US Healthcare Reform in a Green New Deal World

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Healthcare system recommendation report

National health insurance has been a topic of discussion in the United States for over a century, yet even in 2020, this is a widely controversial and argued topic. There are disagreements about who should provide healthcare, who should be responsible for providing insurance, and what role, if any, the government should have in the process. One thing remains clear, however: access to healthcare in the United States is inherently unstable. Through an analysis of the Green New Deal, the current healthcare system, health expenditures and outcomes, private insurance in the US, and a survey of healthcare in other countries, this report aims to answer the following research question:

Would a renovation of the current healthcare system following the initiatives outlined within the GND allow for the effective and efficient provision of equitable quality healthcare to all individuals living within the US?

1

How do the Green New Deal's goals relate to the current healthcare system and efforts for healthcare reform?

2

How is the current US healthcare system structured? What works? What does not work?

3

What are the pros and cons of various forms of private insurance in the US?

4

What does healthcare look like in other countries? How is this useful in discussions of healthcare reform in the US?

5

What are the differences in the cost of healthcare internationally and domestically? How do these differences affect a renovation of the current US healthcare system?

The Green New Deal and Healthcare Reform

The Green New Deal and Healthcare Reform

In the United States, distinct differences in health and access to health care are seen across social classes. A study analyzing the relationship between family income gradients and the health outcomes of children found higher amounts of unmet health needs among children belonging to lower-income families (Larson and Hafon, 2009). Children near the bottom end of the income spectrum were more likely to struggle to obtain specialist care, used primary care services at a lesser rate than higher-income families, had less access to prescription medication use, and were less likely to experience continuity of care from the same health provider. The disparities created a situation where emergency room visits increased, while physical health markers descended the income gradient (Larson and Hafon, 2009). Significant health disparities by wealth are shown to persist from early life throughout adulthood (Avendano et al., 2009).

The Green New Deal acknowledges the lack of adequate health care for a significant portion of individuals in the US as a crisis where essential needs are not being met. In the resolution, the root of the crisis is attributed to the highest levels of income inequality and the lowest levels of upward socioeconomic mobility in the United States since the 1920s, exacerbated by over 40 years of wage stagnation and policies that have diminished workers' rights (H. Res. 109, 2019). The Green New Deal acknowledges the lack of adequate health care for a significant portion of individuals in the US as a crisis where essential needs are not being met. In the resolution, the root of the crisis is attributed to the highest levels of income inequality and the lowest levels of upward socioeconomic mobility in the United States since the 1920s, exacerbated by over 40 years of wage stagnation and policies that have diminished workers' rights (H. Res. 109, 2019). To begin resolving the poor economic conditions that create issues in health care

accessibility, the Green New Deal aims to mobilize economically vulnerable communities by carrying out the following goals:

> (H) creating jobs that can sustain family livelihoods by providing a living wage and retirement security, as well as paid vacations and adequate amounts of personal leave for family and medical reasons;
>
> (I) reinforcing workers' rights to unionize and self-advocate;
>
> (J) standardizing all occupational health, antidiscrimination, and wage policies;
>
> (H. Res. 109, 2019).

However, if the Green New Deal's explicitly stated goals were attempted in isolation, without concurrent reform of the healthcare system itself, issues in health care inaccessibility may persist. While the goals outlined in the Green New Deal could help people afford private health coverage or gain employer-based health coverage, the American healthcare system's decentralization creates its own instability that still disproportionately harms those of low-income. Coverage contingent on income or employment has the potential to be lost or interrupted through a variety of circumstances, including job losses, job changes, increased costs, employer suspension of insurance coverage, and changes from job or private-based insurance to public health insurance. These interruptions in coverage -- where people continue to lose and regain insurance -- are referred to as "churning," and they come at significant cost to both the healthcare system and the individual seeking care (Summer and Mann, 2006). Churning results in higher administrative costs for government bodies, providers, and health insurance companies who must all manage frequently changing enrollments and billing discrepancies that arise from the situation. Unstable insurance coverage also contributes to decreased care satisfaction levels from patients, who lack health care continuity from the same provider as their insurance coverage continues to fluctuate (Summer and

Mann, 2006). In addition, these patients may forgo needed care and health monitoring during times when they are uninsured (Summer and Mann, 2006). A study analyzing the health status of uninsured low-income adults found that when these individuals become enrolled or re-enrolled in public health insurance programs like Medicaid, they eventually require more advanced care that is costlier to both the consumer and the healthcare system (Decker et al., 2013). Situations like these, common under the current American healthcare system, fail to meet another Green New Deal initiative: to manage the effects of long-term health and economic issues (H. Res. 109, 2019).

Conclusions

The Green New Deal underscores the immense income inequality that leads to immense inequality in health. Because income influences private health insurance in the United States, quality health insurance, health care, and positive health outcomes are inaccessible to many groups who can neither afford private health coverage nor meet the various eligibility requirements of public health insurance programs. Even for those insured under such programs, structural gaps exist and quality health care is not guaranteed. Considerations of healthcare reform as it relates to issues of wealth inequality are not only warranted under these conditions, but are also areas of critical examination in the Green New Deal's greater movement towards social equity.

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Current US Healthcare System

Current US Healthcare System

History

Health care services and health insurance in the United States have not always been what they are today. However, services are a constant precipitant for disagreement and calls for reform, specifically into a universal system. Discussions also include how to build a universal system in the US, and if the healthcare system is necessary. Nonetheless, in order to comprehend the current healthcare system, it is important to understand how the current system was established. Understanding this history provides context for recognizing the disparity that exists because of the healthcare system and how this inequity has persisted and evolved over time. This will allow for a more thorough view of systemic flaws and gaps that still exist today.

The US did not possess an organized healthcare system until after the start of World War I (Faguet 2013). Medical schools were unstructured, doctors were paid less, and "hospitals were scarce, poorly equipped, and offered no advantages over home treatment," (Faguet, 2013, p. 12). Today, technology is constantly evolving, which was similarly the case at the turn of the 20th century. This advancement in technology allowed for hospitals to become more useful and treatment more costly. As these advancements occurred, it became apparent that there was a need to improve medical schools. According to the Flexner's report, there was a plan put in motion that drastically reduced the number of medical schools in the United States and improved the quality of the education provided by the remaining schools. At the same time, however, many schools for women and African Americans were shut down because they were considered by Flexner to be "ineffectual and in no position to make any contribution of value," (Faguet, 2013, p.13).

As education in medical schools advanced and the technologies and services provided in hospitals advanced, the cost of health care increased, as stated previously. Health care had reached

a point where it was too expensive for the middle class. This is a drastic difference from when home health care was just as successful as treatment in a hospital, as it had been just a few decades before (Faguet, 2013). Following these changes to the system, health insurance was created in 1929 at Baylor University, following a realization that many unpaid bills at the hospital would remain unpaid because they belonged to low-wage workers (Faguet, 2013). This newfound health insurance was a pre-paid system that provided benefits and protections for both hospitals and patients. It allowed hospitals to have "a steady source of income" and offered "hospital care to enrollees at an affordable price," (Faguet, 2013, p.15). Despite these benefits, however, it is important to note that this form of pre-paid health insurance was created to keep hospitals in business and not necessarily to protect consumers from unforeseen expenses (Faguet, 2013).

Understanding this attempt to streamline medical schools and the healthcare system, in order to have a more efficient and uniform system, provides adequate background information in understanding the current systems that are in place today. Contrarily, the system that exists today is opposite of the streamlined attempt to centralize healthcare and ensure equitable and effective care for individuals. One of the greatest flaws of the healthcare system is its decentralization, which exists on many levels. Instead of a centralized system that allows for a simple, accessible manner for individuals to receive health insurance, treatment, or even prescriptions, there are a multitude of ways to achieve these things. For example, individuals can pay for private health insurance, receive health insurance from their employer, be eligible for government-provided health insurance, have a mix of these options, or choose to not have health insurance (Figure 1). Patients can receive care from various places, such as a hospital, private clinic, or an urgent care facility. Additionally, the databases where healthcare providers store patient data can vary from place to place, which can cause issues when someone needs to see a specialist, moves to a new area, or

simply switches doctors. Health insurance, however, is probably the most apparent way that shows how the healthcare system is decentralized (Figure 1). This graph demonstrates the variety of ways that individuals have options for health insurance and that they are not mutually exclusive. According to Cohen et al., in 2018, 13.3 percent of American adults (aged 18-64) were uninsured, 19.4 percent had public health insurance, and 68.9 had private health insurance (Cohen, Martinez, Terlizzi, 2019).

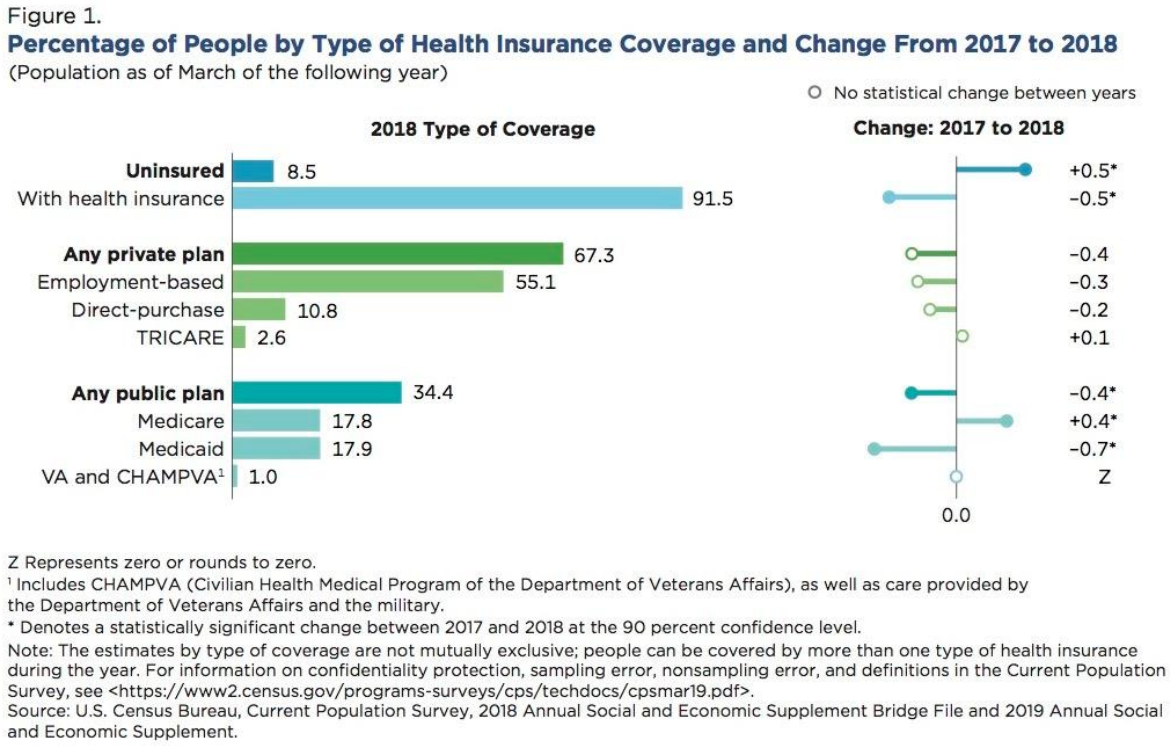

Figure 1. Percentage of People by Type of Health Insurance Coverage and Change from 2017 to 2018. This figure demonstrates the variety of types of healthcare that people in the US possess. Additionally, there is a figure representing the change in these percentages from 2017 to 2018. (Berchick, Barnett, and Upton, 2019).

Medicare and Medicaid

The pre-paid health insurance that began at Baylor University began to spread across the United States. It was a fair option for individuals who could afford to pay for it, but still left

vulnerable populations without the protections that they needed. It was not until later that an overall understanding of healthcare as a right and not a privilege came about. With this idea in mind, in 1965, Medicare was created (Orentlicher, 2012). And yet Medicare was still a privilege, that had to be earned through work and paying taxes, that was only available to a small percentage of the population. Medicare was offered solely to older adults who had "earned their eligibility", ignoring a portion of the population that still had no access to health care or health insurance, (Orentlicher, 2012, p. 329).

The gap that Medicare left for individuals who had not earned this insurance gave way for another form of public health insurance to be created. This insurance, called Medicaid, was to be based on need or provided as an option for those who seemed deserving; it did not have to be earned the way that Medicare did. It was created to cover "poor persons who did not seem responsible for their lack of insurance," (Orentlicher, 2012). However, many individuals were left without insurance because of this idea that only people who did not seem at fault or those who fell in specific categories were eligible. For example, those who were considered to be not responsible for their situation were: "pregnant women, children, parents with dependent children, and persons with serious disabilities" and only if "their family incomes fell below an eligibility threshold," (Orentlicher, 2012, p. 331). Furthermore, unlike Medicare, Medicaid is both federally and state funded, which means that it varies from state to state; this funding structure adds to the decentralization of the healthcare system. Initially, there were a myriad of restrictions on eligibility federally and by state, as outlined previously. With the passing of the Affordable Care Act (ACA), this changed and Medicaid became "a program for all of the poor (defined as families earning no more than 133% of the poverty level)", (Orentlicher, 2012, p. 332).

In addition to people needing to qualify for Medicaid, other barriers prevent individuals and families from either signing up for the program or using it. While this is government-funded health insurance, "qualified persons may be unaware of their eligibility or find it difficult to navigate the application process" and while ACA simplified this process, there is still shame that comes with being a Medicaid patient. This discouraging reason holding individuals back from becoming Medicaid patients, or not using all of its services, is the stigma behind it. Having a reliance on government benefits can be humiliating (Orentlicher, 2012). Another barrier is that once a patient has qualified for Medicaid, they may be in a vulnerable community where, geographically, they do not have access to the resources they need. In other situations, the health care provider that they need to see may not accept Medicaid, as physicians are paid at a lower level than they would be through Medicare or private insurance. Additionally, this Medicaid model is an attempt at a model that would work for wealthier people and "giving people an insurance card and relying on them to find a healthcare provider ignores issues of access for poor persons," (Orentlicher, 2012, p. 333).

Conclusions

While an attempt has been made for universal health care with the Affordable Care Act, the system is still incredibly decentralized and there are still gaps in resources and access for many individuals, as discussed previously. There are people who are unaware of their options, people ashamed over an inability to provide their family with private insurance, and employees who have lost their insurance from their employer because of changes with ACA. Much of the Green New Deal aims to bring equity to the country and minimize inequity through its various goals. Since the Green New Deal strives to provide skills to young adults and bridge the gaps between

socioeconomic classes, these ideals can be implemented in the healthcare system. As mentioned, the healthcare system has advanced over time with new technologies and with these come new skills that can provide jobs. An incorporation of the Green New Deal into a universal health care system, whether ACA or an alternative, can enhance employment and livelihood of the population.

Additionally, a healthcare system that provides equitable care, equitable access, and equitable costs will create a healthier population and one with fewer gaps in resources and care. A universal program will streamline health care and access, but it will also take away the stigma that comes with Medicaid and other types of government assistance. As stated by Orentlicher, "if everyone receives healthcare through the same program, poor individuals do not need to feel that participation in the program automatically identifies them as being poor," (2012, p. 332). A form of universal health care in a Green New Deal world can potentially gap bridges amongst different populations and socioeconomic classes in order to create a more sustainable, healthier system and population. In order to assess the feasibility of a universal healthcare system further, it is important to consider the alternatives that currently exist within the United States, outside of services provided by the government.

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Private Insurance in the US

Private Insurance in the US

Within the United States, there is a vast pool of options for private insurance, which serve as alternatives to universal healthcare. Each type of private insurance is unique and comes with its own set of pros and cons. Citizens can find different health care models to choose from provided on various levels (national, local, individual), or options provided by employers or organizations. There is no set number of mutually exclusive options to choose from, but rather consumers must decide from a wide range of providers and coverage plans, and often they must choose supplemental coverages as well. There are options that may make more sense than others on a case-to-case basis, while others are in general less likely to provide satisfactory health care. The sheer number of options can be confusing to the average consumer and obtaining full information in order to make an informed choice can be difficult. Some of the various options include, but are not limited to, consumer-driven health plan (CDHP), primary care membership, preferred provider organization (PPO), or health maintenance organization (Eskew, 2014; Hatfield, 2006). While having a robust marketplace for goods and services is beneficial to provide consumers with choices to find the best fit, in the world of healthcare, the value of the marketplace can be degraded by the lack of clarity.

As we will see in the following sections of this report, the United States spends the most on healthcare and yet individuals receive low quality care. However, there are still benefits to looking into what coverage already exists before strategizing how to fix the system. Americans will be more comfortable adapting to a new system if they get to keep things that they liked already, such as keeping their doctor, saving the most money possible, and being able to make choices about their insurance (Abdus, 2020). The Affordable Care Act, for example, was a hybrid approach to universal and private healthcare. The law allows citizens to keep their insurance if they like it,

while filling gaps in care coverage for the uninsured. Here we explore some of the options that currently exist in the realm of private insurance in order to assess what is working for customers, and what needs to be fixed.

Table 1. *Exploring Private Healthcare Options in the United States*

Insurance Option	Definition	Pros	Cons
Consumer Driven Health Plan (CDHP)	An umbrella term for health plans, which shift health care costs to consumers for services. Comprised of a medical spending account and a high deductible healthcare coverage insurance.	Incentivizes consumers to notice the implications of the health care choices on cost and quality of the care received, and therefore make choices that are conscious of price; more responsive to consumer needs; more choice, fewer restrictions, less involvement of employers in healthcare decisions; moderate cost for employer providers; cost savings in first year	Shifts more costs on consumers over time, especially high-risk ones; higher deductibles than HMOs or PPOS (Christianson 2004; Hatfield 2006)
Health Savings Account (HSA)	A type of medical savings account for a CDHP. Pay into a health savings account up to a maximum amount per year, earn interest, and spend/withdraw money without tax as long as it's for medical purposes. Available through employers or individuals. Should be paired with a high-deductible health plan.	Save money on total spending and pharmacy spending compared to traditional health plans; workers can continue with their account after leaving their job	Does not decrease health care spending for all patients--patients chronic conditions may pay more (Sasso 2010)
Health Maintenance Organization (HMO)	Coverage or care is only provided by doctors who contract through the HMO, except in emergency or urgent care. Referrals are needed for seeing specialists. Focus on prevention and wellness.	Reduces costs by keeping care within the HMOl; lower hospitalization rates; focus on prevention and wellness helps patients avoid habit-caused conditions; more common form of insurance, so people are more familiar with what it entails	Difficult to get care out-of-network; may not be possible with some plans to get out-of-network care coverage in which case you pay full price; need a referral to see specialists; if your doctor leaves the network you must find a new one (Health 2020; Tussing 1994)

Preferred Provider Organization (PPO)	PPO plans have doctors and hospitals within their network, but patients are allowed to go out-of-network for a higher cost. Offers more benefits than original Medicare.	Able to go out-of-network; more flexibility; more common form of insurance, so people are more familiar with what it entails	Higher cost than HMOs; additional benefits cost extra (Preferred 2020)
Primary Care Membership	Patients pay flat monthly payment directly to their family physician in what is a form of third party free medical practice. Can be supplemented with a high deductible health plan. Mainly seen in rural states such as West Virginia, Washington state, Oregon, Utah.	Lower costs; increase patient access; no insurance company or government involvement; eliminates copays for visits; more patient satisfaction; increased job satisfaction for physicians; can be useful for increasing physicians in rural areas	Varies between physician offices; doesn't always include standard prescriptions; "unauthorized practice of insurance," no insurance companies or government involvement; not legal to practice in all states; doesn't include services outside of primary care umbrella (scope of service); usually needs to be supplemented (Eskew 2014)

Conclusions

The table provides several key takeaways. First, relationships matter. Individuals living in areas that are more rural may prefer to have a closer relationship to their physician's offices and less government involvement, which allows for greater patient satisfaction as shown by the Primary Care Membership option (Eskew, 2014). One of the benefits of a health savings account is that patients can keep their doctor when they leave their job, whereas an HMO requires a patient to find a new doctor if their primary doctor leaves the network (Sasso, 2010; Tussing 1994). When considering a universal care option, it is important to note that both patients and doctors want to be able to have a close relationship with each other, and the federal government should avoid impeding on this relationship.

Secondly, private insurance forces consumers to choose between decreased costs and better care. Lower costs tend to be the pro associated with many of the options, as well as choice in

spending specifically so that patients have the option to lower their personal costs. For example, CDHPs allow patients greater control over their care options in order to lower their personal costs. However, not all patients will have this choice to lower costs if they have chronic conditions, and patients may choose to lower costs at the expense of receiving better care. Having a larger pool of people paying into the insurance system ensures lower costs for all. This is why, unlike other industries in a free market place, insurance makes sense when it is more centralized in order to decrease costs for the individuals. A universal healthcare option may create an increase in taxes, but a decrease in overall cost. Smaller private insurance operations cannot guarantee the breadth of a safety net as a larger option owned by the government or large insurance companies.

Thirdly, most insurance types will charge disproportionately for people with greater medical costs. In a capitalistic marketplace, it is normal for a customer with greater wants or needs to spend more. When it comes to health insurance, paying for medicine or life-saving surgery is an absolute necessity, so customers do not have a choice to lower costs. Patients with medical necessities do not have a choice to decline purchasing care, and therefore carry an unfair burden to pay more. With more people paying into the system by insuring the remaining uninsured in the United States, costs can be reduced for everyone.

Finally, going “out-of-network” can cost consumers more. Oftentimes patients have difficulty getting medical coverage if they need to see a doctor or specialist who is not covered by their health insurance. This is a problem because an individual’s health provider may not have the specialist they need to see, and then the individual may need to pay the full cost of seeing the specialist. A more centralized health system would fix this problem and allow patients to see the doctor they need to see.

Ultimately, there are benefits to having various options for private insurance, but the drawbacks can cause serious problems for consumers.

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Survey of Healthcare in Other Countries

Survey of Healthcare in Other Countries

In addition to considering alternatives to universe healthcare within the United States, it is important to analyze functioning universal healthcare systems outside of the US. This analysis further emphasizes problems and challenges with the US healthcare system by comparing healthcare quality, spending, and health outcomes with other countries. By surveying healthcare systems in other countries, specific pain points in the US healthcare system can be identified while drawing on insights, recommendations, successes, and limitations of healthcare systems across the world. The following section will further frame the challenges with US health care through an analysis of health data while providing a roadmap to healthcare reform in the US through the considerations of case studies from four countries: the UK, France, Japan, and Canada.

The JAMA Network published an article in 2018 titled, "Health Care Spending in the United States and Other High-Income Countries" and found that in 2016, medical spending in the US was nearly double that of 10 other high-income countries, while the US performed worse in many other population health outcomes (Papanicolas, Woskie, & Jha). Total health spending in the US reached 17.8% in 2016, which is above the average of 12% for the collective of 11 countries evaluated in 2018 (Figure 2). While the US government health spending is similar to the amounts measured for other countries, the private spending far exceeds the mean value by almost 6%. The data suggest that the US was an outlier for administration and pharmaceutical spending, indicating these costs are two important drivers of high spending in the US compared to other countries. Further analysis of health care spending in the US can be found in the "Cost Comparison" section.

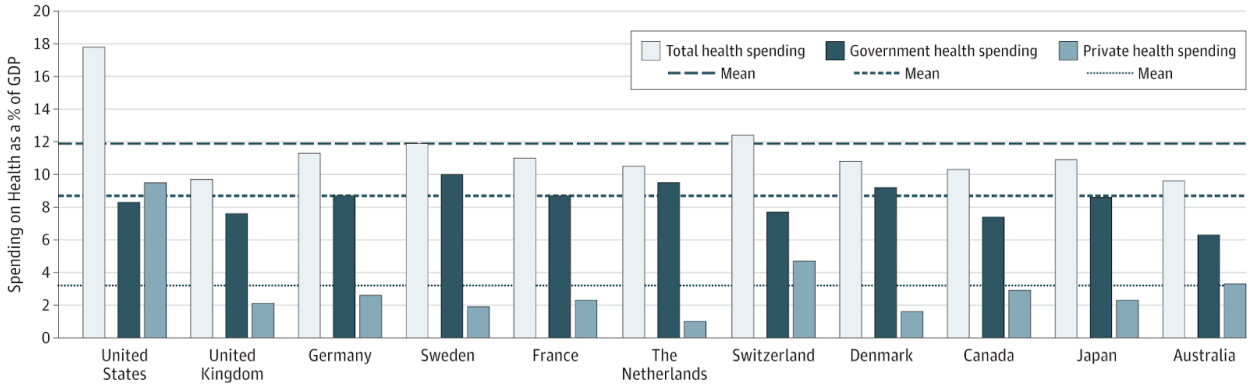

Figure 2. Healthcare Spending as a Percentage of Gross Domestic Product. Dashed lines represent average values. (Papanicolas, Woskie, & Jha, 2018).

It is important to note that the high spending on health care in the US does not lead to increased health care quality or access. The same 2018 article found that about 10% of the US population lacked basic health coverage, while 1% or less of the populations in the 10 comparison countries lacked health care coverage. Additionally, the US had the lowest life expectancy of the compared countries and the highest maternal, infant, and neonatal mortality rates (Figure 3). Other findings of the article show the US ranked below the mean value of the compared countries in factors influencing costs, including the practicing workforce size and number of hospital beds (Papanicolas, Woskie, & Jha, 2018). Comparing US health care to other countries clearly indicates that the spending of healthcare in the US is inefficient and does not lend itself to increased quality or access to healthcare. To draw on the successes and limitations of healthcare systems in other countries, four case studies were evaluated.

Rank (highest to lowest)	1	2	3	4	5	6	7	8	9	10	11	Mean
Determinants of health												
Smoking, % of population aged ≥15 y who smoke daily	France 22.4	Germany 20.9	CHE 20.4	NLD 19	Japan 18.2	Denmark 17	UK 16.1	Canada 14	Australia 12.4	US 11.4	Sweden 11.2	16.6
Alcohol consumption, L per capita in population aged ≥15 y	France 11.9	Germany 11	Australia 9.7	UK 9.5	CHE 9.5	Denmark 9.4	US 8.8	Canada 8.1	NLD 8	Sweden 7.2	Japan 7.2	9.1
Obese or overweight, % of population aged ≥15 y	US 70.1	Australia 63.4	UK 62.9	Canada 60.3	Germany 60	France 49	Sweden 48.3[a]	NLD 47.4[a]	Denmark 47.4[a]	CHE 41[a]	Japan 23.8	55.6
Life expectancy												
Life expectancy in total population at birth, mean, y	Japan 83.9	CHE 83	Australia 82.5	France 82.4	Sweden 82.3	Canada 81.7	NLD 81.6	UK 81	Denmark 80.8	Germany 80.7	US 78.8	81.7
Health-adjusted life expectancy, mean, y	Japan 74.9	CHE 73.1	France 72.6	Canada 72.3	NLD 72.2	Sweden 72	Australia 71.9	UK 71.4	Germany 71.3	Denmark 71.2	US 69.1	72
Life expectancy for women aged ≥40 y, mean, y	Japan 47.7	France 46.4	CHE 45.8	Australia 45.4	Sweden 44.8	Canada 44.8	Germany 43.9	NLD 43.9	UK 43.7	Denmark 43.4	US 42.6	44.8
Life expectancy for men aged ≥40 y, mean, y	CHE 42	Japan 41.8	Australia 41.7	Sweden 41.5	Canada 41.1	NLD 40.8	France 40.6	UK 40.5	Denmark 39.8	Germany 39.4	US 38.7	40.7
Maternal and infant health												
Maternal mortality, deaths per 100 000 live births	US 26.4	UK 9.2	Germany 9	France 7.8	Canada 7.3	NLD 6.7	Japan 6.4	CHE 5.8	Australia 5.5	Sweden 4.4	Denmark 4.2	8.4
Infant mortality, deaths per 1000 live births	US 5.8	Canada 5.1	UK 3.9	CHE 3.9	France 3.8	Denmark 3.7	Germany 3.3	Australia 3.2	Sweden 2.5	NLD 2.5	Japan 2.1	3.6
Neonatal mortality, deaths per 1000 live births	US 4	Canada 3.2	CHE 3.1	Denmark 3	UK 2.7	France 2.6	NLD 2.5	Germany 2.3	Australia 2.3	Sweden 1.7	Japan 0.9	2.6
Neonatal mortality, deaths per 1000 live births excluding <1000 g	Denmark 2.09	NLD 1.96	UK 1.77	Canada 1.63	US 1.61	Sweden 1.56	Germany 1.49	France NA	CHE NA	Japan NA	Australia NA	1.7
Low birth weight, % of total live births	Japan 9.5	US 8.1	UK 6.9	Germany 6.6	NLD 6.5	Australia 6.4	Canada 6.3	France 6.2	Denmark 5	Sweden 4.4	CHE NA	6.6

Figure 3. Population Health among 11 countries. Colors represent individual countries throughout the table. (Papanicolas, Woskie, & Jha, 2018).

Case Study 1: The United Kingdom (UK)

The healthcare system in the UK consists of both a public and private sector. Residents of the UK have the option to opt out of the public care that is provided to residents free-of-charge and in turn can use paid, private healthcare or a combination of private and public care. The UK's National Healthcare System (NHS) is a free, publicly funded system with primary care available to everyone regardless of residential status and secondary care available to residents ("Healthcare in the UK", 2020). The NHS is "known worldwide for being the first healthcare system funded by general taxation, which provides free care at the point of use" ("Healthcare in the UK", 2020). However, the NHS is often characterized as having long wait times, run down facilities, and supply and staff shortages, with all of these issues attributed to a lack of funding (Light, 2011). In his article in the American Journal of Public Health, Donald Light claims that the NHS is well

designed but poorly funded, so the "dreary features" of the UK's system should not deter people from drawing on benefits of its efficient design (2011). Light continues by listing transferable lessons from the NHS that can lead the US to successful healthcare reform.

1. Co-payments used in the US lead to inequities and inaccessibility to care and are ineffective at containing costs. Health care should be free at the point of service to achieve equity in care.
2. The UK considers insurance funded health care systems to be more costly, inequitable, and inhibit "population-oriented prevention or public health gains".
3. The UK encourages incentivizing a strong primary care base.
4. The UK pays more to practitioners who care for patients from deprived areas or who have more deprivation (low income, living alone, etc.)
5. Redirecting funds to underserved areas increases equity.
6. Providing bonuses for practitioners who initiate preventative measures affecting a high percentage of the population incentivizes prevention.
7. The UK encourages paying all subspecialties on the same pay scale to prevent young doctors from choosing a specialty based on pay.
8. Control the cost of pharmaceuticals with drug budgets and incentivize new drug breakthroughs.

(Light, 2011)

These lessons stemming from efficiencies in the NHS are directly correlated to the problems with US healthcare discussed above. Lessons one, two, four, and five are a direct response to inequity, one of the most prevalent issues in US health care. Additionally, number eight on the above list addresses the problem of pharmaceuticals, one of the most prominent drivers of high spending in

the US. While the NHS have flaws, the many successes can serve as lessons to be considered for more equitable and accessible care for all within the US.

Case Study 2: France

In contrast to the UK, the French healthcare system "combines universal coverage with a public–private mix of hospital and ambulatory care" that is available to all legal residents (Rodwin, 2011). The French healthcare system balances national health insurance (NHI) with a private, fee-for-service practice to promote liberalism and choice, diverse options, and solidarity (Rodwin, 2018, p. 49). Victor Rodwin compares French NHI and Medicare in an article in the American Journal of Public Health by claiming the following:

> Like Medicare in the United States, French NHI provides a great degree of patient choice. Unlike Medicare, however, French NHI coverage increases as individual costs rise, there are no deductibles, and pharmaceutical benefits are extensive. In contrast to Medicaid, French NHI carries no stigma and provides better access (2011).

The French NHI is a promising guide for US healthcare reform as it possesses many elements similar to US health care including, "fee-for-service practice, a public–private mix in the financing and organization of health care services, cost sharing, and supplementary private insurance" while achieving high patient satisfaction rates at a much lower cost (percent GDP) than the US. Lessons for the US from French healthcare are summarized by Rodwin as (2011):

1. Universal coverage is possible without a single payer system with legitimate recognition of the government's role to oversee all actors.
2. Coverage does not need to roll out all at once in a big bang approach and can instead continue to evolve through piecemeal efforts.

3. Private insurers do not need to be excluded in the supplemental insurance market under a NHI program.
4. As seen with Medicare/Medicaid, delegating decisions to a local level leads to increased gaps in coverage and the uninsured population.
5. Issues with the current system's financing and accessibility can be solved before restructuring the entire program.

Insights from French NHI continue to address problems with accessibility in the US without expecting the US to abandon certain familiarities with the current system that lead to much of the polarization that is seen in healthcare reform discussions. However, the French healthcare system continues to struggle with inequalities in health outcomes and distribution of resources that would need to be considered when looking at US healthcare reform.

Case Study 3: Japan

Japan's long-established healthcare system is a case of extremes. For many years, Japan's healthcare system has seen low costs, high quality, and expansive coverage, much of which is in figures 2 and 3 above. However, as Japan's population has aged alongside the healthcare system, fragmentation of the system contributed to increased costs and an increase in uninsured individuals. Japan provides an excellent view into the long-term problems associated with different strategies for implementing universal healthcare.

An article titled "Japanese Universal Health Coverage: Evolution, Achievements, and Challenges", explores the limitations of Japan's healthcare system with the goal of recommending a plan for reform and global takeaways. Utilizing social health insurance, Japan expanded insurance to the entire population by 1961 through employee-based and community- based plans (Ikegami et al., 2011). With about 3500 plans, Japan has increased equity in the system over the

years and has contained costs and ensured equity by determining set prices and conditions (Ikegami et al., 2011). However, with increasing disparities between income and age, the Japanese healthcare system is seeing the many limitations associated with social health insurance. These limitations have led to a series of global lessons learned from Japan:

1. Attaining universal health coverage and achieving equitable benefits and rates are separate goals requiring separate strategies. Japan has long succeeded in providing universal coverage, but equity in the coverage continues to be an issue today.
2. Political forces are important in driving a country towards universal coverage.
3. Social health insurance has an inherent weakness of fragmentation by employee and residential statues. Fragmentation of plans lead to varying political agendas that make reform difficult, a problem that is exacerbated by delegating decisions to local regions.
4. Consolidation of plans in Japan can lead to more equitable and efficient care in an ageing population.

(Ikegami et al., 2011)

These lessons from Japan show that even well-established, universal healthcare systems still struggle with equality issues, showing that the two ideas can be disjointed and, therefore, require separate strategies. By utilizing the lessons learned from the establishment of social health insurance in Japan, the US can mitigate the risks associated with disconnected plans when considering health reform, preventing wasted time and efforts on inefficient healthcare strategies.

Case Study 4: Canada

The final case study looks to Canada, who, like the UK, provides universal health care through a publicly funded, single-payer system. Over time, Canadians have remained favorable

towards their healthcare system, which offers easy administrative and enrollment procedures, access to care all across the country, freedom to choose physicians and hospitals, and comparable effectiveness compared to countries who spend more money per capita (Ivers, Brown, & Detsky, 2018). Despite its popularity and effective outcomes, there are many limitations with the system, and support has started to decrease amongst Canadians. After capping physician salaries and reducing medical school class sizes in the 1990s, access to citizens decreased while wait times increased, which contributed to criticisms of Canada for not continuing to improve its healthcare system as medicine and population health has changed (Ivers, Brown, & Detsky, 2018). Canada healthcare is now plagued with months-long wait times and a lack of space in hospitals and has no coverage for outpatient medications (Ivers, Brown, & Detsky, 2018). In short, Canada has become complacent due to the system's ability to remain just good enough over the years, preventing motivation from citizens to enact necessary changes. Looking at Canada's path from the successful implementation of a global benchmark healthcare system to a complacent system achieving just the bare minimum demonstrates the need for continuous improvement of healthcare systems.

Conclusions

The many paths towards achieving equitable healthcare systems around the world provide invaluable lessons to the US as the discussions of healthcare reform continue to dominate politics. From the UK, the US can learn the fundamental ideas behind achieving equitable and accessible care, with specific guides to prevent disparities in health care, such as redirecting funds, minimizing co-pays, and controlling costs of pharmaceuticals. On the other end, France offers methods for the US to provide care that is more equitable without abandoning the private insurance sector and fee-for-service models with which much of the US is so comfortable. From Japan, the US is warned that universal health coverage does not always lend itself to equitable care, providing

a warning against reform options that may lead to a fragmented system. Finally, Canada shows that continuous improvement is vital to the continued success of healthcare systems, and the establishment of a strong system is only the first step in achieving lasting, equitable care.

While this analysis of health care in other countries provides the beginning marks of a path towards healthcare reform, there is a crucial component still to discuss: financing health care systems. The following section will look at a cost comparison of healthcare among the countries discussed above, providing key insights that can be used in conjunction with the lessons found in this section.

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Cost Comparison

Cost Comparison

The goal of this cost comparison is to identify differences in the cost of health care and elucidate how those differences will affect changes to the current US healthcare system. In Table 2, the spending for several countries are compared to broaden the perspective of the US system in the context of countries that have public health systems in place. The countries compared here correspond to countries introduced in Section 4: Survey of Healthcare in Other Countries. The specific spending of Medicare in the US is also extrapolated to highlight how the current US equivalent of a public health system operates.

Table 2. Cost Comparison of Health Systems in 2016 and 2017 (MCBS, 2019; OECD, 2017; OECD, 2020; Press release CMS, 2018).

Cost Comparison of Health Systems in 2016 and 2017						
Cost Comparison Variable	United States	Medicare (US)	Canada	France	Japan	United Kingdom
National Health Expenditure (% of GDP) for 2017	17.1 (OECD, 2020)	3.42 (Press release CMS…, 2018)	10.7 (OECD, 2020)	11.3 (OECD, 2020)	10.9 (OECD, 2020)	9.6 (OECD, 2020)
Healthcare spending (USD per capita) for 2017	1 122 (OECD, 2020)	N/A	749 (OECD, 2020)	463 (OECD, 2020)	608 (OECD, 2020)	629 (OECD, 2020)
Out-of-pocket spending (% of health spending) for 2017	11 (OECD, 2020)	18 (MCBS, 2019)	15 (OECD, 2020)	9.4 (OECD, 2020)	12.8 (OECD, 2020)	16 (OECD, 2020)
Out-of-pocket health spending (USD per capita) for 2016	1 101 (OECD, 2020)	2 876 (MCBS, 2019)	698 (OECD, 2020)	463 (OECD, 2020)	580 (OECD, 2020)	594 (OECD, 2020)
Pharmaceutical spending (USD per capita) for 2016	1 220 (OECD, 2020)	3 956 * (MCBS, 2019)	794 (OECD, 2020)	649 (OECD, 2020)	838 (OECD, 2020)	452 (OECD, 2020)
Insurance spending (% of GDP) for 2017	11.2 (OECD, 2020)	N/A	4.4 (OECD, 2020)	10.6 (OECD, 2020)	7.4 (OECD, 2020)	12.7 (OECD, 2020)
Gross insurance premiums (million USD) for 2017	2 836 293.2 (OECD, 2020)	N/A	87 408.1 (OECD, 2020)	314 318.9 (OECD, 2020)	390 095.6 (OECD, 2020)	394 113.5 (OECD, 2020)

Note. *This value only includes the spending of Medicare beneficiaries on prescription drugs in 2016.

There is a noticeable gap in the cost data in Table 2. When composing this portion of the study, information on the expenditure per capita for selected services, treatments, and drugs was unavailable. Many of the countries evaluated in this report did not have extensive data available

regarding specific costs for health services and medications. The organization responsible for itemized data on itemized health spending is potentially the cause of this lack of information. The International Federation of Health Plans (iFHP), which is a conglomerate of private insurance providers in the global health industry, and publishes comparative price reports every three years. There are companies that are members from the US, Canada, and the UK (iFHP, 2017). However, neither France nor Japan have companies that are members. This may be due to the lack of private insurance companies active in these two countries as a result of their universal health systems. Moreover, the 2017 iFHP Comparative Cost Report, which involved a partnership with the US Health Care Cost Institute (HCCI), did not have expenditures from Canada, France, and Japan (iFHP, 2019). As a result of this apparent gap, the above table lacks the adequate information to provide substantial evidence of the following: cost per capita for health service spending, cost per capita for specific prescription spending, and cost per capita for specific medical treatment spending.

When comparing the National Health Expenditure (NHE) of the US and the case study countries, the US is spending the most on healthcare despite having a private health system. This trend of high NHEs is characteristic of countries that have large economies and populations like the US (Devaux, 2016). The problem, however, is that the US does not follow the trend of better health outcomes that typically correlates with higher NHE (Devaux, 2016). The US spends nearly double that of other countries on health care per capita (Table 2). The leading explanation for high health care costs is that the high amount of money put into the system will result in high health care outcomes (Papanicolas, Woskie & Jha, 2018). For many countries, this is true. Figure 4 shows how in other countries' health spending relates to their life expectancy. The higher the spending, the better the life expectancy. As illustrated below in Figure 4, the US is an outlier when it comes

to this relationship. The US also falls well below the standard of other health care outcomes as well. When comparing high-income countries, US has the highest percentage of adults who are overweight or obese at 70% (Papanicolas, Woskie & Jha, 2018). The US also has a very high infant mortality rate at 5.8 deaths per 1000 live births, which is greater than the average rate of 3.6 deaths per 1000 live births in other high-income countries (Papanicolas, Woskie & Jha, 2018).

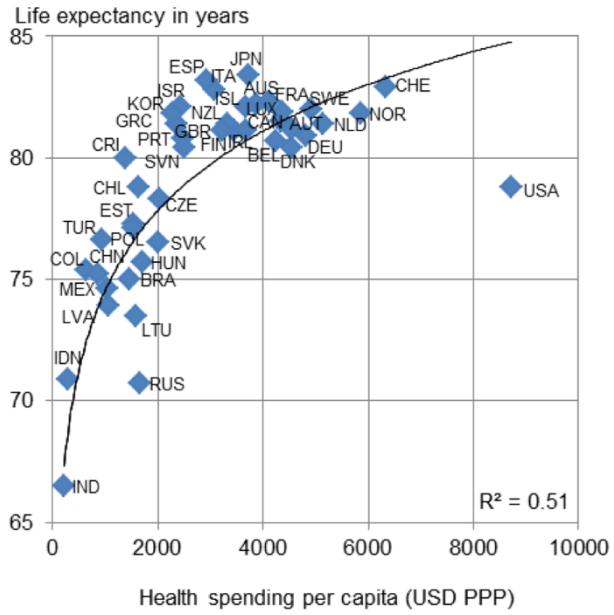

Figure 4. Life Expectancy in Years and Health Spending by Country in 2015 (Devaux, 2016).

One contributor to lower health outcomes for the US may be the high cost of healthcare (Papanicolas, Woskie & Jha, 2018). According to Lyford and Lash's 2019 article "America's Health Care Cost Crisis" the high cost for health care does not only affect the wallets of Americans but how they decide to follow treatments as well (Lyford & Lash, 2019). With high prices of health care, patients have been forgoing prescribed medicine and drugs (Lyford & Lash, 2019). According to Lyford and Lash, "7.5 million older adults reported being unable to pay for a medication prescribed by their doctors" in a 2019 West Health-Gallup survey and about 58 million

adults experienced medication insecurity (Lyford & Lash, 2019). If costs were to increase, the number of patients who are unable to pay for medical treatments will increase. These numbers are the warning signs of a current healthcare cost crisis.

A secondary issue of this system is the steady increase of health care costs. Health care spending is growing at twice the rate of household income (Lyford & Lash, 2019). If these costs continue to grow at the current rate, then the overall US economy could be put under more pressure because of increased employer spending on healthcare. Employer spending increased from around $313 billion in 2000 to over $800 billion in 2019 (Lyford & Lash, 2019). Internationally, the US has a far greater percentage of insurance spending and significantly higher gross insurance premiums than those countries with public health models (Table 2). Business and consumer spending also affects state and federal spending. In 10 years, the number of states that spend more on Medicaid than K-12 education rose from 21 to 44 in 2019 (Lyford & Lash, 2019).

Medicare beneficiaries do not escape these issues. A major flaw of Medicare is the gaps in coverage faced by beneficiaries after switching from private insurance to the public system (Lyford & Lash, 2019). As the cost of medical expenses increase, this gap of coverage widens. Many Medicare beneficiaries have limited or fixed incomes and therefore cannot afford the rising price of healthcare. Medicare beneficiaries face the highest out-of-pocket health costs at $2,876 followed by other insured individuals in the US at $1,101 (Table 2). This suggests that the public health system in the US, Medicare, does not function efficiently compared to the other public health models in the case study countries, who have out-of-pocket costs of nearly half that of the US (Table 2). One reason for the almost double out-of-pocket costs for Medicare beneficiaries is the gap in coverage that occurs with the transition from private to public health systems.

One area of focus to solve this cost crisis is the cost of medication. The US spends the most on pharmaceuticals compared to the case study countries (Table 2). Much of this cost is attributed to spending on prescription and administered drugs. According to the 2017 iFHP Comparative Cost Report, drug prices in the US are double that of most iFHP member countries (iFHP, 2019). For example, the price of the prescription drug Enbrel (Etanercept), a drug used to treat symptoms of arthritis, was $4,635 in the US (iFHP, 2019). The cost in the other six countries in the study ranged from $708 to $2,270, with the cost in the United Kingdom at $922 or 20% of the US price (iFHP, 2019). For Medicare beneficiaries, this cost is even higher than the US average. Drug spending is the largest portion of beneficiary expenditure, at almost a quarter of Medicare beneficiary spending in 2016 (MCBS, 2019). Decreasing this cost would lower the out-of-pocket spending per capita.

One potential reason for such high drug prices is the privatization of the US pharmaceutical industry and their relationship with private insurance companies (Baker, 2017). Another source of high costs is the delivery of unnecessary or low-value care. These services range from $80 billion to $101 billion a year and make up an estimated one fifth of all medical care (Lyford & Lash, 2019). The reason for such high rates of unnecessary or low-value care can be linked to the lack of transparency in the US health system. This lack of transparency relates to the lack of knowledge the public has about health care costs. Many consumers do not know the true cost of treatments and medications because employers and federal programs cover much of the cost and there is no standardized copay system (Baker 2017). The relationship that the federal government has with private companies promotes free markets. This makes it difficult to implement federal price controls. These private industries do have private health care check organizations that attempt to control and decrease costs, however these all are still legally unable to enforce the control of prices

(Baker 2017). A solution to the lack of transparency could be the widespread use of a public health system instead of the current private system.

Conclusions

Having a universal healthcare system would centralize the organization of health care. A standardized system could decrease inequities of coverage between insurance providers by enforcing federal level regulations on the costs of health care services and medication. Currently, there is a lack of information that is shared from private health insurance providers about how they negotiate for lower market prices (Baker, 2017). Increased transparency in the system would encourage the insurance companies, the pharmaceutical industry, and private hospitals to price their services and products competitively with other high-income countries. It would also mean the standardization of copay systems, many of which have tiered systems and formulary placements based on pharmaceutical prices and perceived value to the patient that have caused copays to increase in price since their implementation (Baker 2017). Standardizing this would ensure that people are paying the same percentage of their health care costs out-of-pocket. In conclusion, this would decrease the overall cost of US health care spending making health care more affordable. This decrease in costs is one of the several benefits of implementing a universal healthcare system in the US.

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Concluding Remarks

Concluding remarks

The five sections of this report provide collections of data and information to address five questions:

1. How do the Green New Deal's goals relate to the current healthcare system and efforts for healthcare reform?
2. How is the current US Healthcare system structured? What works? What does not work?
3. What are the pros and cons of various forms of private insurance in the US?
4. What does healthcare look like in other countries? How is this useful in discussions of healthcare reform in the US?
5. What are the differences in the cost of healthcare internationally and domestically? How do these differences affect a renovation of the current US Healthcare system?

Upon reviewing the findings of the above five sections, a renovation of the current US healthcare system is necessary to achieve the efficient provision of equitable quality healthcare to all individuals living within the US. The current healthcare system is decentralized and has a measurable lack of equity. In an article published in the Maternal and Child Health Journal, Larson and Hafon demonstrate this lack of equity in their study aimed to "examine the shape and magnitude of family income gradients in US children's health, access to care, and use of services," (2009, p. 332). They found that "the percentage of children in worse health declined with increasing family income for 15 health indicators," (Larson and Hafon, 2009, p.335). Other examples of inequity that were discovered in this study are that there is significantly less access to health care for children in low income families and that income disparities were associated with unmet health needs (Larson and Hafon, 2009). This study shows the grave inequity that exists in the healthcare system for individuals with varying socioeconomic statuses and the negative health

effects that this has on children. Additionally, the cost of the current healthcare system is significantly higher than in countries that have public health models. Nonetheless, Medicare does not provide enough support to beneficiaries to pay for coverage gaps after changing from a private system to a public system. A universal healthcare system could promote equity by ensuring access to all individuals in the US and helping avoid transitory coverage gaps. This could translate to equity in various aspects of life by reducing the stigma associated with government provided care. By levelling access to basic health care, gaps between classes can also begin to be reduced, one of the primary initiatives of the Green New Deal. Additionally, as mentioned in the "Cost Comparison" section, there should be regulations that address the inequitable quality of care that is provided. The delivery of unnecessary or low-value care is the source of a large portion of health spending for patients that perpetuates the inaccessibility of health care because of avoidable health costs that mainly benefit the revenue of private industries.

This implementation of a universal healthcare system will be a hybrid model that allows individuals to keep their private insurance as a supplementation to the universal system, as desired. In the recommended healthcare system, private insurance companies are required to follow certain stipulations in order to ensure equitable care to all patients. These stipulations will be the base of the model of the universal system as well. For example, all prescriptions must be covered in some manner under every form of insurance. This will be feasible through federal regulations on costs that should be implemented through the reform of the healthcare system, as discussed in Section 5. Patients should not be forced to make economic decisions to save money at the expense of their overall health and wellbeing. Secondly, the importance of relationships in receiving medical care must be preserved. One important relationship in healthcare is the relationship between patients and doctor. Patients should be able to keep their doctor after the healthcare system is overhauled.

This ensures greater patient and doctor satisfaction, and therefore overall more effective and efficient care. A third stipulation example is that patients should be able to see the specialist they require, even if they are “out-of-network.” This should be a part of the primary care covered by the government so that patients have the freedom to see a specialist if they require one, no matter their private insurance. It is important to note that a specialist may be hours away for many individuals. In these situations, this basic care provided by the implementation of a universal healthcare system could provide transportation, access to transportation, or funds to reimburse transportation as well as temporary lodging and food, as needed. Although these will lessen one barrier of access for some individuals, they may still face issues of missing work, needing childcare, or other unforeseen circumstances that come with having to travel for care. These issues could be mitigated by the Green New Deal, which works to establish family-sustaining wages and adequate family and medical leave. This emphasizes the importance of creating healthcare reform that is informed by Green New Deal initiatives. Ultimately, we believe this recommendation will ensure a healthcare system that provides equitable, effective, and efficient care to all individuals living in the US in a Green New Deal world.

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