Global Institute for Sustainable Prosperity

Working Paper No. 129
March 2021

Does the United States Need a Comprehensive National Health System?

A Discussion of Views, Facts, Challenges, and Potential Benefits

David Stewart

Associate Professor of Finance, Winston-Salem State University

Sheilia R. Goodwin

Assistant Professor of Community Health Nursing and Research, School of Health Sciences, Division of Nursing, Winston-Salem State University

Nikolaos Karagiannis

Research Scholar, Global Institute for Sustainable Prosperity

Professor of Economics, Winston-Salem State University

Does the United States Need a Comprehensive National Health System?

A Discussion of Views, Facts, Challenges, and Potential Benefits

David Stewart
Associate Professor of Finance, Winston-Salem State University

Sheilia R. Goodwin
Assistant Professor of Community Health Nursing and Research, School of Health Sciences, Division of Nursing, Winston-Salem State University

Nikolaos Karagiannis
Research Scholar, Global Institute for Sustainable Prosperity
Professor of Economics, Winston-Salem State University

Abstract

This article will first provide the two main theoretical perspectives related to the U.S. health system: the "market-based" view and the "socially sensitive" view. The second main section will discuss important facts and highlights related to the national health situation of the United States compared with other advanced OECD countries. Taking these facts and highlights into consideration, the final sections of this work critically examine the merits and demerits of contrasting approaches to implementing a comprehensive national health and insurance scheme in the United States, and offer concrete policy considerations. Some brief conclusions end the article.

Keywords: universal health, national insurance system, market-based view, socially-sensitive view, the United States

JEL codes: H4, H5, I11, I13, I14, I18, J1

Does the United States Need a Comprehensive National Health System? [1,2]

A Discussion of Views, Facts, Challenges, and Potential Benefits

David Stewart
Associate Professor of Finance, Winston-Salem State University

Sheilia R. Goodwin
Assistant Professor of Community Health Nursing and Research, School of Health Sciences, Division of Nursing, Winston-Salem State University

Nikolaos Karagiannis
Research Scholar, Global Institute for Sustainable Prosperity
Professor of Economics, Winston-Salem State University

1. Introduction

Healthcare in the United States is provided through a combination of private health insurance and public health coverage (e.g., Medicare, Medicaid). Based on latest statistics, around 45 percent of health spending is paid for by the government at either the federal or state and local level. According to the Centers for Medicare & Medicaid Services (CMS Program Statistics, 2018),[3] in 2017, U.S. expenditures on healthcare reached $3,492.1 billion or approximately $10,740 *per capita*, and accounted for 17.9 percent of the nation's Gross Domestic Product (see Figure 1: CMS, 2018). U.S. hospitals are largely owned and operated by private sector institutions, with 3.3 percent owned by the federal government and 15.7 percent that are state, local government, or community owned hospitals (Figure 2: American Hospital Association, 2019). Further, 47.8 percent are nongovernment not-for-profit institutions, 21.3 percent are for-profit, and 11.9 percent are non-federal psychiatric and "other" hospitals. Although nearly 45 percent of health care spending and close to 18 percent of acute care facilities are government-supported (CMS, 2018), the U.S. does not have a universal health care system. This contributes to health disparities when the U.S. is compared to other advanced industrial countries (OECD, 2018).

[1] This paper is an amended version of a draft manuscript that was first submitted to the School of Health Sciences (SOHS) of Winston-Salem State University, North Carolina. Kind encouragement by the SOHS is gratefully acknowledged.

[2] Instead of the term "national health and insurance scheme", other academics and politicians use the terms "universal single-payer system" or "Medicare-for-All" (see, for instance, Nersisyan and Wray 2019, 24). These terms are being used interchangeably throughout the paper.

[3] These are the latest statistics and tables published by the Centers for Medicare & Medicaid Services: CMS Program Statistics 2017 (www.CMS.gov).

Moreover, the United States life expectancy is 78.6 years at birth, up from 75.2 years in 1990; this ranks 22nd out of the 35 industrialized OECD countries, down from 20th in 1990 (OECD 2018; 2020).[4] However, a relatively recent CDC statement indicates that the U.S. life expectancy has been reduced by drug overdoses and suicides over the past several years (Nov. 15, 2019). Of 17 high-income countries surveyed by the National Institutes of Health in 2018, the United States had the highest or near-highest prevalence of obesity, car accidents, infant mortality, heart and lung disease, sexually transmitted infections, adolescent pregnancies, injuries, and homicides (NIH 2019). A 2018 survey of the healthcare systems of 11 developed countries found the U.S. healthcare system to be the most expensive and the worst-performing in terms of healthcare access, efficiency, and equity (OECD Health Statistics 2019). While real incomes remained almost stagnant during the last two decades, health expenses have increased enormously.

What's more, in 2018, there were nearly 41 million people and around 28 million families living in poverty in the United States, with Blacks and Hispanics experiencing the highest poverty rates. The primary reason Americans have problems accessing health care is due to its prohibitively high cost. Based on statistics from the U.S. Census Bureau and the Gallup organization, around 29 million people did not have health insurance in 2018 (U.S. Census Bureau, Annual Social and Economic Supplements, 2018; 2019). Such a large number of people going without health insurance coverage in the United States is one of the primary concerns raised by advocates of health care reform.

With this general background in mind, the article will first provide the two main theoretical perspectives related to the U.S. health system: the "market-based" view and the "socially sensitive" view. The second section will address important facts and emphasize key figures related to the national health situation of the United States. Taking these facts and figures into consideration, the final sections of the article will critically examine the merits and demerits of contrasting approaches to implementing a national health and insurance scheme in the U.S., offering concrete policy considerations. Some brief conclusions end the article.

2. Theoretical Perspectives

In the United States, there have been two main kinds of arguments related to adopting "a national health and insurance scheme"—such as "Medicare-for-All" or a "universal single-payer system"—, particularly during the last decade: the first of these, the "market-based" argument, relies heavily on the neoclassical marginal analysis and the "dollars-and-cents" logic; the second, the "socially-sensitive" approach, emphasizes important principles such as coverage of the health needs of the total population and equity.

According to the proponents of the "market-based" view, mandatory health insurance increases the role of government and the expenses associated with a comprehensive national health and insurance scheme, provides perverse incentives for employers, is heavily subsidized, restrains individual choices, utilizes the "carrot and stick" approach, and offers limited results (e.g., uninsured individuals typically receive less care in a given year and wait longer to get treated). Mandatory health care can result in fewer uninsured individuals but cannot contain fast-rising

[4] See OECD Data (2018), Life expectancy at birth, and OECD (2020), OECD*i*Library. doi: 10.1787/27e0fc9d-en (Accessed on 13 February 2020).

costs in the health care system. Growing burdens on businesses mean that an increasing number may choose to steer employees into the mandatory health system rather than provide health insurance themselves. Consequently, market incentives are crucial to solve the pressing problems of efficiency and cost containment (Richardson, 2011). Some experts also point out countries such as Singapore and the Netherlands that have introduced "managed competition" in health services provision.

There are important exterior attitudes that contribute to the popularity of view. The social and political culture in America is such that a lower percentage of Americans were found to believe that health care for the sick is a government responsibility than citizens from other advanced countries, such as Canada, the U.K., Germany and Sweden (ISSP, 2011). Some interest groups have also done their best to bolster this view. Furthermore, America's political institutions make it difficult for massive entitlement programs to be enacted. As policy experts have pointed out in studies of the U.S. health system, the country does not have a comprehensive national health insurance system because "American political institutions are structurally biased against this kind of comprehensive reform" (Schuck & Wilson, 2008, p. x). The political system is prone to inertia, as any attempt at comprehensive reform must pass through the obstacles of congressional committees, budget estimates, conference committees, amendments, all while under threat of a potential veto or significant vocal public opposition or condemnation (Bond & Smith, 2016). Lobbyism plays a substantial role in the inertia as well.

Ultimately, the U.S. remains the only advanced industrialized nation without a comprehensive national health insurance system because of the many ways America is exceptional. The U.S. culture is remarkably individualistic, favoring personal initiatives over government responsibility, its lobbyists stay very politically involved as they spend billions to ensure that private insurers maintain their status in the health system, and American institutions are designed in a manner that limits major welfare programs and social policy changes (Bond & Smith, 2016).

From the "socially-sensitive" point of view, a number of studies have confirmed that prices and administrative costs in the U.S. are significantly higher compared with those in other developed countries that have some type of single-payer system. In a 2003 study, Anderson, Hussey and Petrosyan argued that prices account for much of the higher healthcare spending in the U.S. This is particularly disturbing when considering that real wages have remained almost stagnant during the last 20 years or so while healthcare prices have gone up excessively and disproportionately. A more recent study confirmed the results of their earlier study, despite all the reforms that have occurred since 2003, including Obamacare (Anderson, Hussey, & Petrosyan, 2019). Papanicolas, Woskie and Jha reached a similar conclusion that, "the United States spent approximately twice as much as other high-income countries on medical care" (2018). Nor do Americans receive more care—by some measures, they actually receive *less* care, as is exemplified by the data that there are fewer visits being made to physicians. However, the country is still spending more, a difference that is largely explained by higher prices. A 2019 study by Anderson et al. further demonstrated that the difference between prices paid in the private and public sectors has widened considerably since 2003. It is the greater dependence on private payers, rather than on the government as single-payer, that accounts for higher costs. Despite the increasing costs of healthcare in the U.S., the country is among the poorest performers in providing healthcare among industrialized nations.

Prohibitively high cost is the primary reason Americans have problems accessing health care. The rate of adults without health care insurance peaked at 18.0 percent in 2013 prior to the ACA mandate, fell to 10.9 percent in the third quarter of 2016, and rose to 13.7 percent in the fourth quarter of 2018, based on Gallup surveys beginning in 2008 (Gallup Personal Health Issues, 2020). At over 40 million, the number of people without health insurance coverage in the United States is one of the primary concerns raised by advocates of health care reform. Lack of health insurance is associated with increased mortality—about sixty thousand preventable deaths per year, depending on the study reviewed. Studies done at Harvard Medical School indicated that millions of Americans skip medications due to their high cost, and nearly 45,000 annual deaths are associated with a lack of patient health insurance. Studies also found that uninsured working Americans have an approximately 40 percent higher mortality risk compared to privately insured working Americans (Harvard Health Publishing, various).

Rising health care costs in the United States are in part the result of administrative costs. For instance, governance and administration costs accounted for 8 percent of total national health expenditures in the U.S. compared to a range of 1 to 3 percent in the other countries (Papanicolas, Woskie, & Jha (2018) calculated an OECD average of about 3 percent). Administrative costs on the provider side are comparatively high in the U.S. as well. For instance, over 24 percent of U.S. hospital spending is on administration, compared to around 13 percent in Canada.

3. Important Facts and Statistics

The U.S. healthcare system is notorious for its high costs and below par outcomes. The statistics highlighted in the following paragraphs are based on historical and projected national expenditures collected in the last five years as well as on international comparisons between the U.S. and other advanced OECD countries between 1970 and 2018 (CDC, 2018; CMS, 2018 and 2019; U.S. Census Bureau, 2018 and 2019).[5]

Historical NHE, 2018

- In 2017, 8.8 percent of the U.S. population (28.5 million people) did not have health insurance at any point during the year (Current Population Survey–Annual Social and Economic Supplement). The uninsured rate and number of uninsured people in 2017 were not statistically different from 2016, which was also 8.8 percent (28.1 million).
- The percentage of people with health insurance coverage for all or part of 2017 was 91.2 percent, not statistically different from the rate in 2016. Between 2016 and 2017, the number of people with health insurance coverage increased by 2.3 million, up to 294.6 million.
- In 2017, private health insurance coverage continued to be more prevalent than government coverage, at 67.2 percent and 37.7 percent, respectively. Of the sub-types of health insurance coverage, employer-based insurance was the most common, covering 56.0 percent of the population for some or all of the calendar year, followed by Medicaid (19.3 percent), Medicare (17.2 percent), direct-purchase coverage (16.0 percent), and military coverage (4.8 percent).

[5] Again, these are the latest figures and tables on Medicare enrollment, utilization, and expenditures published by the Centers for Medicare & Medicaid Services: CMS Program Statistics 2017.

- Between 2016 and 2017, the rate of Medicare coverage increased from 16.7 percent in 2016 by 0.6 percentage points to cover 17.2 percent of people for part or all of 2017. However, managed care, where payers use various means intended to improve quality and limit cost, has become ubiquitous.
- The military coverage rate increased by 0.2 percentage points to 4.8 percent during this time. Coverage rates for employment-based coverage, direct-purchase coverage, and Medicaid did not statistically change between 2016 and 2017.
- In 2017, the percentage of uninsured children under age 19 (5.4 percent) was not statistically different from the percentage in 2016. For children under age 19 in poverty, the uninsured rate (7.8 percent) was higher than for children not in poverty (4.9 percent).
- Across different States, disparities in health care and health outcomes are widespread. Minorities are more likely to suffer from serious illnesses and less likely to have access to quality health care, including preventative services. Between 2016 and 2017, the percentage of people without health insurance coverage at the time of interview decreased in three states and increased in fourteen states. Between 2016 and 2017, the uninsured rate did not statistically change for any race. In 2017, non-Hispanic Whites had the lowest uninsured rate among the races and Hispanic-origin groups (6.3 percent). The uninsured rates for Blacks and Asians were 10.6 percent and 7.3 percent, respectively. Hispanics had the highest uninsured rate (16.1 percent).
- The U.S. life expectancy is 78.6 years at birth, up from 75.2 years in 1990; on this issue, the country ranks 42nd among 224 nations and 22nd out of the 35 industrialized OECD countries, down from 20th in 1990. In 2016 and 2017, life expectancy in the U.S. dropped for the first time since 1993. Of 17 high-income countries studied by the National Institutes of Health, in 2017, the United States had the highest or near-highest prevalence of obesity, car accidents, infant mortality, heart and lung disease, sexually transmitted infections, adolescent pregnancies, injuries, and homicides. The underutilization of preventative measures, high rates of preventable illness, and prevalence of chronic disease suggest that the U.S. healthcare system does not sufficiently promote wellness (CMS, National Health Expenditure Data: Historical, 2019).

Projected NHE, 2018-2027

- Under current law, national health spending is projected to grow at an average rate of 5.5 percent per year from 2018-27 and to reach nearly $6.0 trillion by 2027.
- Healthcare spending is projected to grow 0.8 percentage points faster than Gross Domestic Product (GDP) per year over the 2018-27 period; as a result, the health share of GDP is expected to rise from 17.9 percent in 2017 to 19.4 percent by 2027.
- Key economic and demographic factors fundamental to the health sector are anticipated to be the major drivers of health care spending during 2018-27.
- Prices for health care goods and services are projected to grow somewhat faster over 2018-27 (2.5 percent compared to 1.1 percent for 2014-17).
- As a result of comparatively higher projected enrollment growth, average annual spending growth in Medicare (7.4 percent) is expected to exceed that of Medicaid (5.5 percent) and private health insurance (4.8 percent).

- The impacts of Medicare enrollment are the key reason the share of health care spending sponsored by federal, state, and local governments is expected to increase by 2 percentage points over the projection period, reaching 47 percent by 2027.
- The insured share of the population is expected to remain stable at around 90 percent throughout 2018-27 (CMS, National Health Expenditure Data: Projections, 2019).

International Comparisons, 1970-2018

- Relative to the size of its wealth, the U.S. spends a disproportionate amount of money on health care. As would be expected, wealthy countries like the U.S. tend to spend more per person on health care and related expenses than lower income countries. However, even as a high-income country, the U.S. spends more per person on health than comparable countries.
- On average, other wealthy countries spend about half as much per person on health than the U.S. spends. Comparing health spending in the U.S. to other countries is complicated, as each country has unique political, economic, and social attributes that contribute to its spending. Because health spending is closely associated with a country's wealth, the remaining charts compare the U.S. to similar OECD countries—those that have above median national incomes (as measured by GDP) and also have above median income per person.
- Since 1980, the gap between U.S. health spending and that of other countries has widened. This has also been the case with the difference between health spending as a share of the economy in the U.S. and comparable OECD countries.
- In 2016, the U.S. spent about 8.5 percent of its GDP on health care out of public funds, which was essentially equivalent to the average of the other comparable countries. However, private spending on health care in the U.S. is much higher than any comparable country, comprising 8.8 percent of GDP in the U.S., compared to a 2.7 percent average of the GDP of other nations.
- Over the last three decades, the U.S. has increased both public and private sector spending on health care at a faster rate than similar countries. Comparable countries increased private sector spending from 1.4 percent to 2.7 percent of GDP from 1970 to 2017, while the U.S. increased private sector spending from 3.9 percent to 8.8 percent during the same period. In 2017, the U.S. spent around 8.5 percent of its GDP on health care through public funds, a rate similar to comparable countries (Sawyer and Cox 2018: Figures 1-7).

4. A Facts-based Critical Assessment

Health care in the United States is provided by many distinct organizations. Health care facilities are largely owned and operated by private sector businesses. 58 percent of community hospitals are non-profit, 21 percent are government owned, and 21 percent are for-profit. "Adoption of [a] single-payer national health system (replacing for-profit private insurers) would significantly reduce the resources devoted to unusual ways of paying for healthcare. It would eliminate the private insurance sector's participation, reduce employers' costs of administering healthcare plans, reduce the costs incurred by doctors and hospitals due to billing insurers as well as pursuing patients for uncovered cost, lower the costs of appealing denials, and cut costs

associated with patients avoiding early treatment of diseases (because of the actual or expected out-of-pocket costs) that become chronic and expensive maladies" (Nersisyan & Wray, 2019, 26. See also U.S. Census Bureau, New 2018 Service Annual Survey Data Released).

The health of the population is viewed as a measure of the overall effectiveness of the healthcare system. The extent to which the population lives longer, healthier lives signals an effective system and significantly contributes to a healthier human capital. Yet, one concern about the health system is that the health gains do not accrue uniformly to the entire population. Those who are insured may be underinsured because they cannot afford adequate medical care. In practice, the uninsured are often treated, with the cost being covered through taxes and other fees, shifting the bill onto taxpayers. Forgone medical care due to extensive cost sharing may ultimately increase costs due to downstream medical issues; this dynamic may be one factor to high health care expenditures in the U.S. when compared to other countries.

From a macroeconomic standpoint, "while the distribution of spending between private and public sectors would change, causing a lot of anxiety about potentially ballooning government deficits, there is nothing about government spending that necessarily makes it more inflationary than private spending—all else equal". Indeed, according to estimates by Nersisyan and Wray, Medicare-for-all "could save from 2.61 percent to 3.67 percent of GDP, depending on the assumptions, while providing healthcare to the whole population". Consequently, "if private spending on healthcare costs falls by more than the increased spending by [Federal] government, the movement to single-payer will be deflationary, not inflationary" (Nersisyan and Wray, 2019, 30-31). Others predict savings of about 1.58 percent of GDP (Pollin et al., 2018, 27). "What will really matter is the overall increase of demand on resources" while implementing a national health and insurance scheme and, perhaps, focusing more on preventive medicine (Nersisyan & Wray, 2019, 27).

Moreover, a large demographic shift in the United States is putting pressure on the medical system as "baby boomers" reach retirement age. The demographic shift to an older population is projected to increase medical spending in the United States by at least 5 percent, creating a funding challenge that the government—through Medicare and other social services—, insurance companies, and individual savings accounts will strain to absorb. All these factors put pressure on wages and working conditions, with some healthcare jobs seeing salary reductions (Papanicolas, Woskie, & Jha, 2018).

5. Suggestions for a Comprehensive National Health System

It is our opinion that everyone should be included in a single-payer public plan covering all medically necessary services, including: acute, rehabilitative, long-term, and home care; mental health services; dental services; occupational health care; prescription drugs and medical supplies; and preventive and public health measures. Boards of experts and community representatives would determine which services were unnecessary or ineffective, and these would be excluded from coverage. As in Canada, alternative insurance coverage for services included under the national health program would be eliminated, as would patient copayments and deductibles. Whether a universal health and insurance coverage scheme enhances economic growth or productivity or whether it contributes to a more fair and better society depends on how

such a national health program is constructed, as well as which services are particularly emphasized, given that a just society takes care of its citizens' basic social needs.

Clearly, the "Medicare-for-all" proposal is completely different from the Certificate of Need (CON) that many States have. Although there is a large degree of variation between different States, CON laws are basically designed to control the growth and associated costs of health care facilities and services, to coordinate the planning of healthcare facilities, and to avoid duplication (Kagan, 2018). Universal coverage would solve the crucial problem in health care by eliminating the financial barriers to it. Considering existing health disparities in the U.S., a single comprehensive program is necessary both to ensure equal access to care and to minimize the complexity and expense of billing and administration. The public administration of insurance funds would save tens of billions of dollars each year.

The complexity of the current insurance system, with its multiplicity of payers, forces U.S. hospitals to spend more than twice as much as Canadian hospitals on billing and administration and requires U.S. physicians to spend about 10 percent of their gross incomes on excess billing costs (OECD, 2019). Eliminating insurance programs that duplicated the national health program coverage, though politically thorny, would clearly be within the prerogative of the U.S. Federal government. Failure to do so would require continuation of the costly bureaucracy necessary to administer and deal with such programs (Pollin at al., 2018; Nersisyan & Wray, 2019).

Copayments and deductibles endanger the health of poor people who are sick, decrease the use of vital inpatient medical services as much as they discourage the use of unnecessary ones, discourage preventive care, and are unwieldy and expensive to administer. Canada has few such charges, yet health costs are lower than in the United States and have risen more slowly. In contrast, the increasing copayments and deductibles in the U.S. have failed to slow the escalation of costs. Instead of the confused and often unjust dictates of insurance companies, a greatly expanded program of technology assessment and evaluation of cost-efficiency would guide decisions about covered services, as well as about the allocation of funds for capital spending, drug formularies, and other issues (OECD, 2019; Papanicolas, Woskie, & Jha, 2018).

Current capital spending greatly affects future operating costs as well as the distribution of resources. Effective health planning requires that funds go to establishing high-quality, efficient programs in the areas of greatest need. Under the existing reimbursement system, which combines operating and capital payments, prosperous hospitals can expand and modernize, whereas impoverished ones cannot, regardless of the health needs of the population they serve or the quality of services they provide. The national health program would replace this implicit mechanism for distributing capital with an explicit one, which would facilitate monetary allocation on the basis of need and quality of care already available. Insulating these crucial decisions from distortion by narrow interests would require the rigorous evaluation of the technology and assessment of needs, as well as the active involvement of providers and patients (Nersisyan & Wray, 2019).

What Keynes (1940) was arguing in *How to Pay for the War* is very relevant here. To implement his framework in the United States, one would need a different public finance outlook that emphasizes the fundamental principles of "social justice" and "ability-to-pay" in order to reduce

inequality at the top and effectively address tax avoidance and loopholes. Given that about 47 to 51 percent of the Federal revenue comes from individual income taxes, around 6-11 percent from corporate income taxes, and 33-35 percent from payroll taxes that fund social insurance programs, such a view clearly assumes that raising taxes on rich and wealthy Americans would enable them to make a more equitable and meaningful contribution to the Federal tax revenue (Tax Policy Center, and Office of Management and Budget (OMB), various fiscal years).

Still, funds for the construction or renovation of health facilities and for purchases of major equipment would be appropriated from the national health program budget. The funds would be distributed by state and regional health-planning boards composed of both experts and community representatives. Capital projects funded by private donations would require approval by the health-planning board if they entailed an increase in future operating expenses. The national health program would pay owners of for-profit hospitals, nursing homes, and clinics a reasonable fixed rate of return on existing equity. Since virtually all new capital investment would be funded by the national health program, it would not be included in calculating the return on equity (Nersisyan & Wray, 2019).

In short, the health care system of the United States is failing. Tens of millions of people are uninsured, costs are skyrocketing, and the bureaucracy is expanding. The federal government has the important responsibility to support adequate social services and promote the well-being of citizens. Reforms can only succeed by addressing old problems with socially-sensitive solutions. The solution that is being emphasized here is a national health program that would: first, fully cover everyone under a single, comprehensive public insurance program; second, pay hospitals and nursing homes a total annual amount to cover all operating expenses; third, fund capital costs through separate appropriations; fourth, pay for physicians services and ambulatory services either through fee-for-service payments with a simplified fee schedule and mandatory acceptance of the national health program payment as the total payment for a service or procedure (assignment), through budgets for hospitals and clinics employing salaried physicians, or on a *per capita* basis (fee); fifth, be funded, at least initially, from the same sources as at present, but with payments disbursed from a single pool; and, last of all, contain costs through savings on bureaucracy and billing, improve and make health planning more proficient, and establish overall health care spending limits.

6. Concluding Remarks

As expected, our paper leaves many vexing problems unsolved. Much detailed planning would be needed to ease dislocations during the implementation of a "Medicare-for-all" program. Neither the encouragement of preventive health care and healthful lifestyles nor improvements in occupational and environmental health would automatically follow from the institution of a national health program. Similarly, racial, linguistic, geographic, and other nonfinancial barriers to access would persist. The need for continuing to fund higher education for health care providers in times of shortage would be no less pressing. Establishing research priorities and allocating and directing funds to high-quality investigations would be no easier. Further work in the area of long-term care would be required. Regional health planning and capital allocation would make possible—but not ensure—the fair and efficient allocation of resources. Although

all these problems would not be instantaneously solved, a comprehensive national health program would establish a framework for addressing them.

Through this paper, assuming that modern forms of intervention ought to be socially-sensitive and egalitarian (given the range and magnitude of health problems in the United States), we seek to provide a realistic framework for genuine public debate of fundamental health policy requirements. A national health and insurance scheme or a universal "Medicare-for-all" will undoubtedly encounter powerful opponents in the health insurance industry, firms that do not now provide health benefits to employees, and medical entrepreneurs. However, it will also have allies. For instance, most physicians (56 percent) support a single-payer health system, and about half (49 percent) support "Medicare-for-all" (Bluth, 2017; Finnegan, 2019).[6] Many of the largest corporations would enjoy substantial savings if such a proposal were adopted. More significantly, the great majority of Americans would greatly benefit from a universal, comprehensive, publicly administered national health program. If mobilized, such public conviction could override even the most strenuous private and political opposition. Most importantly, a sophisticated understanding of the needs for socially sensitive government action is a requisite to an appropriate selection of thorough, technically proficient, and well-planned strategies and policies.

References

Anderson, G. F., Hussey, P. and Petrosyan, V. (2019), "It's Still The Prices, Stupid: Why The US Spends So Much On Health Care, and A Tribute To Uwe Reinhardt", *Health Affairs*, **38** (1): 87-95, January. https://doi: 10.1377/hlthaff.2018.05144

Anderson, G. F., Hussey, P. and Petrosyan, V. (2013), "It's The Prices, Stupid: Why The United States Is So Different From Other Countries?", *Health Affairs*, **22** (3): 89-105, May-June. https://doi.org/10.1377/hlthaff.22.3.89

Bluth, R. (2017), "Doctors Warm to Single-Payer Health Care", Kaiser Health News, August 16. https://khn.org/news/doctors-warm-to-single-payer-health-care/

Bond, J. R., and Smith, K. B. (2016), *Analyzing American Democracy: Politics and Political Science* (2nd ed.), London: Routledge.

Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, Tables **42** & **43**.

https://www.cdc.gov/nchs/data/hus/2018/042.pdf

https://www.cdc.gov/nchs/data/hus/2018/043.pdf

[6] See Bluth (2017), "Doctors Warm to Single-Payer Health Care", and Finnegan (2019), "Poll Finds 49% of Doctors Support 'Medicare-for-All'".

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/2017/2017_Main

https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/NHE-Presentation-Slides.pdf

https://www.dol.gov/wb/stats/earnings-text.htm

Congressional Budget Office, Health Care, https://www.cbo.gov/topics/health-care

Finnegan, J. (2019), "Poll Finds 49% of Doctors Support 'Medicare-for-All' ", FierceHealthcare, May 30. https://www.fiercehealthcare.com/practices/poll-finds-49-doctors-support-medicare-for-all

Harvard Health Blog, *Harvard Health Publishing*, various. https://www.health.harvard.edu/blog/

Health Care Facts, Health Care in America

https://www.healthcarefacts.info/?utm_source=pm_search&utm_content=C4&gclid=EAIaIQobChMIgYO16fP55QIVA-iGCh05xwAnEAAYASAAEgKOOfD_BwE

Kagan, J. (2018), "Certificate of Need", Health Insurance Basics, *Investopedia*, June 7. https://www.investopedia.com/terms/c/certificate-of-need.asp

Keynes, J. M. (1940), *How to Pay for the War: A Radical Plan for the Chancellor of the Exchequer*, London: Macmillan.

Nersisyan, Y. and Wray, L. R. (2019), "How to Pay for the Green New Deal", Levy Economics Institute of Bard College, Working Paper No. **931**, May.

OECD (2019), OECD Health Statistics 2019, OECD.STAT.

http://www.oecd.org/els/health-systems/health-data.htm

OECD (2018), OECD Health Statistics, OECD*i*Library.

https://www.oecd-ilibrary.org/social-issues-migration-health/data/oecd-health-statistics_health-data-en

https://www.taxpolicycenter.org/briefing-book/what-are-sources-revenue-federal-government

https://www.cbpp.org/research/federal-tax/policy-basics-where-do-federal-tax-revenues-come-from

OECD (2020), Life expectancy at birth, OECD*i*Library.

https://data.oecd.org/healthstat/life-expectancy-at-birth.htm

OECD (2018), Life expectancy at birth, OECD Data. https://doi: 10.1787/27e0fc9d-en (Accessed on 13 February 2020).

Office of Management and Budget (OMB), Washington DC: http://www.whitehouse.gov/omb/budget/HISTORICALS

Papanicolas, I., Woskie, L. R. and Jha, A. K. (2018), "Health Care Spending in the United States and Other High-Income Countries", *Clinical Review & Education*, JAMA **319** (10), 1024-1039, American Medical Association. doi:10.1001/jama.2018.1150

Pollin, R., Heintz, J., Arno, P., Wicks-Lim, J., and Ash, M. (2018), "Economic Analysis of Medicare-for-All", Amherst, MA: Political Economy Research Institute, November 30.

Richardson, C. R. (2011), "Mandatory Health Insurance: Lessons from Massachusetts", 93-104 in *Modern Competitiveness in the Twenty-first Century: Global Experiences*, edited by J. M. Bailey, C. Chin-Loy, N. Karagiannis and Z. Madjd-Sadjadi, Lanham MD: Lexington Books.

Sawyer, B. and Cox, C. (2018), "How Does Health Spending in the U.S. Compare to Other Countries?", Peterson-KFF, Health System Tracker (December 7). https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#item-start

Schuck, P. H., and Wilson, J. Q. (eds.) (2008), *Understanding America: The Anatomy of An Exceptional Nation*, New York: Public Affairs Books.

U.S. Census Bureau (2018), "Health Insurance Coverage in the United States: 2017", Report No. **P60-264**, Washington DC, September 12.

U.S. Census Bureau, Current Population Survey (CPS) – Annual Social and Economic Supplements (ASEC) and the American Community Survey (ACS)

https://www.census.gov/topics/health.html

https://www.census.gov/topics/health/data.html

https://www.census.gov/programs-surveys/cps/data-detail.html

https://www.statista.com/statistics/184955/us-national-health-expenditures-per-capita-since-1960/

http://w.issp.org/survey-topics/

Appendix

Figure 1

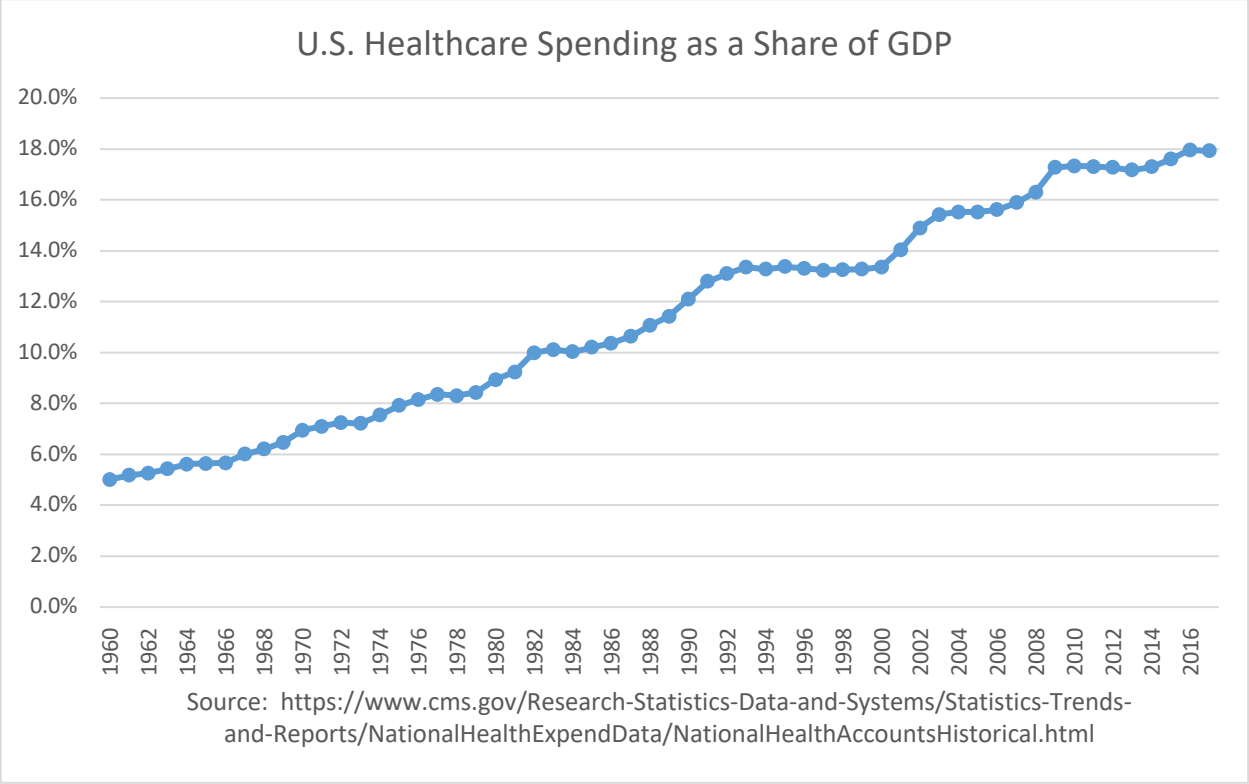
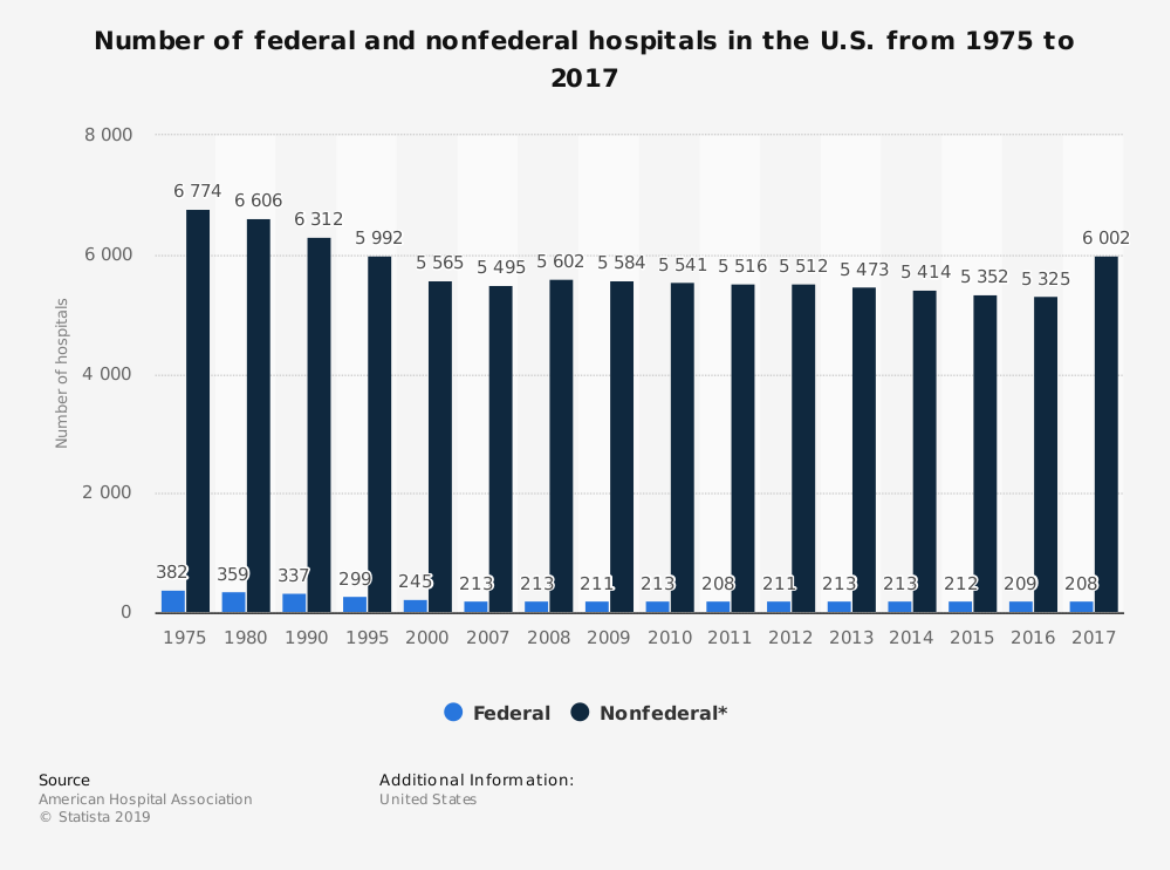


Figure 2


Number of federal and nonfederal hospitals in the U.S. from 1975 to 2017
8 000
6 000
4 000
2 000
0
Number of hospitals
6 774
6 606
6 312
5 992
5 565
5 495
5 602
5 584
5 541
5 516
5 512
5 473
5 414
5 352
5 325
6 002
382
359
337
299
245
213
213
211
213
208
211
213
213
212
209
208
1975
1980
1990
1995
2000
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
Federal
Nonfederal*
Source
American Hospital Association
© Statista 2019
Additional Information:
United States