an important next step by deciding which “benefits” will be “covered” by our future universal healthcare system, Green Mountain Care (GMC).

For the Healthcare Is a Human Right Campaign, the answer to this question is simple: we have a human right to receive the healthcare services each of us needs, when we need them. This obviously includes dental, vision, hearing and long-term care; in essence, all care deemed medically necessary and appropriate for a patient by a doctor.

Rather than develop “benefits packages” that artificially restrict access to care, Vermont must use its resources in a cost-effective way that does the most good for everyone’s health. In a universal healthcare system, based on shared goals of protecting and improving the health of all Vermont residents, the insurance model is made obsolete. As we are replacing the private insurance-based system with a public universal system, the concept of “benefits packages” loses its meaning. This paradigm shift is supported by Act 48, Vermont’s universal healthcare law, which requires access for all Vermont residents to “comprehensive,” “appropriate,” and “medically necessary health services.” It also prohibits systemic barriers to GMC, including costs, for all residents in need of healthcare.

Health insurance is not healthcare. In an insurance market, policyholders bet against sickness by buying “benefits packages,” which determine what type of healthcare treatment and services the insurer will pay for and what they won’t cover. “Coverage,” therefore, is based on financial protection, a calculation of risk, and a focus on catastrophic health emergencies. Care, under this model, is denied to those who cannot afford the best “benefits package” or cannot pay out-of-pocket costs, such as co-pays, deductibles, and co-insurance. In fact, insurance companies only make money if their product is not used, which is why they charge co-pays and deductibles to deter access. Thus, “benefits packages” perpetuate the insurance model and artificially restrict access to care, which results in poorer health outcomes.

Health services provided through GMC must be freely accessible without cost barriers, enabling Vermont residents to take responsibility for seeking the healthcare they need as early as possible,

avoiding a deterioration of their health. User fees, or so-called “cost-sharing” such as co-pays, deductibles and co-insurance, discourage people from seeking necessary care and filling prescriptions, causing them to become sicker. They shift the financial burden onto sick people, rather than spreading the costs among all of us. Not only do user fees produce healthcare bills that cut into families’ budgets for rent and food, but they lead to a delay of care, poorer health conditions and greater use of more costly emergency and inpatient hospital care.

User fees (misleadingly called “cost-sharing”) are the wrong kind of limit to unnecessary care. Instead, Vermont must remove the incentives that currently encourage providers to compete with each other - a competition which drives up the price of care and reduces efficiency of care. By eliminating the financial incentives to use expensive equipment or brand medication, medical efficacy is increased and costs are reduced. Payment reform can address some of these cost drivers, as can other provider-level measures, such as compulsory generic prescribing and shared decision-making with patients. Doctors and hospitals must be responsible for using medical resources wisely. We could establish an independent expert body, accountable to the people, to provide evidence-based guidance on which treatments and drugs available at different costs and effectiveness represent the best quality of care and the best value for money.

Decisions about how to manage the costs of health services must be guided, system-wide, by the principles of universality and equity. To ensure that GMC, our new universal health care system, puts people’s health needs first, we must proceed from a presumption that everyone should get the medically necessary care they need. This approach reverses the premise of restricted access in an insurance-based system, where many health services are denied or restricted from the outset, and the patient then has to argue for or buy additional services. Once the system has shifted to prioritizing health needs, then the state can put regulatory processes in place to guide allocation of public resources in a way that maximizes health outcomes for the entire Vermont population.

A universal system focused on people’s health will provide healthcare on a different basis from “benefits packages” sold in insurance coverage plans. A universal system puts people’s health first and invests public money into keeping our population healthy, with a focus on preventative and primary care. People need healthcare throughout their lives; neither the prevention nor the treatment of illnesses is an unexpected occurrence against which we can insure ourselves. Since it’s a not a matter of insurance, the best way to provide healthcare is as a public good, publicly financed and administered, as Act 48 requires. Similar to public education, fire services, and other public goods, the use of healthcare must be independent from payment and not restricted arbitrarily. Healthcare services must be designed to keep the population healthy, not limit individual “benefits.”