Determining the Characteristics Needed for a Universal Healthcare System in the U.S.

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Abstract

Attitudes of Americans toward government intervention in healthcare are changing. The Affordable Care Act survived Trump's attempt to sabotage it. Some see the U.S. trending to implement universal healthcare. The intent of this paper is to determine what elements are needed for a universal healthcare system in the United States. Various models and world rankings of other systems are examined to determine what would be best for the U.S. to meet the three elements of the World Health Organization's definition of universal healthcare. Moving from a market-based, fragmented, patchwork of services to a more efficient and effective national, single payer system is essential. Embedding a right to healthcare in the U.S. Constitution would be ideal. Americans will have to accept that some Americans would be asked to pay for others' care. Delivery of services can be achieved by using a mix of private sector and public organizations. What is optimum depends on factors like cost, history, and tolerance of government intervention.

Purpose

The purpose of this paper is to determine the essential characteristics or elements needed for a universal healthcare system in the United States. Some see the United States trending toward a universal healthcare system (Moore, 2018). It is time to determine what kind of system the U.S. needs. The Affordable Care Act (ACA) survived its early critics and continues today despite the open attempt by the Trump administration to repeal or sabotage it. The ACA is the only other major healthcare legislation since the enactment of Medicare and Medicaid in 1965 (Moore, 2020). Universal healthcare may be in the future of the United States. Some surveys indicate Americans may be ready for a change in the U.S. healthcare system.

America's Changing Attitudes toward Government in Healthcare

A survey published in the Journal of the American Medical Association concluded that people with private insurance, either bought on their own or via an employer-sponsored plan, were most likely of any health care users to say their access to care was poor, their costs high, and their satisfaction low. Public programs like Medicare, Medicaid, and the Veterans Health Administration were viewed favorably, more than any form of private insurance. The researchers concluded "This survey undermines the idea that people don't trust a system simply because government might be involved in it." (Kreidler, 2021)

On the other hand Rosenbloom (2020) notes that 63% of Americans favor "universal healthcare coverage," but that drops to 49% when the phrase "single payer national health plan" is used. In 2006, 72% Republicans favored federal action for healthcare but by 2020 only 42% supported the same idea. Measuring attitudes requires attention to details and acknowledging there may be no uniformity in the change.

DiJulio, et al (2015) report that 58% of Americans support the idea of Medicare for all. Opinions at the time of the poll fell along political party lines with 81% Democrats and 60% independents in support, while 63% Republicans oppose it. More recently, the Kaiser Family Foundation (2020) reported similar results in 2020 with views following similar political lines.

The implications of this research is that a universal healthcare system with government components may be becoming more acceptable to Americans. Attitudes may be shifting, making the overall possibility of universal healthcare with government involvement more feasible. What that system would look like is an open question and needs examination.

A Definition

The World Healthcare Organization (nd) defines universal healthcare as "ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation, and palliation) of sufficient quality to be effective while also

ensuring that the use of these services does not expose the user to financial hardship. This definition will serve as the criteria for a healthcare system in the U.S.

Methods to Determine Characteristics of Universal Healthcare

There are several methods that can be considered to arrive at the characteristics needed for a universal healthcare system. One is to examine the models that would achieve the outcomes needed. Another is to examine the rankings of world systems and adopt the best. A variation of that ranking method is to examine the rankings, review the consistently top rated systems, and examine the elements commonly found in those systems. Let's examine what is available in the literature regarding those methods.

National Models to Achieve Universal Healthcare

A number of sources have proposed how the goal of universal healthcare might be achieved. The literature indicates not all universal healthcare systems are the same.

Zieff, et al (2020) argue that while implementation of universal healthcare would be complicated and challenging, the shifting from a market-based system to a universal healthcare system is necessary. The intent is to facilitate and encourage sustainable, preventive health practices and be more advantageous for the long-term public health and economy of the U.S. (Zieff, et al, 2020).

Zieff, et al (2020) also note that the United Kingdom's National Health Services is a traditional universal healthcare system with few options or minimal use of privatized care. Switzerland, the Netherlands, and Germany use a blended system with substantial government and market based components. Zieff, et al (2020) conclude that universal healthcare does not necessarily preclude the role of private providers within the healthcare system.

The Commonwealth Fund (retrieved 2022) provides a brief description of universal healthcare in Australia, Brazil, Canada, China, Denmark, England, France, Germany, India, Israel, Italy, Japan, Netherlands, New Zealand, Norway, Sweden, Switzerland, and Taiwan. While the United States is included in the description, the U.S. system is not classified as universal healthcare like the other 18 nations.

Arno and Caper (2020) discuss Medicare for All as the transformation of U.S. healthcare. Arno and Caper (2020) describes the U.S. healthcare problem as its failure to have any public policy to constrain the excesses of for-profit corporations that have focused on enhancing the wealth of their owners. After itemizing the negative costs and poor quality care, these authors suggest several reforms like a public option, a Medicare option, Medicare buy-in, and Medicare extra. The authors note however that all these options leave in place wasteful, inefficient, and costly private commercial health insurers. According to Arno and Caper (2020), eliminating the private insurers would result in the largest savings when moving to a single-payer network. The next largest savings would be for the federal government to use its negotiating leverage to buy prescription drugs. The overall conclusion reached by Arno and Caper (2020) is that no

reform other than a publicly financed, single–payer universal health care will solve the U.S. problem and achieve the largest savings.

The American Academy of Family Physicians (AAFP) (nd) outlines in a policy statement what a new system in the U.S. should be. The AAFP (nd) recognizes health as a basic human right for every person who should have universal access to timely, acceptable, and affordable healthcare of appropriate quality. Unlike the current fragmented and uncoordinated system, the new one proposed by the AAFP (nd) should re-emphasize the centrality of primary care, reinvigorate the primary care infrastructure and redesign the primary care delivery and payment. The current focus in the U.S. on specialty care has created fragmentation, decreased quality, and increased cost, according to the AAFP. The AAFP (nd) also argues for the creation of patient-centered medical homes and a movement from the fee for service payment system to a population based care. Some of the elements in the AAFP (nd) framework include establishing a medical home for all, which could be achieved via several types of models.

Those models include a Bismarck approach, considered a single payer model. Also suggested is a pluralistic mix of for-profit, not for profit, and government organizations that provides insurance for all. The AAFP adds the options of a public option and a Medicare/Medicaid buy-in approach. All proposals would be required to ensure ambulatory patient services, emergency service, hospitalization, maternity and newborn care, pediatric services, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services, lab services, prevention and wellness, and chronic disease management.

Bulter (nd) suggests a universal healthcare system would need to expand community clinics, create other points of access, and expand gaps in Medicaid. That system would reform tax treatments to create Medicare for All. It would allow program flexibility and state innovation as a national system with state variations. Bulter (nd) cautions that given the polarization in healthcare views, redesigning a system would be no easy task.

State-based Models and Attempts to Achieve Universal Healthcare

Yi, J (2022) observes that more states are proposing single-payer healthcare systems, but they are not succeeding in completing the process. Bills for single–payer plans that were introduced in California, Massachusetts, Iowa, Ohio, and Vermont have failed. Public options have passed in Colorado, Nevada, and Washington. Yi (2020) argues that any healthcare reform would be easier to implement at the federal level rather than a state-by-state patchwork. Singh. M (2022) suggests California could become the first U.S. state to offer universal health care to residents. That debate continues in California while Vermont and New York are making similar attempts.

Constitutional Basis and Reality of Federal Involvement in Universal Healthcare

David Rosenbloom (2020) sees Medicare for All as a government run, single payer, national insurance program. Rosenbloom (2020) then cites that no legal issues block

federal action to implement health programs. Rosenbloom (2020) cites the Affordable Care Act (ACA) as a demonstration of this. When one strips out the attempt of the ACA to remove any Medicaid from states who did not expand Medicaid, the ACA has been determined constitutionally sound. While the Supreme Court ruled the federal government cannot force states to expand Medicaid or mandate insurance coverage, federal taxing powers can be used as leverage on those who do not have insurance.

Rosenbloom (2020) notes that payment systems can also ask some to pay for others' care and coverage. Furthermore, he concludes that Covid19 revealed disparities among Black, Brown, and older populations. The Veterans Administration establishes that the government is allowed to provide care and can set or negotiate prices it will pay for hospital or physician fee schedules or prescription drugs. A constitutional basis for universal healthcare exists according to Rosenbloom (2020).

Meyer (2019) suggests a path to universal healthcare coverage will require minimizing political polarization. He notes that the Trump administration repeatedly attempted to sabotage the ACA but offered no constructive alternatives. Other more progressive advocates seem to be insisting on only a Medicare for All system that is likely an unacceptable scheme in the view of others.

Rankings of Best Systems by Country

While one approach to selecting the elements of universal healthcare is to select the best model, another is to select the country with the highest rated system. One variation of this is to select elements shared by the highest rated systems, those top ranked the most often by the most raters.

Statistica ranked the world health systems in 2021, with the top ten being Japan, Singapore, South Korea, Norway, Taiwan, Israel, China, Iceland, Netherlands, and Sweden.

The World Population Review (2022) ranked the top ten best healthcare systems in the world in 2022 to be South Korea, Taiwan, Denmark, Austria, Japan, Australia, France, Spain, Belgium, and the United Kingdom.

The Commonwealth Fund (nd) cited research that placed the U.S. in last place among seven other countries they examined, Australia, Canada, Germany, the Netherlands, New Zealand, United Kingdom, based on healthcare performance measures.

Other than the clear indication that the U.S. is an outlier, little can be concluded about the elements needed for a universal care system just based on rankings. Rankings vary on their basis and the source of the rankings. Using rankings or a variation would require more in depth quantitative study than warranted for our purpose of discovering elements for a system.

Selecting the Elements for a Universal Healthcare system

One need only to watch the Frontline video “Sick Around the World” based on T.R. Reid’s (2008) visits to five developed countries with universal healthcare systems to recognize the five nations’ systems are all unique, but share some essential characteristics. Japan, Great Britain, Germany, Taiwan, and Switzerland all have different elements due in part to their goals, history, methods of delivery, and payment systems (Reid, 2008). Yet all are ranked in the upper echelons of world healthcare rankings and seem to meet the WHO definition of universal healthcare (Commonwealth Fund, nd; Statistica, 2021; World Population Review, 2022) and seem to meet the WHO definition of universal healthcare (WHO, nd). This suggests the characteristics may vary but can still reach a similar end, universal healthcare.

The WHO definition in brief requires access to care, sufficient quality to be effective, and the users are not exposed to financial hardship. This describes a number of systems like those visited by T.R. Reid (2008), all meeting the WHO definition, but use various models of universal healthcare, yet all are ranked closely together. However, the WHO definition does not in any manner describe the U.S. market-based system.

Market Systems Will Not Achieve Universal Healthcare

A system tolerating thousands without insurance and some receiving minimal or no care would not meet the access criteria. A system where there is death due to lack of care or where bankruptcy occurs due to health costs would also not meet the criteria.

A market system per se will not guarantee access to care or protect all from financial hardship. Those with financial means may find high quality and effective treatment in a market system. Market systems allow those with means to exchange dollars for care. The market does not accept participation from those without dollars. The retired, elderly, disabled who cannot work, and the low income have no or limited participation in the market system.

Medicare and Medicaid were enacted in the U.S. in 1965 and the Affordable Care Act passed in 2010 to address this market reality and address other market limitations. The market not caring for those without dollars is not a failure or flaw in the market, but an inherent feature in the market system. Those who suggest keeping the market and adjusting it to achieve universal healthcare are ignoring the economic reality. T.R. Reid (2008) asked officials in Taiwan what they took from the U.S. system when designing their new universal healthcare system. The answer was nothing. They explained that nothing could be taken from a system that is just allowed to operate. (Reid, 2008) Given the low ranking the U.S. has with other systems as seen by the Commonwealth Fund (nd), the market-based system appears to be a core problem in achieving universal healthcare. Of those describing models to achieve universal coverage (Zieff, et al, 2020: AAFP, nd: Arno and Caper, 2020; Rosenbloom, 2020) none include the market as a useful mechanism to reach universal healthcare. Zieff, et al (2020) make it clear the U.S. must move from a market-based system, but notes this does not preclude the use of the private sector in service delivery.

Single Payer: An Essential Element

The importance of the polls indicating Americans are becoming more open to government intervention to achieve universal healthcare is because government involvement appears to be an essential element or path. Other nations like the United Kingdom, Taiwan, and Japan have invested heavily into single-payer systems and government delivery of services. (Reid, 2008) Still other nations like Switzerland and Germany have more of a mixed private and government delivery system. (Reid, 2008) Based on this analysis the one essential characteristic for a universal healthcare system that emerges is it needs to be a single-payer system. This is so assuming a nation commits to ensuring everyone is to have access to care. An essential element in universal healthcare is the single payer.

Choice of Delivery of Service Options

If a nation commits to quality care that is effective, the achievement of that element has options. There are many models and highly ranked systems that use government or private services or a blend of both. All work at some level. Which is best for the U.S. is dependent on a number of factors.

One factor is related to how much government Americans are willing to allow in their healthcare. Both Meyer (2019) and Bulter (nd) refer to the polarization in America, which can affect the mix, some preferring less government. This is a difficult factor to measure. Some who have experienced the Veterans Administration or other military benefits may inconsistently praise government healthcare and work for it, but still resist government intervention in other aspects of their life. Others may resist all government intervention. Others welcome or encourage government services over the private sector. Some will argue that all government or all private sector service delivery is not a good idea, and a mix of both is needed for balance. Universal healthcare can be implemented with varying degrees of government involvement, but the single payer is essential.

Arno and Caper (2020) aptly present a second factor to consider when deciding how services will be delivered. Using a public option or Medicare for All delivery form to insure everyone offers the greatest cost savings to a system. The more a system uses private insurers to participate say Arno and Caper (2020) the more the system will cost.

A third consideration on how much a mix of government and private sector will be used to deliver services is to recognize the large amount of private sector participation there is now and make any reductions in that gradual. This is to ensure full employment, allowing changes in jobs from private to public sector. It also recognizes not disrupting the importance of professional and patient relationships for stable quality of care. Cost savings can be gained via regulation, not just by converting private services to public.

The AAFP (nd) promotes more specific elements in their universal care proposal, like having a medical home and replacing fee for service with a more capitated model. Other

interest groups have similar ideas, and while value based ideas need to be heard, debated, and included, these ideas are not essential.

Ensuring No Financial Hardships

Few complaints about user costs are directed at nations with universal healthcare. However, there are concerns in some about higher general taxes and low reimbursement rates for professionals and hospitals delivering services. Some systems have minimal co-pays; others have none. Reid (2008) while in Switzerland asks how many go bankrupt due to healthcare costs only to be told none. If there were even one, said the respondent, that would be a scandal.

If a system does move from fee for service to pay mechanisms like capitation or pay for performance, those cost savings will put less pressure on asking users to pay more taxes or co-pays. A willingness to regulate private carriers or move to more government insurance will enhance savings, and reduce pressure on users to pay more.

Useful Rankings

Rankings of nations' universal healthcare have had little value in determining for this paper what specific type of system should be implemented. The rankings that do matter are outcomes achieved by a system. Just as we used the WHO definition to identify universal healthcare goals, the intended and actual outcomes in a system are useful for a system to adjust its policies and practices. Outcomes, like life expectancy, should be measured periodically to monitor system performance.

Preferred Elements for Universal Care

Several states have attempted or debated universal healthcare (Sing, 2022; Yi, 2022). Generally, a national system is more likely to achieve universal care than a patchwork of state models. Yi (2022) acknowledges that would be easier. At any rate, the nationwide, single-payer system that the U.S. creates will need to accommodate some state differences and innovation. Like the Medicaid waiver system, the federal government should allow reasonable variations in the states.

Another preferred, but not required, element is to embed the nation's commitment to universal healthcare into the U.S. Constitution with an amendment ensuring each American's right to healthcare. Rosenbloom (2020) assures us the federal government can legally implement universal healthcare. However, our political history is not sufficiently stable to guarantee no disruption in the commitment.

The nation, after a 45-year drought in healthcare legislation, finally passed a major piece of healthcare legislation, the Affordable Care Act, only to watch it almost repealed within a few years of its enactment. The real polarization at the root of this instability is mentioned by Meyer (2019) and may easily threaten even well crafted universal healthcare legislation.

If a Constitutional Amendment process were achieved, the long-term prospects and stability of a universal healthcare system would be more protected. Such a constitutional amendment would ensure every American's right to healthcare. However, the difficulty and time needed to do such an amendment should not be minimized. The challenge and time needed to do such an amendment, while worth the effort, explains why enacting an amendment is preferred, but not an essential element.

Conclusions and Summary

After analysis of several models and considering rankings of worldwide systems, the essential step for the U.S. is to move from its dominant market-based health care system to a national, single payer system. To achieve the three criteria of the WHO definition, the U.S. must adopt a single payer system more like Medicare for all Americans.

Attitudes in America are changing toward less resistance to government intervention in healthcare. A state-by-state system has the potential to perpetuate the current, fragmented, inefficient, and ineffective patchwork of services dominated by an imperfect market with a sprinkle of government programs like Medicaid, Medicare, the Veterans Administration, and Affordable Care Act insurance regulations.

While the commitment to a single payer is essential, services may be delivered with more of a balance of private sector and government organizations. However, the more the private sector is used, the more likely costs rise (Arno and Caper, 2020). The more the single payer controls rates and drug prices, the more efficient the system. The effectiveness of service delivery may be optimized by a blend of government and private sector services.

While the attempt to derive needed characteristics from world rankings produced little contribution for this paper, rankings do have a role in healthcare. Monitoring the outcomes like mortality rates resulting from a system will be essential to adjust system practices to achieve the desired quality and goals.

Embedding all Americans' right to healthcare and the nation's commitment to universal healthcare in the U.S. Constitution would be ideal. However, recognizing the political polarization Meyer (2019) mentions, makes that preferred, but not essential. A Constitutional amendment while difficult to achieve, would minimize any disruption of the system over the long-term.

Meeting the requirement of WHO (nd) to ensure no financial burden on users means the system needs to optimize the use of private sector and government service delivery to keep costs down. It also must accept Rosenbloom's (2020) observation that some can pay for others' care and coverage.

Interested parties like insurance companies, pharmaceuticals, and a multitude of providers, like the AAFP, whose proposal is mentioned in this paper (nd), will have more detailed ideas for how a system should operate. It is important to include these parties

in the creation of the details of the system through review and debate. Implementing those ideas can contribute to the efficiency and effectiveness of a U.S. universal healthcare system.

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