The Feminist Case For Single Payer

BY NATAOSH SHURE

It's time to take health care away from the power of bosses and spouses.

In the spring of 1969, a dozen feminists gathered at a women’s conference in Boston and came to a sober conclusion: their encounters with the United States health-care system had been overwhelmingly negative. They felt unsettled by doctors, alienated from their bodies, grifted by fees, and altogether powerless to navigate an industry they believed objectified them just as popular culture did.

The conference launched a years-long project, with each participant delving into some aspect of anatomy, sexuality, or society related to women’s health. The result was a self-published volume of essays called *Women and their Bodies*, which the Boston Women’s Health Book Collective used to provide women with a resource produced from their own perspectives and experiences.

Within a few years, the landmark feminist booklet was re-dubbed *Our Bodies, Ourselves*, released by Simon and Schuester, and sold millions of copies. In 2012, the Library of Congress named it one of the most significant works in American history. In recent years, it has inspired *Trans Bodies, Trans Selvhes*, which similarly seeks to be a health-care guide “by and for” the transgender community.

While *Our Bodies, Ourselves* is remembered for its role in the history of women’s health and culture, less attention is paid to its political context. In the 1970s, the small collective became one of the first feminist organizations to demand a single-payer health-care
system: “Suffice it to say that capitalism is incapable of providing good health care, both
curative and preventive, for all people,” one entry read. “Cost-benefit analysis trades off
the benefit to the people of collective public health in favor of the cost to the people of
private, patch-up medical care. The capitalist medical care system can be no more
dedicated to improving the people’s health than can General Motors become dedicated to
improving the people’s public transportation.” In a subsequent edition, they expounded:
“We believe that health care is a human right and that a society should provide free health
care for itself . . . Health care cannot be adequate as long as it is conceived of as insurance.”

If the book’s then-radical content has so permeated mainstream culture that it would
strike readers as obvious today, the same is not the case for its authors’ critique of
American health care. In fact, nearly fifty years after the collective articulated its vision for
a universal system, “feminist” arguments against single-payer pepper politics and the media.

In June, Planned Parenthood of California refused to endorse a bill for a statewide single-
payer system, contending that it was critical to focus on defending the Affordable Care Act
(ACA) against GOP attacks instead. Vice cast it as a job-crusher for the mostly women of
color who work in healthcare administration. In 2016, presidential candidate Hillary
Clinton — whose campaign foregrounded her feminist credentials — famously declared
single-payer would “never, ever come to pass.” More recently, Senator Bernie Sanders’s
release of an expansive Medicare for All bill has been met with skepticism by media
personalities who backed Clinton for her feminist credentials. At the very least, it seems
clear that single-payer health care is rarely framed as a feminist issue.

Some mainstream feminists knock single payer as a distraction from the fight to defend
the ACA. But while the Affordable Care Act undeniably improved some women’s lives, it
could not dismantle gendered barriers to care.

Of all systems, single-payer is capable of going furthest to eliminate them. That’s the
vision that Our Bodies, Ourselves adopted nearly half a century ago, and it must be taken
up again today.
The Double Bind

One of the pervasive ways women are disadvantaged under the ACA is its reliance on employer-based coverage. In the United States, World War II-era wage freezes helped entrench a system of employer-provided health insurance, a perk meant to attract workers in a squeezed labor market.

Eventually, Medicare and Medicaid were devised as a safety net for those shut out of private plans, and the ACA expanded that safety net. Still, job-based plans remain the bedrock on which our insurance system is built.

Under this system, it’s harder for women to get health insurance in the first place. The strains of childrearing and elder care make women more likely to seek more flexible employment, like part-time, remote, or freelance work. These forms of employment tend not only to pay less, but are less likely to include health insurance benefits.

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Those that do provide inferior ones: companies with majority-female workforces tend to offer less generous health-care coverage than those that are majority male. And less than one-third of low-income workers receive any health insurance through work. Jobs paying at or around the minimum wage are most often occupied by women, the majority of whom
are women of color. Trans women face even higher levels of poverty than cis women, and are frequently saddled with impossibly high out of pocket costs.

Then there are the 25 percent of non-elderly adult women insured as dependents of a working spouse, which weakens their control over both their insurance coverage and their relationship. Health insurance has been found to be a common reason for getting married — and for staying married when one would rather not — especially among low-income people. Upon the loss of a spouse’s coverage, it’s difficult and expensive to continue receiving the same care. COBRA coverage — a program that allows people who lose employer-based insurance to remain on it, so long as they pony up the amount formerly contributed by employers — is often the only way to maintain provider networks, but it’s wildly expensive and eventually expires. Ultimately, divorce leaves some sixty-five thousand women uninsured each year, with men being far more likely to maintain coverage after their marriages dissolve.

Women’s unpaid domestic work puts further pressure on the contradictory demands of home, work, and the need to access coverage. Women disproportionately shoulder the responsibility of caring for others, putting them in an impossible situation when it comes to child and elder care: in order to maintain health insurance, they can’t take too much time off work. As a result, they’re forced to spend a significant portion of their wages on private care for the hours they’re on the job. For low-income women who don’t qualify for insurance through employers, the problem can be severe, made worse still by right-wing efforts to impose higher copays and out-of-home work requirements on Medicaid recipients, or to defund programs like CHIP that help parents pay for their children’s health insurance.

During particularly urgent health episodes, like childbirth or a relative’s protracted illness, women opt to take unpaid time off instead of risking their jobs. Notoriously, the United States is one of only a handful of countries that doesn’t guarantee paid maternity leave, exacerbating the financial stress of an already pricey phase of life. The Labor Department has found that nearly one-third of women who take unpaid time off for their own or dependents’ health issues fall into serious credit card debt.
Our Health, Our Selves

None of this is to say that the Affordable Care Act was a total wash for women. The ACA’s Medicaid expansion provided public health insurance to anyone with income below 137 percent of the federal poverty line, and federal subsidies (however inadequate) to anyone making below 400 percent. Because of the gendered wage gap, the effect was to extend insurance to more women than men. The law also took on health discrimination, by mandating that men and women pay equal premiums, ending gatekeeping based on preexisting conditions or the ability to become pregnant, and requiring that plans sold on state exchanges cover maternity care and birth control.

The ACA’s overhaul of the individual insurance market has helped somewhat to delink insurance from employment. Before the ACA, reproductive-age women faced considerable difficulties getting coverage on the individual market, since insurers were free to charge sky-high premiums to hedge against the possibility of having to shell out for maternity care. But even if premiums are more highly regulated, increased cost-sharing still means that patients pay stiff prices simply for getting the care they need: reproductive-aged women still spend over 60 percent more than men do in out-of-pocket health-care costs.

At the same time, while state ACA exchanges offer an alternative to employer-provided plans, the exchange plans remain inferior. Both tiers of insurance are plagued by narrowing provider networks, and ever-rising out of pocket costs – leading millions to forego insurance because it’s too unaffordable, or find themselves stuck with plans they can’t even afford to use. And that’s with the ACA.

In short, the dynamics that make the American health-care system so hostile to women remain largely unscathed after the ACA: the pervasive commodification of healthcare and dependent care in the United States, coupled with employment-based gatekeeping, engineers an impossible bind for women: they face more challenges accessing the health-care system and pay more for their care when they do, out of lower incomes that are further squeezed by child and elder care costs.
By removing power over health care from employers and spouses, and replacing unequal tiers with one unified insurance pool, we could fund our health-care system with progressive taxes. That way, we could guarantee everyone the care they need, and make it free at the point of service. Ability to pay, pre-existing conditions, employment status, and gender would cease to be barriers. Building Medicare for All — with robust guarantees for tougher-to-access services like abortion and gender affirming care — would force American society as a whole to address the care disparities women face.

ABOUT THE AUTHOR

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