Healthcare in the United States of America

0. Healthcare: Definitions and Implications

In this paper, healthcare (or "care", "healthcare services") will refer to the organized provision of services for the improvement or optimization of mental and physical wellbeing. This is a very complex topic, making discussion of its details important for students to navigate the realities of the American healthcare system.[1] In fact, for every claim about the healthcare system in this paper there is likely some evidence or argument disputing it. This is thus not meant to be a comprehensive repository of all healthcare research done about the United States, but rather a guide to healthcare in the US that outlines the major issues researchers think about with regards to healthcare access in the US.

To limit the scope of this paper, there will be a specific focus on 1) major medical care providers, i.e. doctors and hospitals, and 2) insurance coverage for access to such providers' services. This paper will also discuss 3) previous and potential future policy reforms to the healthcare system and the challenges policymakers face.

However, first is a discussion of why healthcare is an important issue at all. What issues does our healthcare system have? Comparing it to those of other countries with similar economies and "levels of development" is revealing. A 2016 Commonwealth Fund study comparing adults in the United States versus those living in 11 other countries found that Americans are more likely to go without healthcare because of the cost or struggle to get healthcare without resorting to the emergency department.[2] (It should be noted that the US did comparatively better on specialized care and discharge planning.) In fact, it even goes as far as to say that "One-third (33%) of U.S. adults went without recommended care, did not see a doctor when sick, or failed to fill a prescription because of costs". The Affordable Care Act of 2014 seemed to improve access to care, but not enough to reverse this trend.

Spending on healthcare overall is much higher in the United States than other OECD countries. Per a Brooking Institute report from 2018, what the US spends in public and private health

---

[1] Joy, Kevin. "Health Literacy in Schools: Health Insurance & Public Policy." University of Michigan Health Lab Blog, University of Michigan Health, 10 Nov. 2016, https://labblog.uofmhealth.org/industry-dx/a-new-prescription-for-k-12-educators-teach-kids-about-health-care.

[2] Osborn, Robin. "In New Survey of 11 Countries, U.S. Adults Still Struggle with Access to and Affordability of Health Care." U.S. Adults Still Struggle with Access to and Affordability of Health Care, The Commonwealth Fund, 16 Nov. 2016, https://www.commonwealthfund.org/publications/journal-article/2016/nov/new-survey-11-countries-us-adults-still-struggle-access-and

expenditures is almost twice that of the average of OECD countries.[3] It spends more on administrative costs—processing insurance claims, determining eligibility for services, authorizing health services, and so on—as a percent of its GDP than other countries. Its healthcare prices are much higher than other countries. Altogether, healthcare appears far more expensive in the US than any other country of a similar economy.

This is very important because healthcare is a huge part of the economy. Per the same Brookings Institute report, in 2018, the healthcare sector employed eleven percent of workers, spending on healthcare totalled ten percent of GDP, and in some cases the cost of major health events exceeded the value of poorer households. That same year, Moody's Investor Service warned that rising healthcare costs could eat up government, corporate, and household budgets; hurt consumer spending and confidence; stall economic growth by halting investments in other sectors; and make American firms less competitive due to rising costs of subsidizing worker healthcare.[4]

It is therefore no surprise that lots of political debate has been focused on healthcare insurance in the past decade. The health consequences of being uninsured are huge. Americans without health insurance see physicians less regularly and delay or avoid medical care, even when necessary. The result is that uninsured Americans are sicker, have shorter life-spans, and are more susceptible to chronic illnesses or diseases that require preventative or chronic treatment or testing, like cancer.[5]

Many studies establish health outcome disparities over various categories such as race, sex, gender, and sexual orientation. On aggregate, ethnic and racial minorities have higher rates of and suffer more from chronic diseases such as heart disease and cancer, and are more likely to

---

[3]Nunn, Ryan, et al. "A Dozen Facts about the Economics of the US Health-Care System." Brookings Institute, Brookings Institute, 9 Mar. 2022, https://www.brookings.edu/research/a-dozen-facts-about-the-economics-of-the-u-s-health-care-system/.

[4]Sanborn, Beth Jones. "Healthcare Spending in the U.S. Sends Damaging Ripple Effect across Other Major Sectors, Households, Moody's Report Says." Healthcare Finance News, HIMSS Media, 18 Sept. 2018, https://www.healthcarefinancenews.com/news/healthcare-spending-us-sends-damaging-ripple-effect-across-other-major-sectors-households.

[5]American College of Physicians-American Society of Internal Medicine. "No Health Insurance? It's Enough to Make You Sick - Scientific Research Linking the Lack of Health Coverage to Poor Health." American College of Physicians-American Society of Internal Medicine, Mar. 2000, https://www.acponline.org/acp_policy/policies/no_health_insurance_scientific_research_linking_lack_of_health_coverage_to_poor_health_1999.pdf.

die earlier.[6] This has been attributed to income disparities over race and ethnicity, a lack of insurance coverage from immigration status, geographic location relative to accessible high-quality healthcare, and racial stereotyping/unconscious biases in providers.[7] Mortality rates for women have increased in the United States from 2004 to 2014, and HIV/AIDS remains prevalent among gay/bisexual men (accounting for 81% of new cases according to the CDC), especially African-American gay/bisexual men. Overall, "social determinants" of health like poverty, living environment, stable employment and shelter, and healthcare access and quality result in health disparities for minorities in the United States.[8] [9]

The future outlook for the US healthcare system is mixed. Aside from accessibility and cost issues that will be explored further in this paper, there are other major sources of instability on the horizon. One important one is aging: as life expectancies increase, the number of elderly Americans is expected to as well, leading to higher demand for health services and therefore likely more required Medicare and Medicaid spending, with the CMS estimating national health spending to hit $6 trillion by 2027.[10] Another is the COVID-19 pandemic, which the American Hospital Association argues has led to healthcare expenses increasing by around a fifth from pre-pandemic levels, increased physician burnout rates, critical staff shortages, and rising labor

---

[6] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Baciu A, Negussie Y, Geller A, et al., editors. Communities in Action: Pathways to Health Equity. Washington (DC): National Academies Press (US); 2017 Jan 11. 2, The State of Health Disparities in the United States. Available from: https://www.ncbi.nlm.nih.gov/books/NBK425844/.

[7]Williams, D R, and T D Rucker. "Understanding and addressing racial disparities in health care." Health care financing review vol. 21,4 (2000): 75-90. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194634/.

[8]"About Social Determinants of Health (SDOH)." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 10 Mar. 2021, https://www.cdc.gov/socialdeterminants/about.html.

[9]Ndugga, Nambi, and Samantha Artiga. "Disparities in Health and Health Care: 5 Key Questions and Answers." Kaiser Family Foundation, 12 May 2021, https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/.

[10]Inserro, Allison. "Aging Population Continuing to Drive National Health Spending, Report Says." AJMC, AJMC, 30 July 2020, https://www.ajmc.com/view/aging-population-continuing-to-drive-national-health-spending-report-says.

costs.[11] More than a third of American hospitals were estimated to have had negative operating margins in 2021.[12]

However, the healthcare system and industry is also set to change in new ways. As a result of the COVID-19 pandemic, telehealth, referring to the use of technology to access healthcare remotely or virtually, is significantly more utilized by consumers now, who are also more open to using it, as are health providers.[13] The telehealth industry is thus receiving much more attention and investment now. The increase in available health data, as well as the large market for artificial intelligence applications in healthcare—one estimate puts it at 6 billion dollars—could make healthcare more accessible, improve diagnostics, and lead to more preventative care as well.[14] Adoption of AI has been relatively slower than other markets, possibly due to regulatory barriers.[15] Despite this, some industry leaders think that there will soon be a shift in the way healthcare works as a result of digitization.[16]

However, trends in healthcare services are incomplete if not taken into account with the capacity for individuals to access and afford them. This paper will therefore next introduce the major healthcare providers and spenders in the United States, and their roles in the overall healthcare system—as well as how they may be contributing to a perceived cost crisis.

---

[11]Hughes, Stacey. "AHA Letter Re: Challenges Facing America's Health Care Workforce as the U.S. Enters Third Year of Covid-19 Pandemic: AHA." American Hospital Association, 1 Mar. 2022, https://www.aha.org/lettercomment/2022-03-01-aha-provides-information-congress-re-challenges-facing-americas-health.

[12]KaufmanHall. "Financial Effects of Covid-19: Hospital Outlook for the Remainder of 2021: AHA." American Hospital Association, Sept. 2021, https://www.aha.org/guidesreports/2021-09-21-financial-effects-covid-19-hospital-outlook-remainder-2021.

[13]Bestsennyy, Oleg, et al. "Telehealth: A Quarter-Trillion-Dollar Post-Covid-19 Reality?" McKinsey Company, McKinsey Company, 28 Feb. 2022, https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality.

[14]"Five Distinct Trends Are Converging to Determine How Artificial Intelligence (AI) and Robotics Will Define New Health." PwC, June 2017, https://www.pwc.com/gx/en/industries/healthcare/publications/ai-robotics-new-health/five-trends.html.

[15]Goldfarb, Avi, and Florenta Teodoridis. "Why Is AI Adoption in Health Care Lagging?" Brookings Institute, Brookings Institute, 9 Mar. 2022, https://www.brookings.edu/research/why-is-ai-adoption-in-health-care-lagging/.

[16]McCain, Kelly. "Healthcare Leaders Discuss 2022 Tech, Investment and Digitalization Outlook." World Economic Forum, 17 Jan. 2022, https://www.weforum.org/agenda/2022/01/biggest-healthcare-shifts-experts-expect-to-see-in-2022/.

1. Healthcare Providers: Costs and Concerns

Healthcare in the United States is provided through a mix of different kinds of "healthcare providers" (or "providers"). This paper will first introduce two major players in healthcare provision who are also the top sources of healthcare spending—doctors and hospitals—and their particular features that may contribute to high healthcare costs.

Hospitals connect patients to physicians, nurses, and other healthcare workers, as well as various medical supplies such as hospital beds, IVs, and surgical equipment. Though hospitals in the US may each have unique specialties or types of patients, they share many common characteristics too. For example, the vast majority of hospitals are "acute-care" hospitals, meaning they provide short-term care or intensive care, as opposed to "chronic-care" (ex: rehabilitation, chronic illness, psychiatric care, etc).[17]

Of the over six thousand hospitals in the United States, close to one half of them are non-profit hospitals.[18] A non-profit hospital still charges patients for their services, but the money it makes goes back into the hospital, versus a for-profit hospital, where profit goes to investors of the hospital. However, non-profit hospitals are not immune to market pressures. The pandemic has accelerated the trend of (even non-profit) hospitals "consolidating", meaning they are increasingly merging and owned by the same corporations or boards. The Federal Trade Commission and many healthcare researchers believe this drives costs up due to a lack of competition.[19] [20] [21] The American Hospital Association disagrees.[22]

Being major hubs of healthcare in the United States, the accessibility of hospitals is of major significance for Americans in need of services, cost being a major barrier. Another factor leading

---

[17]Mitchell, Erica. "Types of Hospitals in the US." Health.Care. | An Educational Blog, EOS Services, 6 Jan. 2017, http://blog.eoscu.com/blog/types-of-hospitals-in-the-us.

[18]"Fast Facts on U.S. Hospitals, 2022: AHA." American Hospital Association, American Hospital Association, 2022, https://www.aha.org/statistics/fast-facts-us-hospitals.

[19]Lopez, Eric, and Karyn Schwartz. "What We Know about Provider Consolidation." Kaiser Family Foundation, 2 Sept. 2020, https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/.

[20]Gale, Arthur H. "Bigger but not better: hospital mergers increase costs and do not improve quality." Missouri medicine vol. 112,1 (2015): 4-5. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6170097/.

[21]Miller, Brian J., et al. "Reversing Hospital Consolidation: The Promise of Physician-Owned Hospitals: Health Affairs Forefront." Health Affairs, 12 Apr. 2021, https://www.healthaffairs.org/do/10.1377/forefront.20210408.980640.

[22]"The Value of Hospital Mergers: AHA." American Hospital Association, 2018, https://www.aha.org/bibliographylink-page/2018-04-20-value-hospital-mergers.

to the inaccessibility of hospitals is their geographic distribution. The New York Times reported in April of 2020 that approximately 8.6 million people in the US live in areas where it takes 30 minutes or longer to drive to the nearest hospital, which bodes poorly for those in need of urgent care, who are disproportionately older and rural residents.[23] Rural hospitals are also closing at a fast rate, a trend potentially exacerbated by the pandemic.

Physicians (or "doctors") are another main healthcare provider. Physicians are not tied to specific hospitals, but rather work overwhelmingly in private practice, many of them working solo.[24] The way physicians bill treatments is rather particular and, some researchers argue, is highly contributive to high healthcare costs. Generally, in the case of privately-insured patients (more on that below), physicians charge patients based on a "fee-for-service" (FFS) model.[25] This means physicians charge patients a fee for each service provided. These fees are typically determined by "fee schedules" negotiated between physicians and health insurers. Some issues with the FFS model are that it can incentivize physicians to provide unnecessary services to patients or fraudulently report services.

Another major factor to consider in the discussion of healthcare costs coming from physicians is supply. There has been some debate as to whether the US suffers from a doctor shortage. Many argue that the high levels of medical school debt, restrictions on immigrants with medical experience, and time spent to become a doctor–4 years of an undergraduate degree, 4 years of medical school, and more years spent as a poorly paid resident–have unnecessarily constrained the supply of doctors.[26] Others argue that there are in fact enough doctors to provide primary care to every American, pointing the blame at other barriers to access.[27] This debate depends on the definitions researchers use when counting the different kinds of doctors in the US.[28]

---

[23]Koeze, Ella, et al. "Where Americans Live Far from the Emergency Room." The New York Times, The New York Times, 26 Apr. 2020, https://www.nytimes.com/interactive/2020/04/26/us/us-hospital-access-coronavirus.html.

[24]De Lew, N et al. "A layman's guide to the U.S. health care system." Health care financing review vol. 14,1 (1992): 151-69. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193322/.

[25]Rice, Thomas. "Chapter 2 - Key Components of National Health Insurance Systems." Health Insurance Systems: An International Comparison, Academic Press, London, United Kingdom, 2021, pp. 9–33. Available at: https://www.sciencedirect.com/science/article/pii/B9780128160725000043.

[26]Thompson, Derek. "Why America Has so Few Doctors." The Atlantic, Atlantic Media Company, 14 Feb. 2022, https://www.theatlantic.com/ideas/archive/2022/02/why-does-the-us-make-it-so-hard-to-be-a-doctor/622065/.

[27]Kerns, Christopher, and Dave Willis. "The Problem with U.S. Health Care Isn't a Shortage of Doctors." Harvard Business Review, 1 Feb. 2021, https://hbr.org/2020/03/the-problem-with-u-s-health-care-isnt-a-shortage-of-doctors.

[28]Kruse, Jerry. "Shortage or Surplus of Physicians in the United States." JAMA Network, American Medical Association, 19 Sept. 2017, https://jamanetwork.com/journals/jama/fullarticle/2654375.

Doctors can either be generalists, also known as “primary care physicians” or PCPs, or specialists, meaning they focus on a particular field of medicine. Primary care physicians are important to the well-being of patients who simply need a doctor to regularly visit for basic health services and preventative care, but many argue the US suffers from a PCP deficiency: in 2018, only 32% of providers were PCPs.[29] This has been attributed to income gaps between specialists and PCPs and poorly designed tuition subsidy strategies.

More broadly, the high comparative cost of medical school tuition, along with the time required in the United States to attend medical school and train in residency, creates what many authors argue is a structural incentive for doctors to maximize their earnings by specializing in the highest-paying fields. As a result, though the United States is well-known for its medical innovations and its niche specialists, an increase in the proportion of PCPs would likely increase average life expectancy and reduce medical costs.

[29]Steinwald, Bruce, et al. “We Need More Primary Care Physicians: Here's Why and How.” Brookings Institute, Brookings Institute, 9 Mar. 2022, https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/07/08/we-need-more-primary-care-physicians-heres-why-and-how/.

2. Healthcare Financing: Public and Private

Health services are usually either paid for out-of-pocket or by health insurance. Out-of-pocket means the consumer (the patient, that is) pays the provider (physician/hospital) directly for services charged, whereas health insurance financing means health insurers pay providers instead. Health insurers can be public (ie, government) or private (via insurance companies).

This paper will first explain the basics of a private health insurance plan, with much of the explanation based on Stanford Vaden Medical Services' online guide.[30] Customers pay "premiums" to health insurance companies who use that money to reimburse hospitals and doctors for their health services. This pools the "risk" of all consumers, since the odds that any individual consumer has to spend a significant amount of money on healthcare in a given year are relatively small. This way, the impact of more costly emergency services should theoretically be shared by everyone in the same "pool".

However, the health insurance company does not completely pay for all health services. For example, there is usually a "deductible", meaning the amount of money a customer needs to spend on their own on health services before insurance companies begin to pay instead. There is also often a "copay", meaning the amount that the customer has to pay instead of the insurance company. A similar concept is "coinsurance", which is a share of health costs customers need to pay. Generally, higher premium plans have lower copays and coinsurance. Collectively, these are called "cost sharing".

If a particular health service, known as a "health benefit" or just "benefit", is listed under an insurance policy as qualifying for the insurance company to pay for, it is called "covered". This *does not* mean there is no copay or that the insurance company covers *all of the cost*, just *some so long as the customer has reached their deductible already*. Because of the Affordable Care Act, insurance companies are required to cover some "essential health benefits" like emergency services, hospitalization, preventative care, mental health services, and more.

Private insurance plans can be obtained in a number of ways. Customers can simply privately purchase them from insurance companies, possibly via the Affordable Care Act's marketplace. More commonly, insurance can be provided to patients by their employers. Employers subsidize health insurance plans for their workers as added benefits to positions, which is encouraged by these benefits' immunity to tax laws and the Affordable Care Act's employer mandate. Under

[30] "How U.S. Health Insurance Works." Vaden Health Services, https://vaden.stanford.edu/insurance-referral-office/health-insurance-overview/how-us-health-insurance-works.

the employer mandate, employers of businesses of a particular size must offer affordable healthcare plans to their workers or face a penalty.[31]

The other source of healthcare financing in the US is publicly financed health insurance, specifically Medicare and Medicaid. Medicare is federally financed health insurance for those over the age of 65 and with End Stage Renal failure. Medicare has three main parts: A, B, and D[32]. Part A covers in-hospital care and otherwise acute care (as opposed to chronic care). Paying Medicare taxes over one's career qualifies Americans for premium-less access to Part A, or else Medicare enrollees must pay for Part A.[33] Part B, which covers physician services and certain outpatient care, must be paid for regardless, typically by deducting part of Social Security. Part D gives Medicare enrollees the additional option of adding prescription drugs to their insurance plans, which could cover things like HIV/AIDs treatment or insulin. In the case of Parts B and D, participation is very common because the federal government covers about 75% of costs.[34]

Medicare differs from private insurance in that generally, Medicare pays less to providers. Unlike the negotiated prices physicians and doctors set with private insurance companies, Medicare unilaterally establishes a prospective price system that prescribes how much a particular service ought to be compensated to hospitals and physicians.[35] This depends on the "diagnosis-related group" (DRG) it belongs to, or in other words the category of health service the provider gives to patients. One report published by the Kaiser Family Foundation estimated private insurers pay around double the Medicare rate to providers for nearly all hospital services, and over 140 percent the Medicare rate for physician services. This is concerning for providers seeking to maximize their profit, but is meant to lower costs for patients and improve efficiency.

---

[31]"Employer Mandate." Cigna, 2022, https://www.cigna.com/employers-brokers/insights/informed-on-reform/employer-mandate.

[32]"Parts of Medicare." Medicare, U.S. Centers for Medicare and Medicaid Services, https://www.medicare.gov/basics/get-started-with-medicare/medicare-basics/parts-of-medicare.

[33]"Who Is Eligible for Medicare?" HHS.gov, U.S. Department of Health & Human Services, 11 Sept. 2014, https://www.hhs.gov/answers/medicare-and-medicaid/who-is-eligible-for-medicare/index.html.

[34]Rice, Thomas. "Chapter 12 - United States." Health Insurance Systems: An International Comparison, Academic Press, London, United Kingdom, 2021, pp. 191–222. Available at https://www.sciencedirect.com/science/article/pii/B9780128160725000195

[35]Neuman, Tricia, and Eric Lopez. "How Much More than Medicare Do Private Insurers Pay? A Review of the Literature." Kaiser Family Foundation, Kaiser Family Foundation, 1 May 2020, https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/.

Established to supplement Medicare, Medicaid is a state-run program receiving federal funding that provides additional healthcare coverage for poor Americans, subject to additional restrictions by states, including but not limited to disability status and whether or not one has dependent children. The ACA expanded Medicaid to include all adults who make less than 138% the poverty level, but after a constitutional challenge that made its way to the Supreme Court, this expansion is optional, and many states still have very strict Medicaid qualification requirements.

Medicaid, which via the federal government covers 90% of costs for those enrolled post-ACA, is especially important for the elderly and others who need some special services.[36] In particular, Medicaid covers preventative care and long-term care like nursing homes, which accounted for nearly half of all Medicaid expenditures in the nineties; because of the difficulty of accessing Medicaid, there have been cases of middle-class elderly Americans releasing a large amount of their assets upon retirement in order to be eligible for Medicaid-financed nursing homes and end-of-life care.[37] However, despite Medicaid being restricted to certain (now expanding) populations and being on average funded 60% by the federal government, it is often one of the highest costing items in state budgets.[38]

The various sources of funding and their expenditures is summarized in the below chart from economics professor Uwe E. Reinhardt.[39] As is clear from the complexity of the description here and the chart, the United States has one of the most complicated health financing systems in the world. This leads many commentators to blame administrative costs for high healthcare costs in the US.

Another more elementary explanation, however, is simply that prices as set by private insurers and healthcare providers are too high. In 2003, Reinhardt published a groundbreaking paper titled, “It’s the Prices, Stupid: Why the United States Is So Different from Other Countries,”

---

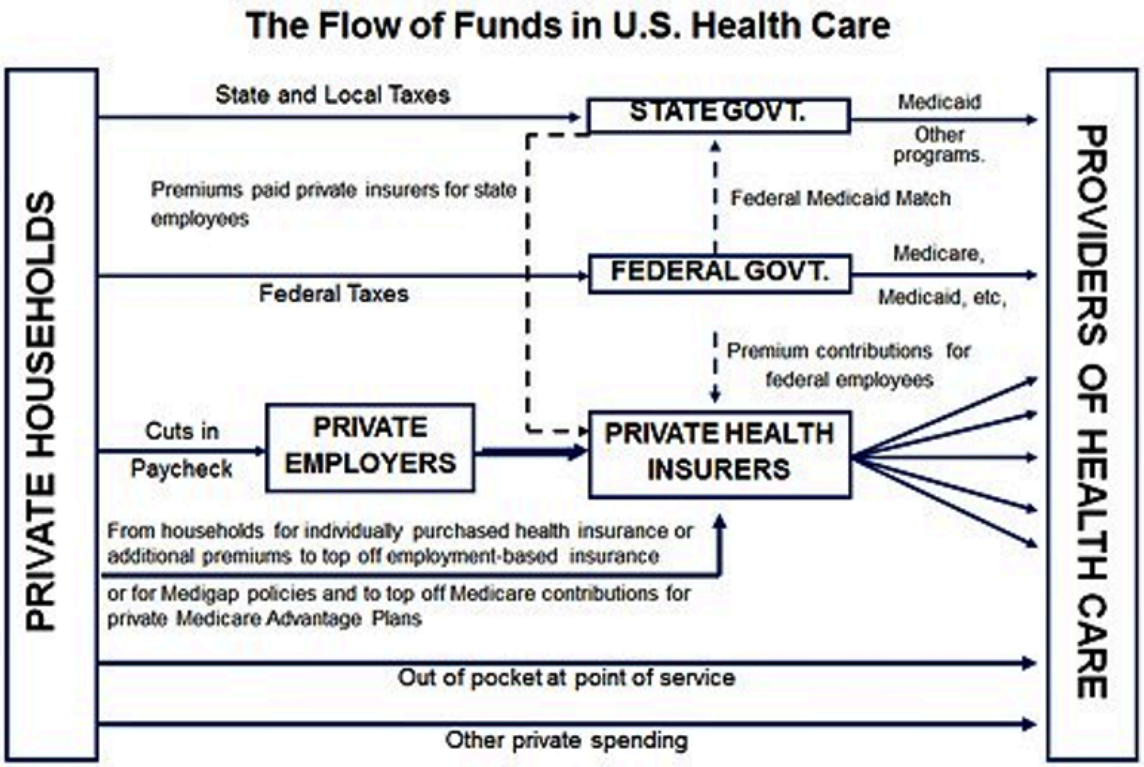
[36]Rice, Thomas. “Chapter 12 - United States.” Health Insurance Systems: An International Comparison, Academic Press, London, United Kingdom, 2021, pp. 191–222. Available at https://www.sciencedirect.com/science/article/pii/B9780128160725000195

[37]De Lew, N et al. “A layman's guide to the U.S. health care system.” Health care financing review vol. 14,1 (1992): 151-69. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193322/.

[38]Rice, Thomas. “Chapter 12 - United States.” Health Insurance Systems: An International Comparison, Academic Press, London, United Kingdom, 2021, pp. 191–222. Available at https://www.sciencedirect.com/science/article/pii/B9780128160725000195

[39]Reinhardt, Uwe E. “The Money Flow from Households to Health Care Providers.” The New York Times, The New York Times, 30 Sept. 2011, https://economix.blogs.nytimes.com/2011/09/30/the-money-flow-from-households-to-health-care-providers/.

arguing that because the US did not seem to use health services much more than other similar OECD countries, the only explanation for healthcare spending rates rising is the high rates.[40] His colleagues published an updated article in 2019 in his memory highlighting the rising difference in prices set by private versus public health insurers and the continued problems with high healthcare prices.[41] This is another major reason for calls for government intervention in the insurance market: advocates argue that unless regulated like other countries (such as Canada, Japan, or Taiwan), the private market will continue to set healthcare prices that are too high.



Source: Reinhardt, Uwe E. *The Money Flow from Households to Health Care Providers,* 2011.

[40]Anderson, Gerard F., et al. "It's the Prices, Stupid: Why the United States Is so Different from Other Countries." Health Affairs, vol. 22, no. 3, 2003, pp. 89–105., https://doi.org/10.1377/hlthaff.22.3.89. Available at: https://www.researchgate.net/publication/10751536_It's_The_Prices_Stupid_Why_The_United_States_Is_So_Different_From_Other_Countries.

[41]Anderson, Gerard F., et al. "It's Still the Prices, Stupid: Why the US Spends so Much on Health Care, and a Tribute to Uwe Reinhardt." Health Affairs, Health Affairs Journal, 1 Jan. 2019, https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05144.

3. Healthcare Reform: Possibilities and Challenges

With many issues in the healthcare system in the United States, reformers suggest many different pieces of legislation implementable on the federal or state level to improve health outcomes and reduce health spending. However, these reforms are not only often difficult to pass and implement, many object that these reforms have their own disadvantages as well.

As has been mentioned throughout the paper, the most recent politically controversial yet impactful (positive or negative) piece of federal healthcare legislation was the Affordable Care Act (ACA) of 2010, also known as Obamacare. To avoid repetition, its provisions will not be reviewed over again, but the response to the ACA was notable. It faced many legal challenges on the basis that it overextended the constitutional authority of Congress. Notably, in *NFIB v. Sebelius*, the Supreme Court found that the Individual Mandate of the ACA, which penalized individuals who did not purchase or maintain a minimum amount of health insurance, was a constitutional use of Congress' power to tax and spend, but that provisions of the ACA forcing states to expand Medicaid were an overreach of its Commerce Clause authority.[42] (The ACA's penalty was changed to $0 starting 2018 by the 2017 Republican tax reform bill).[43]

In the wake of the ACA, healthcare has still remained a major issue. More dramatic insurance coverage policies have been proposed and debated, most notably Medicare-For-All, which refers to an umbrella of different bills proposed in Congress that would abolish private health insurance and establish a "single-payer" healthcare system.[44] The California Department of Health and Human Services also recently considered a similar "unified-financing" system that it said could reduce healthcare spending, give universal coverage, and expand long-term care.[45]

"Single-payer" proposals encompass a variety of different financial arrangements, but they mostly share the common feature of the government providing universal (as in, everyone

---

[42]"National Federation of Independent Business v. Sebelius." Oyez, www.oyez.org/cases/2011/11-393. Accessed 2 Apr. 2022.

[43]Norris, Louise. "Is There Still a Penalty for Being Uninsured in 2021?" Verywell Health, 8 Dec. 2021, https://www.verywellhealth.com/obamacare-penalty-for-being-uninsured-4132434.

[44]Kliff, Sarah, and Dylan Scott. "We Read 9 Democratic Plans for Expanding Health Care. Here's How They Work." Vox, Vox, 13 Dec. 2018, https://www.vox.com/2018/12/13/18103087/medicare-for-all-explained-single-payer-health-care-sanders-jayapal.

[45]Healthy California for All Commission. "Estimated Effects of Unified Financing in California: Summary of Methods and Assumptions." CalHHS, State of California, 8 July 2021, https://www.chhs.ca.gov/wp-content/uploads/2021/07/Estimated-Effects-of-Unified-Financing-in-California-Summary-of-Methods-and-Assumptions-7-8-21.pdf.

qualifies) and comprehensive (as in, including a large swath of important) healthcare benefits.[46] Additional provisions that often characterize "single-payer" systems are limitations on cost-sharing (deductibles, copays) and restricted or prohibited enrollment in private health insurance systems.

Single-payer is highly controversial, but according to the nonpartisan Congressional Budget Office, a single-payer healthcare system would mean the US would spend significantly less on administrative healthcare costs, and that Americans would overall have higher access to health services and lower out-of-pocket spending on healthcare.[47] The result would be higher demand for healthcare, but also likely higher supply, as providers would spend less time on administrative tasks. The CBO warns that this would require a $1.5 trillion to $3.0 trillion federal investment in 2030, likely raised in taxes, which could depress economic growth due to reduced incentives to work and invest. It also raises the concern of higher wait times if demanded health services were to outgrow the available supply.

Advocates of single-payer emphasize that universal coverage could reduce healthcare costs in the long-run, and that reducing administrative costs would highly improve quality of care.[48] In particular, the Economic Policy Institute argues that a policy like Medicare-For-All would improve the economy, both in terms of its effect on the healthcare sector and businesses and workers overall.[49] Not only does it argue that reduced administrative costs would improve physician's quality of life and let them see more patients, but it argues that severing health insurance from employment would make labor and business creation more dynamic. By having employers compensate work with wages instead of health insurance subsidies, Medicare-For-All could lead to higher wages and remove the pressures of health insurance administration from want-to-be small business owners.

---

[46]Liu, Jodi L, and Robert H Brook. "What is Single-Payer Health Care? A Review of Definitions and Proposals in the U.S." Journal of general internal medicine vol. 32,7 (2017): 822-831. doi:10.1007/s11606-017-4063-5. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5481251/.

[47]Swagel, Phill. "How CBO Analyzes Proposals for a Single-Payer Health Care System." Congressional Budget Office, Congressional Budget Office, 10 Dec. 2020, https://www.cbo.gov/publication/56898.

[48]Weisbart, Ed. "Would Medicare for All Be the Most Beneficial Health Care System for Family Physicians and Patients? Yes: Improved Medicare for All Would Rescue an American Health Care System in Crisis." American Family Physician, 1 Oct. 2020, https://www.aafp.org/afp/2020/1001/p389.html.

[49]Bivens, Josh. "Fundamental Health Reform like 'Medicare for All' Would Help the Labor Market: Job Loss Claims Are Misleading, and Substantial Boosts to Job Quality Are Often Overlooked." Economic Policy Institute, 5 Mar. 2020, https://www.epi.org/publication/medicare-for-all-would-help-the-labor-market/.

However, the elimination of private insurance has been criticized, especially by industry leaders, as stifling innovation in the insurance and healthcare sectors.[50] Private health insurance, it can be argued, allows for more innovative ways of cost-sharing or otherwise reducing healthcare costs and making the healthcare system more efficient by experimenting with different policies.[51] Though the United States is a global leader in health innovation—which is strongly linked to improvements in life expectancy—as demonstrated by its domination in its number of clinical trials and patents, this criticism sometimes confuses the difference between the way health insurance works and health products are made, which is more affected by intellectual property laws and patents.[52]

Some also propose replacing the fee-for-service system, sometimes in conjunction with single-payer, with a few possible alternatives. One alternative currently being adopted in much of the public and private sector is a "value-based payment" system, where providers are reimbursed for their quality, efficiency, and efficacy of care.[53] Such a system rewards providers who demonstrate quality care by providing data on health outcomes, which both encourages better data infrastructure and better quality of care.

Another alternative to FFS is a "global budgeting" system.[54] This would set a particular budget for each provider per year, and then leave the allocation of such a budget to each provider, aside from some limitations on spending such as political donations.[55] By limiting hospitals'

---

[50]Zahn, Max, and Andy Serwer. "'I Hope AOC Is Paying Attention,' It's a 'Bad Time' for Medicare for All: Health Care CEO." Yahoo! Finance, Yahoo!, 31 Mar. 2022, https://finance.yahoo.com/news/i-hope-aoc-is-paying-attention-its-a-bad-time-for-medicare-for-all-health-care-ceo-144757771.html.

[51]Globerman, Steven. "Blog: Private Health Insurance, Not Government Bureaucracy, Spurs Health-Care Innovation." Fraser Institute, 13 Sept. 2019, https://www.fraserinstitute.org/blogs/private-health-insurance-not-government-bureaucracy-spurs-health-care-innovation.

[52]Carroll, Aaron E., and Austin Frakt. "Can the U.S. Repair Its Health Care While Keeping Its Innovation Edge?" The New York Times, The New York Times, 9 Oct. 2017, https://www.nytimes.com/2017/10/09/upshot/can-the-us-repair-its-health-care-while-keeping-its-innovation-edge.html.

[53]LaPointe, Jacqueline. "What Is Value-Based Care, What It Means for Providers?" RevCycleIntelligence, 2 Mar. 2022, https://revcycleintelligence.com/features/what-is-value-based-care-what-it-means-for-providers.

[54]Emanuel, Ezekiel J., et al. "Meaningful Value-Based Payment Reform, Part 1: Maryland Leads the Way." Health Affairs, Health Affairs Forefront, 9 Feb. 2022, https://www.healthaffairs.org/do/10.1377/forefront.20220205.211264.

[55]Dayen, David. "The Best Part of Medicare for All That You Haven't Heard About." The American Prospect, 7 Mar. 2019, https://prospect.org/health/best-part-medicare-heard/.

expenditures by mandate, this could limit the growth of healthcare costs and even encourage them to reduce unnecessary utilization of healthcare services. Maryland, which has an "All-Payer" system with global budgeting, requires all insurers, public and private, to pay the same amount to hospitals for the same treatment, while establishing global budgets for providers. Some studies suggest Maryland's healthcare system is one of the most effective ones in the country at reducing costs while keeping the same quality of care.[56] [57]

There have also been many challenges to these reforms from healthcare providers, especially from the American Hospital Association and the American Medical Association, the latter representing physicians in the United States. Some arguments against Medicare-For-All are that the various price reduction strategies discussed above would financially hurt providers, leading to declining incomes for doctors, more layoffs, higher hospital consolidation, and more.[58] [59]

There are other reforms that have been proposed and attempted to improve the healthcare system. One alternative that has been proposed to the single-payer model is the public option, which establishes a universally accessible healthcare plan financed and administered by states or the federal government while retaining the ability for Americans to purchase private insurance instead. Advocates say that public option is the most politically feasible reform because it keeps the choice for Americans to keep their healthcare plans and can avoid the high price-tag of Medicare-For-All if it is paid for only by Americans who use it, much like private insurance.[60] However, it has been criticized for not ensuring universal insurance coverage for all Americans, as some still may not opt-in due to costs.[61] Other concerns include the fact that the

---

[56]Emanuel, Ezekiel J., et al. "Meaningful Value-Based Payment Reform, Part 1: Maryland Leads the Way." Health Affairs, Health Affairs Forefront, 9 Feb. 2022, https://www.healthaffairs.org/do/10.1377/forefront.20220205.211264.

[57]Emanuel, Ezekiel J., et al. "Meaningful Value-Based Payment Reform, Part 2: Expanding the Maryland Model to Other States." Health Affairs, 10 Feb. 2022, https://www.healthaffairs.org/do/10.1377/forefront.20220207.85767.

[58] Pipes, Sally. "Single-Payer Will Worsen Healthcare Workers' Plight." Forbes, Forbes Magazine, 25 Oct. 2021, https://www.forbes.com/sites/sallypipes/2021/10/25/single-payer-will-worsen-healthcare-workers-plight/?sh=61cdff732b07.

[59]LaPointe, Jacqueline. "Greater Volumes, Consolidation Likely under Medicare for All." RevCycleIntelligence, 8 July 2019, https://revcycleintelligence.com/news/greater-volumes-consolidation-likely-under-medicare-for-all.

[60]Herzlinger, Regina, and Richard Boxer. "The Case for the Public Option over Medicare for All." Harvard Business Review, 10 Oct. 2019, https://hbr.org/2019/10/the-case-for-the-public-option-over-medicare-for-all.

[61]Tanen, Ezra. "Will the Public Option Provide Universal Access to Affordable Health Insurance?" Georgetown Law, 3 Nov. 2020, https://www.law.georgetown.edu/poverty-journal/blog/will-the-public-option-provide-universal-access-to-affordable-health-insurance/.

federal government would have to keep premiums at a market rate if it establishes a public option out of fear it would drive private insurance out of business. An alternate reform would provide universal vouchers to purchase private healthcare insurance plans.[62]

If the above reforms could be called "demand-side" fixes because they help consumers afford health services, another school of thought advocates for "supply-side" solutions. According to such advocates, much of the increase in healthcare spending is due to inefficiencies in the healthcare system and an insufficient supply of services due to unnecessary regulations and restrictions. A notable paper from the Niskanen Center called "Cost Disease Socialism" identified high healthcare costs as a result of Baumol's cost disease, when the productivity of a sector–in this case, healthcare–does not grow as quickly as the overall economy does, causing the cost to increase without an equivalent increase in supply to bring it down.[63] In this view, regulation would only slow private innovation-driven growth while accelerating demand, continuously pushing prices upward. Reforms to increase the overall supply of healthcare services or providers by deregulating physician-owned hospitals, increasing the supply of doctors, or allowing the FTC to investigate anti-competitive activity by non-profit hospitals are supply-side solutions that could fix this.[64] [65] [66]

However, regardless of the feasibility or desirability of sweeping healthcare reform, perhaps the most immediate challenge remains the issue of how to pass and implement any reform. As mentioned above, federal reforms—especially those as ambitious as Medicare-For-All—face great legal threats from political enemies and those who object on the grounds that it stretches Congressional spending power too far.[67] This is also why, though state innovation is typically

---

[62]Emanuel, Ezekiel J., and Victor R. Fuchs. "A Comprehensive Cure: Universal Health Care Vouchers." Brookings Institute, Brookings Institute, 28 July 2016, https://www.brookings.edu/research/a-comprehensive-cure-universal-health-care-vouchers/.

[63]Teles, Steven M., et al. "Cost-Disease Socialism: How Subsidizing Costs While Restricting Supply Drives America's Fiscal Imbalance." NIskanen Center, Sept. 2021, https://www.niskanencenter.org/wp-content/uploads/2021/09/Cost-Disease-Socialism.pdf.

[64]Miller, Brian J., et al. "Reversing Hospital Consolidation: The Promise of Physician-Owned Hospitals." Health Affairs, 12 Apr. 2021, https://www.healthaffairs.org/do/10.1377/forefront.20210408.980640.

[65]Thompson, Derek. "Why America Has so Few Doctors." The Atlantic, Atlantic Media Company, 14 Feb. 2022, https://www.theatlantic.com/ideas/archive/2022/02/why-does-the-us-make-it-so-hard-to-be-a-doctor/622065/.

[66]Rosalsky, Greg. "The Untamed Rise of Hospital Monopolies." NPR, NPR, 20 July 2021, https://www.npr.org/sections/money/2021/07/20/1017631111/the-untamed-rise-of-hospital-monopolies.

[67]Tahir, Darius, and Alice Miranda Ollistein. "'Death By a Thousand Lawsuits': The Legal Battles That Could Dog 'Medicare For All'." POLITICO, 10 June 2019, https://www.politico.com/story/2019/06/10/medicare-lawsuit-1356592.

fertile ground to test policies like single-payer healthcare, there has not been a feasible one passed; states do not have the authority to regulate employer-provided health insurance, rely on federal funds for Medicare/Medicaid, and must pay for additional expenses with taxes.[68]

Moreover, voters are reluctant to support or pay for such reforms. For instance, though Democrats in the United States are generally in favor of healthcare reforms, many even supporting Medicare-For-All, they are also generally content with their own healthcare plans and providers.[69] This explains why, in a 2019 Hill survey, Americans said that they supported the idea of universal coverage, but few supported plans that would abolish private insurance.[70] Dramatic reforms to the healthcare system may therefore be difficult to actualize soon, though discussing how to do so is nonetheless valuable.

[68]Yi, Jean. "More States Are Proposing Single-Payer Health Care. Why Aren't They Succeeding?" FiveThirtyEight, FiveThirtyEight, 9 Mar. 2022, https://fivethirtyeight.com/features/more-states-are-proposing-single-payer-health-care-why-arent-they-succeeding/.

[69]Thomson-DeVeaux, Amelia. "Americans Want the Health Care System to Change. Just Not Their Own Health Care." FiveThirtyEight, FiveThirtyEight, 19 Dec. 2019, https://fivethirtyeight.com/features/americans-want-the-health-care-system-to-change-just-not-their-own-health-care/.

[70]Klein, Ezra. "Why Aren't Voters More Willing to Abandon a Health System That's Failing?" Vox, Vox, 29 July 2019, https://www.vox.com/policy-and-politics/2019/7/29/8910387/medicare-for-all-insurance-private-abolish-bruenig.

Addendum. Critical Health Perspectives

As an addendum to the above discussion of the healthcare system and potential government reforms, here is a brief discussion of how other academic fields and political perspectives read the issue of healthcare.

Not all academics approach health through the same lens, particularly in the humanities. The way health is described has been problematized from a huge swath of perspectives. Some take issue with the perceived unjust hierarchization of healthcare, whether this being the privileging of Western healthcare in discussion and in practice, or the very social position of the healthcare provider (in particular, the doctor) itself. "Critical studies" scholars, often focusing on particular social categories like disability and gender, may take issue with how health is discussed or conceptualized, though this does not necessarily preclude discussions of healthcare reform.[71]

In fact, some may question the application of many analytic tools from the humanities to concrete political questions, such as whether the federal government ought to reform drug pricing or the healthcare insurance system. Even those within the humanities have criticized the tendency for such academic inquiry to miss the forest for the trees and fail to offer meaningful plans for changing the world.[72] This is not to over-accentuate the tension between critical perspectives and health advocacy. Indeed, there are many wishing for dramatic—liberatory, even—transformations to our social and economic systems who see reforms such as Medicare-For-All as an important intervention into how we understand health and economics that can expand the horizon of the political.[73]

[71]Viney, William, et al. "Critical Medical Humanities: Embracing Entanglement, Taking Risks." Medical Humanities, Institute of Medical Ethics, 1 June 2015, https://mh.bmj.com/content/41/1/2.

[72]Bryant, Levi. "Underpants Gnomes: A Critique of the Academic Left." Larva Subjects, 11 Nov. 2012, https://larvalsubjects.wordpress.com/2012/11/11/underpants-gnomes-a-critique-of-the-academic-left/.

[73]Fong, Benjamin Y., et al. "Medicare For All Is A Strategy." Jacobin, 11 June 2019, https://www.jacobinmag.com/2019/11/medicare-for-all-strategy-priority-single-payer-bernie-sanders.

Bibliography

"About Social Determinants of Health (SDOH)." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 10 Mar. 2021, https://www.cdc.gov/socialdeterminants/about.html.

American College of Physicians-American Society of Internal Medicine. "No Health Insurance? It's Enough to Make You Sick - Scientific Research Linking the Lack of Health Coverage to Poor Health." American College of Physicians-American Society of Internal Medicine, Mar. 2000, https://www.acponline.org/acp_policy/policies/no_health_insurance_scientific_research_linking_lack_of_health_coverage_to_poor_health_1999.pdf.

Anderson, Gerard F., et al. "It's Still the Prices, Stupid: Why the US Spends so Much on Health Care, and a Tribute to Uwe Reinhardt." Health Affairs, Health Affairs Journal, 1 Jan. 2019, https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05144.

Anderson, Gerard F., et al. "It's the Prices, Stupid: Why the United States Is so Different from Other Countries." Health Affairs, vol. 22, no. 3, 2003, pp. 89–105., https://doi.org/10.1377/hlthaff.22.3.89. Available at: https://www.researchgate.net/publication/10751536_It's_The_Prices_Stupid_Why_The_United_States_Is_So_Different_From_Other_Countries.

Bestsennyy, Oleg, et al. "Telehealth: A Quarter-Trillion-Dollar Post-Covid-19 Reality?" McKinsey Company, McKinsey Company, 28 Feb. 2022, https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality.

Bivens, Josh. "Fundamental Health Reform like 'Medicare for All' Would Help the Labor Market: Job Loss Claims Are Misleading, and Substantial Boosts to Job Quality Are Often Overlooked." Economic Policy Institute, 5 Mar. 2020, https://www.epi.org/publication/medicare-for-all-would-help-the-labor-market/.

Bryant, Levi. "Underpants Gnomes: A Critique of the Academic Left." Larval Subjects, 11 Nov. 2012, https://larvalsubjects.wordpress.com/2012/11/11/underpants-gnomes-a-critique-of-the-academic-left/.

Carroll, Aaron E., and Austin Frakt. “Can the U.S. Repair Its Health Care While Keeping Its Innovation Edge?” The New York Times, The New York Times, 9 Oct. 2017, https://www.nytimes.com/2017/10/09/upshot/can-the-us-repair-its-health-care-while-keeping-its-innovation-edge.html.

Dayen, David. “The Best Part of Medicare for All That You Haven't Heard About.” The American Prospect, 7 Mar. 2019, https://prospect.org/health/best-part-medicare-heard/.

De Lew, N et al. “A layman's guide to the U.S. health care system.” Health care financing review vol. 14,1 (1992): 151-69. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193322/.

Emanuel, Ezekiel J., and Victor R. Fuchs. “A Comprehensive Cure: Universal Health Care Vouchers.” Brookings Institute, Brookings Institute, 28 July 2016, https://www.brookings.edu/research/a-comprehensive-cure-universal-health-care-vouchers

Emanuel, Ezekiel J., et al. “Meaningful Value-Based Payment Reform, Part 1: Maryland Leads the Way.” Health Affairs, Health Affairs Forefront, 9 Feb. 2022, https://www.healthaffairs.org/do/10.1377/forefront.20220205.211264.

Emanuel, Ezekiel J., et al. “Meaningful Value-Based Payment Reform, Part 2: Expanding the Maryland Model to Other States.” Health Affairs, 10 Feb. 2022, https://www.healthaffairs.org/do/10.1377/forefront.20220207.85767.

“Employer Mandate.” Cigna, 2022, https://www.cigna.com/employers-brokers/insights/informed-on-reform/employer-mandate.

“Fast Facts on U.S. Hospitals, 2022: AHA.” American Hospital Association, American Hospital Association, 2022, https://www.aha.org/statistics/fast-facts-us-hospitals.

“Five Distinct Trends Are Converging to Determine How Artificial Intelligence (AI) and Robotics Will Define New Health.” PwC, June 2017, https://www.pwc.com/gx/en/industries/healthcare/publications/ai-robotics-new-health/five-trends.html.

Fong, Benjamin Y., et al. “Medicare For All Is A Strategy.” Jacobin, 11 June 2019, https://www.jacobinmag.com/2019/11/medicare-for-all-strategy-priority-single-payer-bernie-sanders.

Gale, Arthur H. “Bigger but not better: hospital mergers increase costs and do not improve quality.” Missouri medicine vol. 112,1 (2015): 4-5. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6170097/.

Globerman, Steven. “Blog: Private Health Insurance, Not Government Bureaucracy, Spurs Health-Care Innovation.” Fraser Institute, 13 Sept. 2019, https://www.fraserinstitute.org/blogs/private-health-insurance-not-government-bureaucracy-spurs-health-care-innovation.

Goldfarb, Avi, and Florenta Teodoridis. “Why Is AI Adoption in Health Care Lagging?” Brookings Institute, Brookings Institute, 9 Mar. 2022, https://www.brookings.edu/research/why-is-ai-adoption-in-health-care-lagging/.

Healthy California for All Commission. “Estimated Effects of Unified Financing in California: Summary of Methods and Assumptions.” CalHHS, State of California, 8 July 2021, https://www.chhs.ca.gov/wp-content/uploads/2021/07/Estimated-Effects-of-Unified-Financing-in-California-Summary-of-Methods-and-Assumptions-7-8-21.pdf.

Herzlinger, Regina, and Richard Boxer. “The Case for the Public Option over Medicare for All.” Harvard Business Review, 10 Oct. 2019, https://hbr.org/2019/10/the-case-for-the-public-option-over-medicare-for-all.

“How U.S. Health Insurance Works.” Vaden Health Services, https://vaden.stanford.edu/insurance-referral-office/health-insurance-overview/how-us-health-insurance-works.

Hughes, Stacey. “AHA Letter Re: Challenges Facing America's Health Care Workforce as the U.S. Enters Third Year of Covid-19 Pandemic: AHA.” American Hospital Association, 1 Mar. 2022, https://www.aha.org/lettercomment/2022-03-01-aha-provides-information-congress-re-challenges-facing-americas-health.

Inserro, Allison. “Aging Population Continuing to Drive National Health Spending, Report Says.” AJMC, AJMC, 30 July 2020, https://www.ajmc.com/view/aging-population-continuing-to-drive-national-health-spending-report-says.

Joy, Kevin. “Health Literacy in Schools: Health Insurance & Public Policy.” University of Michigan Health Lab Blog, University of Michigan Health, 10 Nov. 2016, https://labblog.uofmhealth.org/industry-dx/a-new-prescription-for-k-12-educators-teach-kids-about-health-care.

KaufmanHall. “Financial Effects of Covid-19: Hospital Outlook for the Remainder of 2021: AHA.” American Hospital Association, Sept. 2021, https://www.aha.org/guidesreports/2021-09-21-financial-effects-covid-19-hospital-outlook-remainder-2021.

Kerns, Christopher, and Dave Willis. “The Problem with U.S. Health Care Isn't a Shortage of Doctors.” Harvard Business Review, 1 Feb. 2021, https://hbr.org/2020/03/the-problem-with-u-s-health-care-isnt-a-shortage-of-doctors.

Klein, Ezra. “Why Aren't Voters More Willing to Abandon a Health System That's Failing?” Vox, Vox, 29 July 2019, https://www.vox.com/policy-and-politics/2019/7/29/8910387/medicare-for-all-insurance-private-abolish-bruenig.

Kliff, Sarah, and Dylan Scott. “We Read 9 Democratic Plans for Expanding Health Care. Here's How They Work.” Vox, Vox, 13 Dec. 2018, https://www.vox.com/2018/12/13/18103087/medicare-for-all-explained-single-payer-health-care-sanders-jayapal.

Koeze, Ella, et al. “Where Americans Live Far from the Emergency Room.” The New York Times, The New York Times, 26 Apr. 2020, https://www.nytimes.com/interactive/2020/04/26/us/us-hospital-access-coronavirus.html.

Kruse, Jerry. “Shortage or Surplus of Physicians in the United States.” JAMA Network, American Medical Association, 19 Sept. 2017, https://jamanetwork.com/journals/jama/fullarticle/2654375.

LaPointe, Jacqueline. “Greater Volumes, Consolidation Likely under Medicare for All.” RevCycleIntelligence, 8 July 2019, https://revcycleintelligence.com/news/greater-volumes-consolidation-likely-under-medicare-for-all.

LaPointe, Jacqueline. “What Is Value-Based Care, What It Means for Providers?” RevCycleIntelligence, 2 Mar. 2022, https://revcycleintelligence.com/features/what-is-value-based-care-what-it-means-for-providers.

Liu, Jodi L, and Robert H Brook. “What is Single-Payer Health Care? A Review of Definitions and Proposals in the U.S.” Journal of general internal medicine vol. 32,7 (2017): 822-831. doi:10.1007/s11606-017-4063-5. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5481251/.

Lopez, Eric, and Karyn Schwartz. “What We Know about Provider Consolidation.” Kaiser Family Foundation, 2 Sept. 2020, https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/.

McCain, Kelly. “Healthcare Leaders Discuss 2022 Tech, Investment and Digitalization Outlook.” World Economic Forum, 17 Jan. 2022, https://www.weforum.org/agenda/2022/01/biggest-healthcare-shifts-experts-expect-to-see-in-2022/.

Miller, Brian J., et al. “Reversing Hospital Consolidation: The Promise of Physician-Owned Hospitals.” Health Affairs, 12 Apr. 2021, https://www.healthaffairs.org/do/10.1377/forefront.20210408.980640.

Miller, Brian J., et al. “Reversing Hospital Consolidation: The Promise of Physician-Owned Hospitals: Health Affairs Forefront.” Health Affairs, 12 Apr. 2021, https://www.healthaffairs.org/do/10.1377/forefront.20210408.980640.

Mitchell, Erica. “Types of Hospitals in the US.” Health.Care. | An Educational Blog, EOS Services, 6 Jan. 2017, http://blog.eoscu.com/blog/types-of-hospitals-in-the-us.

National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Baciu A, Negussie Y, Geller A, et al., editors. Communities in Action: Pathways to Health Equity. Washington (DC): National Academies Press (US); 2017 Jan 11. 2, The State of Health Disparities in the United States. Available from: https://www.ncbi.nlm.nih.gov/books/NBK425844/.

Ndugga, Nambi, and Samantha Artiga. "Disparities in Health and Health Care: 5 Key Questions and Answers." Kaiser Family Foundation, 12 May 2021, https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/.

Neuman, Tricia, and Eric Lopez. "How Much More than Medicare Do Private Insurers Pay? A Review of the Literature." Kaiser Family Foundation, Kaiser Family Foundation, 1 May 2020, https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/.

Norris, Louise. "Is There Still a Penalty for Being Uninsured in 2021?" Verywell Health, 8 Dec. 2021, https://www.verywellhealth.com/obamacare-penalty-for-being-uninsured-4132434.

Nunn, Ryan, et al. "A Dozen Facts about the Economics of the US Health-Care System." Brookings Institute, Brookings Institute, 9 Mar. 2022, https://www.brookings.edu/research/a-dozen-facts-about-the-economics-of-the-u-s-health-care-system/.

Osborn, Robin. "In New Survey of 11 Countries, U.S. Adults Still Struggle with Access to and Affordability of Health Care." U.S. Adults Still Struggle with Access to and Affordability of Health Care, The Commonwealth Fund, 16 Nov. 2016, https://www.commonwealthfund.org/publications/journal-article/2016/nov/new-survey-11-countries-us-adults-still-struggle-access-and.

"Parts of Medicare." Medicare, U.S. Centers for Medicare and Medicaid Services, https://www.medicare.gov/basics/get-started-with-medicare/medicare-basics/parts-of-medicare.

Pipes, Sally. “Single-Payer Will Worsen Healthcare Workers' Plight.” Forbes, Forbes Magazine, 25 Oct. 2021, https://www.forbes.com/sites/sallypipes/2021/10/25/single-payer-will-worsen-healthcare-workers-plight/?sh=61cdff732b07.

Reinhardt, Uwe E. “The Money Flow from Households to Health Care Providers.” The New York Times, The New York Times, 30 Sept. 2011, https://economix.blogs.nytimes.com/2011/09/30/the-money-flow-from-households-to-health-care-providers/.

Rice, Thomas. “Chapter 2 - Key Components of National Health Insurance Systems.” Health Insurance Systems: An International Comparison, Academic Press, London, United Kingdom, 2021, pp. 9–33. Available at https://www.sciencedirect.com/science/article/pii/B9780128160725000043.

Rice, Thomas. “Chapter 12 - United States.” Health Insurance Systems: An International Comparison, Academic Press, London, United Kingdom, 2021, pp. 191–222. Available at https://www.sciencedirect.com/science/article/pii/B9780128160725000195.

Rosalsky, Greg. “The Untamed Rise of Hospital Monopolies.” NPR, NPR, 20 July 2021, https://www.npr.org/sections/money/2021/07/20/1017631111/the-untamed-rise-of-hospital-monopolies.

Sanborn, Beth Jones. “Healthcare Spending in the U.S. Sends Damaging Ripple Effect across Other Major Sectors, Households, Moody's Report Says.” Healthcare Finance News, HIMSS Media, 18 Sept. 2018, https://www.healthcarefinancenews.com/news/healthcare-spending-us-sends-damaging-ripple-effect-across-other-major-sectors-households.

Steinwald, Bruce, et al. “We Need More Primary Care Physicians: Here's Why and How.” Brookings Institute, Brookings Institute, 9 Mar. 2022, https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/07/08/we-need-more-primary-care-physicians-heres-why-and-how/.

Swagel, Phill. “How CBO Analyzes Proposals for a Single-Payer Health Care System.” Congressional Budget Office, Congressional Budget Office, 10 Dec. 2020, https://www.cbo.gov/publication/56898.

Tahir, Darius, and Alice Miranda Ollistein. "'Death By a Thousand Lawsuits': The Legal Battles That Could Dog 'Medicare For All'." POLITICO, 10 June 2019, https://www.politico.com/story/2019/06/10/medicare-lawsuit-1356592.

Tanen, Ezra. "Will the Public Option Provide Universal Access to Affordable Health Insurance?" Georgetown Law, 3 Nov. 2020, https://www.law.georgetown.edu/poverty-journal/blog/will-the-public-option-provide-universal-access-to-affordable-health-insurance/.

Teles, Steven M., et al. "Cost-Disease Socialism: How Subsidizing Costs While Restricting Supply Drives America's Fiscal Imbalance." NIskanen Center, Sept. 2021, https://www.niskanencenter.org/wp-content/uploads/2021/09/Cost-Disease-Socialism.pdf.

Thompson, Derek. "Why America Has so Few Doctors." The Atlantic, Atlantic Media Company, 14 Feb. 2022, https://www.theatlantic.com/ideas/archive/2022/02/why-does-the-us-make-it-so-hard-to-be-a-doctor/622065/.

Thomson-DeVeaux, Amelia. "Americans Want the Health Care System to Change. Just Not Their Own Health Care." FiveThirtyEight, FiveThirtyEight, 19 Dec. 2019, https://fivethirtyeight.com/features/americans-want-the-health-care-system-to-change-just-not-their-own-health-care/.

"The Value of Hospital Mergers: AHA." American Hospital Association, 2018, https://www.aha.org/bibliographylink-page/2018-04-20-value-hospital-mergers.

Viney, William, et al. "Critical Medical Humanities: Embracing Entanglement, Taking Risks." Medical Humanities, Institute of Medical Ethics, 1 June 2015, https://mh.bmj.com/content/41/1/2.

Weisbart, Ed. "Would Medicare for All Be the Most Beneficial Health Care System for Family Physicians and Patients? Yes: Improved Medicare for All Would Rescue an American Health Care System in Crisis." American Family Physician, 1 Oct. 2020, https://www.aafp.org/afp/2020/1001/p389.html.

"Who Is Eligible for Medicare?" HHS.gov, U.S. Department of Health & Human Services, 11 Sept. 2014, https://www.hhs.gov/answers/medicare-and-medicaid/who-is-eligible-for-medicare/index.html.

Williams, D R, and T D Rucker. "Understanding and addressing racial disparities in health care." Health care financing review vol. 21,4 (2000): 75-90. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194634/.

Yi, Jean. "More States Are Proposing Single-Payer Health Care. Why Aren't They Succeeding?" FiveThirtyEight, FiveThirtyEight, 9 Mar. 2022, https://fivethirtyeight.com/features/more-states-are-proposing-single-payer-health-care-why-arent-they-succeeding/.

Zahn, Max, and Andy Serwer. "'I Hope AOC Is Paying Attention,' It's a 'Bad Time' for Medicare for All: Health Care CEO." Yahoo! Finance, Yahoo!, 31 Mar. 2022, https://finance.yahoo.com/news/i-hope-aoc-is-paying-attention-its-a-bad-time-for-medicare-for-all-health-care-ceo-144757771.html.