

HEALTH EQUITY & HEALTHCARE SERVICES AS A PUBLIC UTILITY

Utility-style healthcare reform presents
a transformative solution to rising
costs, limited access, and systemic
inequities

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HEALTHCARE AS A PUBLIC UTILITY

ABSTRACT

Twenty-first-century healthcare in the United States is in a state of dysfunction. The nation spends more per capita on healthcare than other developed economies, yet health outcomes are too often inferior in comparison. Inequities in health outcomes and access to quality healthcare continue to plague rural and racial minority communities, which further widen the gap between the nation's haves and have-nots.

Given the failures of the present system, new approaches to healthcare delivery must be explored. This white paper examines the critical issues of escalating inequality in the US. healthcare system, unfair healthcare industry practice, stagnating competition, and how the implementation of a healthcare utility model can drive systemic reform to improve health outcomes for all Americans.



INTRODUCTION

Rising healthcare costs and poor health outcomes have presented challenges to American citizens and employers for decades. Despite spending more on healthcare per capita than other developed economies, health disparities have widened between the country's socioeconomic, racial, and other cultural groups¹.

Unchecked profiteering and manipulation of US healthcare regulation and policy have resulted in the expansion of large for-profit corporate healthcare conglomerates and contraction of impactful competition in the healthcare delivery space. In addition, healthcare deserts are rapidly growing in areas home to many of America's most vulnerable populations further accelerating the growth of health disparities².

As healthcare reform continues to be a matter of utmost importance for all Americans, different approaches to the industry must be identified, studied, and implemented. Treating healthcare as a public utility, while not a novel idea, may be part of a solution to restore healthcare accessibility and affordability in the United States, as well as unlock economic opportunity for US employers.



HEALTH INEQUITY IS A CONSEQUENCE OF THE STATUS QUO

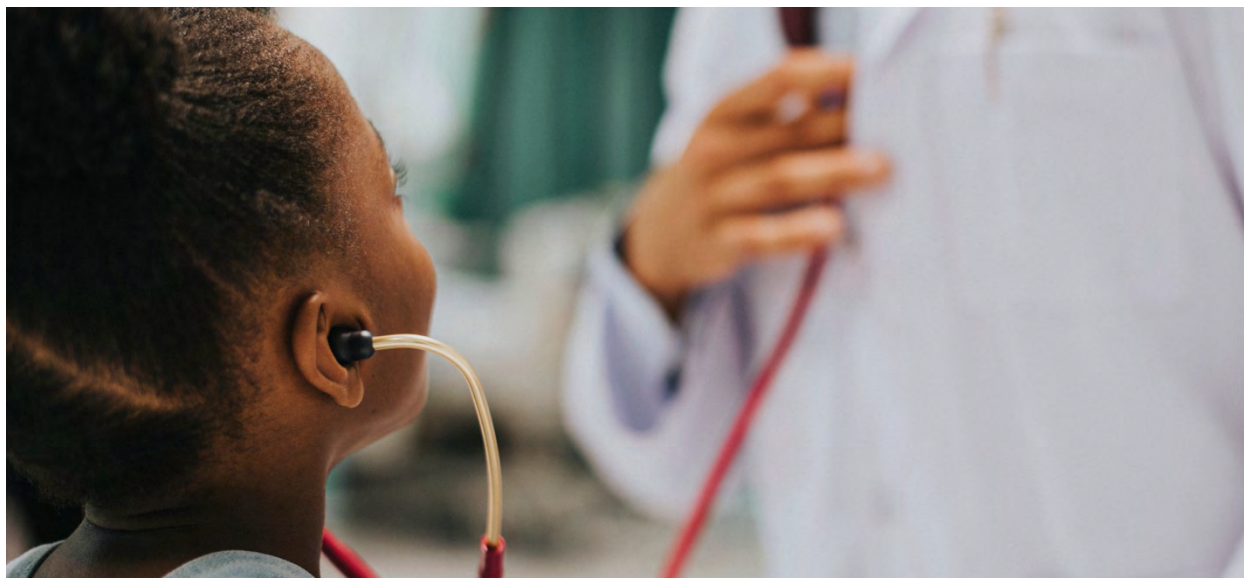
On July 22nd, 1946, the World Health Organization (WHO) adopted its constitution asserting that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”³. Since then, global public health has improved by leaps and bounds exemplified by the near elimination of deadly infectious diseases such as smallpox and polio. In the United States, disease rates for measles and syphilis have dropped 99.95% and 75.81% respectively⁴, and from 1959 to 2016, average life expectancy in the United States has increased from 69.9 years to 78.9 years⁵.

While overall national health outcomes have unquestionably improved, some Americans experienced these gains unequally. A 1999-2018 Society of Actuaries analysis on US all-cause mortality shows that Black and Native American populations experience higher age-adjusted mortality rates than White non-Hispanic Americans⁶. This mortality gap is more pronounced when considering deaths due to diabetes or stroke.

The impact of the COVID-19 pandemic further demonstrates a wide health equity gap. In a 2020 analysis, Millet et. al note that US counties that were disproportionately black (defined as $\geq 13\%$ black) accounted for 52% of COVID-19 diagnoses despite only 20% of US counties being in that demographic category⁷. That same year, the COVID-19 death rate for non-Hispanic blacks was double that of non-Hispanic whites (61.5/100,000 vs. 30.3/100,000).

The causes of health outcome inequities are multifaceted and are inextricably linked with access to quality healthcare or the lack there-of. Healthcare deserts are geographic areas where access to healthcare is inadequate or lacking altogether. While the quantitative element of the healthcare desert definition may vary from one analysis to another, there is little doubt that the phenomenon is worsening in the United States.

For many Americans, especially for those in rural communities, pharmacies are their primary healthcare touchpoint. Research published by the CHOICE Institute found that according to national 2022 census-tract-level data, 15.82 million American adults were living in pharmacy deserts. This definition underestimates challenges to pharmaceutical access as the census tracts were defined as pharmacy deserts if they met both a low access and low-income criteria. Based solely on pharmacy availability, the CHOICE Institute estimates 34 million adults, or roughly 13.2% of the US population, experienced low access to pharmacy. Over seven thousand pharmacies were closed from 2019 to 2024, further worsening healthcare access⁸.



A key driver of these pharmacy closures is unchecked industry practice by large healthcare conglomerates and their pharmacy benefit management (PBM) entities. Two of these practices, spread pricing and patient steering, have put small independent pharmacies out of business in critical areas where access is already scarce. Spread pricing occurs when PBMs reimburse pharmacies a lower amount than they bill to plan sponsors. While PBM-affiliated pharmacies may be able to absorb losses due to low reimbursements due to vertical integration, independent pharmacies may not. Patient steering occurs when PBMs put systems in place to encourage patients to fill prescriptions at PBM-affiliated pharmacies rather than local independently run pharmacies. According to a 2024 Federal Trade Commission report on PBM practices, roughly 10% of independent retail pharmacies were closed between 2013 and 2022^{9,10}.

PUBLIC UTILITIES, UNIVERSAL ACCESS, AND MODEST EARNINGS

Public utilities are entities that provide services fundamental to daily life and economic activity such as electricity, water, and telecommunications. Southern Company, American utility holding company headquartered in Atlanta, exemplifies this model by delivering electricity and natural gas to millions of customers across several states, including Alabama, Georgia, Florida, and Mississippi. Operating within a regulated framework, Southern Company is obligated to ensure reliable and affordable energy services equitably to all customers within its geographic service areas. This regulatory structure limits pricing flexibility and profit margins, thereby introducing a level of public accountability and curbing excessive profit-seeking behavior. For example, the

Georgia Public Service Commission (PSC) sets the return on equity (ROE) for Georgia Power, a subsidiary of Southern Company, at 11.9%. Should the company exceed this threshold, customers are eligible for rebates on their power bills, ensuring that profits are not disproportionately high at the expense of consumers¹¹.



Drawing a parallel to healthcare, inpatient and outpatient services are equally essential and should be treated with the same regulatory oversight as public utilities. By adopting a utility-based model for healthcare, similar to that of Southern Company, it is possible to ensure universal access, equitable pricing, and the prevention of excessive profit-seeking behaviors that can compromise the quality and accessibility of care. Implementing such a model would align healthcare services with the foundational principles of public utilities, prioritizing the well-being of the community over shareholder profits.



ADVANCES IN HEALTHCARE AS A UTILITY

Structured around a Healthcare Utility Model, Civica Rx was stood up in 2018 as a non-stock, nonprofit, 501(c)(4) social welfare organization to address the increasingly prevalent challenges drug shortages injected into the healthcare system.

Consolidation and lack of competition allowed pharmaceutical manufacturers to demand higher prices for drugs they knew they alone could supply. This forced providers to make difficult purchasing decisions that often resulted in shortages of these drugs. Some hospital systems practiced “hoarding” shortage drugs which further lessened the supply available to other providers. As of the publishing of this paper, the American Society of Health-System Pharmacists estimates that approximately generic 238 drugs are in shortage.

Civica Rx is financed directly by its customers or members, rather than by external investors or venture capitalists seeking returns. This alignment ensures the utility’s primary objective is delivering products and services at the lowest sustainable cost rather than maximizing profit or returns to financiers. Members, therefore, have incentives aligned with the utility’s mission and benefits directly from cost savings and increased¹². The company provides over fifty generics to member hospital systems, and to ensure market equity, all member hospital systems pay the same low price effectively eliminating preferential pricing. Civica Rx has partnered with Phlow Corp., a

public benefit corporation, to manufacture these generic pharmaceuticals domestically in the near future - reducing supply chain dependencies on China.



Civica Script is a subsidiary of Civica Rx that brings the healthcare utility model to the outpatient and retail pharmaceutical industry. While Civica Rx is purely nonprofit, as a public benefit company, Civica Script has adopted a hybrid structure to allow it to engage actively in the retail pharmaceutical marketplace, working closely with insurers and other stakeholders. The structure enables Civica Script to balance commercial agility with a strong public benefit mission, using its earnings primarily to support ongoing operations, expand offerings, and keep medication prices low.

As universal access is a key component of any utility service, some lessons may be learned from the U.S. Postal banking programs of the 20th century. The U.S. postal banking program, particularly its historical iteration from 1911 to 1967, offers a compelling precedent for the healthcare utility model by demonstrating how public physical infrastructure can be leveraged to deliver essential services equitably and affordably¹³. Like the Postal Savings System, which provided low-cost, government-backed financial services to underserved populations through a trusted, nationwide network, a healthcare utility model can use existing health system infrastructure to distribute essential medicines and services at the lowest sustainable cost. Both models reject profit maximization in favor of broad access and public welfare, showing that systems managed by stewards—not shareholders—can succeed in markets where private actors have failed to meet social needs. The postal banking model’s emphasis on accessibility, standard pricing, and community trust directly parallels the mission of health utilities like Civica Rx, offering a historic blueprint for how government-aligned,

mission-driven enterprises can disrupt inequitable markets and promote systemic resilience.



INDUSTRY EXCESSES AND CORRECTION THROUGH UTILITY

In 2024, the largest three pharmacy benefit managers controlled 80% of the market¹⁴. The pharmacy benefit divisions of UnitedHealth Group (OptumRx), CVS Health, and Cigna (Evernorth/ExpressScripts) have grown earnings to nearly \$20 billion through a range of opaque tactics: spread pricing, formulary steering, rebate gatekeeping, and vertical consolidation that blunts competition and inflates margins. These practices not only have driven financial gains but also inflated share prices, with UnitedHealth Group's stock price rising over 80%, CVS Health's by more than 35%, and Cigna's by over 70% between 2020 and 2024. This share value growth directly incentivizes and justifies outsized executive compensation packages - \$65 million in 2024 alone for the top leaders of those firms - rewards that are made possible only through a business model that systematically extracts value from patients, plan sponsors, and the public¹⁵⁻¹⁷.

This dynamic is not an unavoidable feature of healthcare markets – it is a governance failure that utility principles can correct. A public utility framework constrains runaway profiteering by placing limits on rate-setting, requiring transparent reinvestment into public benefit, and subordinating executive compensation to mission outcomes rather

than shareholder return. Under such a model, the financial windfalls that currently flow upward – reflecting by soaring stock valuations and escalating executive pay – would be redirected toward affordability, accessibility, and public health outcomes. Civica Rx has proven this model’s viability: as a nonprofit utility, it supplies critical drugs to one third of U.S. hospitals without fueling executive enrichment or speculative equity markets. Reimagining key healthcare functions – particularly controlling access to life-sustaining medications – as utilities would realign incentives toward care, not capital, and ensure that gains are reinvested in communities, not concentrated in boardrooms.



HEALTHCARE STABILITY AND ECONOMIC OPPORTUNITY

Civica Rx and Civica Script strengthen the stability of healthcare delivery for their members, and ultimately the American public. Financial stability surrounding healthcare can also have large economic impacts. Automotive manufacturers have long recognized Canada’s publicly funded healthcare system’s ability to lower manufacturing labor costs.

In 2010, the Canadian Auto Workers Union (CAW) which represents Ford, General Motors, and DaimlerChrysler published a letter¹⁸ in support of Canada’s publicly funded healthcare system. They contend that employers “enjoy significant total labor cost savings because most health care services are supplied through public programs (rather than through private insurance plans). CAW’s internal analysis found that labor costs in Canada were on average 34% lower than those in the United States – 25% of the savings was attributable to lower healthcare costs¹⁹.

Cost savings impact businesses of all sizes, not just the “Big 3” auto makers represented by CAW. A public healthcare system can also ease financial planning for small business by reducing administrative overhead and providing cost certainty to enable growth and competitiveness in their respective market. Introducing a public utility model to the US healthcare system has the potential to dramatically labor costs for employers and incentivize onshoring of manufacturing.



CONCLUSIONS

Traditional utilities are defined as such because they provide essential services where there is a universal need. Through regulation and government oversight, they are obligated to deliver services regardless of geographic or demographic differences in communities – all at transparent equitable pricing. Akin to how traditional regulated utilities foster public-private collaborations, health care utilities can use collaborative partnerships between health systems, philanthropies, and the government to maintain affordability and access, particularly benefiting underserved communities.

Health inequity is a critical issue affecting not only individuals but the broader healthcare industry as well. Health outcome gaps experienced by underserved communities weaken the American workforce and are all too often the result of unchecked industry practice. By reigning in unfair business practices, restoring competition, and exploring innovative approaches to physical infrastructure, healthcare utility models in the United States have the potential to influence healthcare cost, access, and health equity and would represent a transformative approach to healthcare delivery.

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