Public Policy

Healthcare in the United States: Why Socialized Medicine Could Cure Nation

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Abstract

The United States of America is the only industrialized country in the world that does not provide some form of universal health coverage. Criticism of socialized healthcare reform often echoes McCarthy-era fears of socialism. Developed nations across the globe have implemented many variations of socialized healthcare tailored to fit each nation's unique economic and cultural situations. These same developed countries are not considered socialist or communist by any stretch of the imagination, yet this remains a typical American argument for why universal healthcare would become detrimental to the social and political realms of the United States. To determine if and how the United States would benefit from universal healthcare, it is essential to evaluate how the current American healthcare system works and who is benefiting, understand the current stigmas rooted in America's history that Americans hold regarding universal healthcare, and finally to assess how other developed countries have fared under different forms of universal healthcare. Through this evaluation, it becomes clear that through some mix of the different types of universal healthcare, the US could significantly improve the healthcare system within a decade, reducing the inequity of care and accessibility to medicine that the country currently faces, in such a way that national fears of even the word "socialized" are properly cared for.

The American Healthcare System: The Current Situation

To address why or how the United States of America would benefit from universal healthcare, it is essential first to understand how the existing American healthcare system functions, who profits from the system, and who does not. The current American healthcare system is an amalgamation of private, federal, non-profit, and for-profit medical care institutions and insurers. Federal programs include a national Medicare program for citizens over 65 years old, a Medicaid program for low-income individuals and families, the Children's Health Insurance Program, and various programs for citizens with disabilities and veterans. A population report completed by the United States Census Bureau estimated that roughly 92 percent of the people in the country have some type of medical coverage.[1] Within this covered group, private insurers covered 55 percent of the nation through private insurance provided by their employers.[2] Medicaid covers an additional 17.9 percent of the population.[3] Medicare accounts for another 18.2 percent of the population.[4] In 2010, President Barack Obama signed the Patient Protection and Affordable Care Act to expand access to insurance; furthermore, in 2014, the federal government introduced the following expansions: parental coverage was extended for young people until the age of 26, the expansion for Medicaid eligibility, and the requirement for most Americans to secure health coverage or face a penalty.[5] By 2018, the number of unprotected adults dropped by about eight percent, leaving 8.5 percent of the population uncovered, accounting for roughly 27.5 million Americans.[6]

Of these 27.5 million uninsured people, 5.7 percent are white, 17.7 percent are Hispanic or Latino, and 18.8 percent identified as Native American or Native Alaskan.[7] Additionally, an estimated 10.8

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[1] US Census Bureau et al., US Census Bureau (2019), https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf.
[2] Roosa Tikkanen et al., "United States."
[3] Roosa Tikkanen et al., "United States."
[4] US Census Bureau et al., US Census Bureau.
[5] Sarah M. Lyon, Ivor S. Douglas, and Colin R. Cooke, "Medicaid Expansion under the Affordable Care Act. Implications for Insurance-Related Disparities in Pulmonary, Critical Care, and Sleep," *Annals of the American Thoracic Society* 11, no. 4 (May 11, 2014): 661–67, https://doi.org/10.1513/annalsats.201402-072ps.
[6] US Census Bureau et al., US Census Bureau.
[7] "Census Bureau Releases New Report on Health Insurance by Race and Hispanic Origin," *United States Census Bureau* (Patricia Ramos, November 22, 2022), United States Census Bureau, https://www.census.gov/newsroom/press-releases/2022/health-insurance-by-

percent of Native Hawaiian and Pacific Islanders living in the United States had no health coverage, and 10.9 percent of Black Americans had no coverage.[8] It is also reported that people of color who are insured receive worse care than most white Americans, often receiving care that is an estimated 35 percent worse than their white counterparts, judged by overall health outcomes.[9] The current American healthcare system results in many federal programs overlooking many minorities and low-income families. These significant disparities in nationwide coverage are why so many Americans argue that the American healthcare system is broken. If universal healthcare were implemented in the US, not only would access to care and insurance increase for low-income families, but universal healthcare would also standardize the basic level of care across racial and ethnic lines in a capacity that private insurers cannot. However, in many specific regions of the country, insurers hold prejudices against certain racial and ethnic groups that could cloud their judgment when choosing whether or not to insure a person for a reasonable price based on an applicant's economic status. When insurers only offer incredibly high prices that are out of an American's income level, based on subconscious prejudices, companies exclude many Americans. These subconscious prejudices go beyond the typical factors considered when creating prices for health care plans, including age, in what region of a state an individual resides in, whether or not the individual smokes, and the number of people in an individual's family.[10]

Furthermore, US healthcare costs are exceptionally high, especially compared to other similarly developed nations. In 2021, US health expenditures per capita were $12,914, compared to a global average of $6,125.[11] Despite the high costs of healthcare, Americans do not receive the highest possible quality care.[12] The US scores

race.html#:~:text=The%20U.S.%20uninsured%20rate%20in,in%20the%20nation%20at%2017.7%25.

[8] Tikkanen et al., "United States."

[9] Tikkanen et al., "United States."

[10] Tikkanen et al., "United States."

[11] Matthew McGough et al., "How Does Health Spending in the US Compare to Other Countries?," Peterson-KFF Health System Tracker, February 15, 2023, https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#GDP%20per%20capita%20and%20health%20consumption%20spending%20per%20capita,%202021%20(U.S.%20dollars,%20PPP%20adjusted).

[12] Roosa Tikkanen and Melinda K Abrams, "US Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes?," US Health Care from a Global Perspective, 2019 | Commonwealth Fund, January 30, 2020, https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019?gclid=Cj0KCQjw7pKFBhDUARIsAFUoMDbVZBN2PrzOlYBZvEe8qGs1PvCiAAxHemHZb_FjjCnAbSdQ0LSPChYaAmLYEALw_wcB.

significantly lower than other industrialized countries on many critical health issues, including increased maternal mortality, suicide rates, avoidable hospital visits, and life expectancy.[13] These other developed countries have been able to standardize the level of care across their respective nations to ensure that what citizens give up financially for a universal healthcare system is made up for with high-quality treatment.

The combination of high percentages of uninsured people and increased healthcare costs can leave many citizens on the brink of bankruptcy if they or a family member develops a severe illness. Even Americans with health insurance often have to pay high out-of-pocket fees after their insurance plan is applied to the costs of a medical procedure or service. In Oregon, the price of a tonsillectomy, a simple and common surgery in the US, is $7,467 without insurance at an outpatient center.[14] For a low-income individual or family, the cost of this surgery is far too great. Even with insurance, a tonsillectomy would cost, on an average insurance plan, $3,585.[15] Still, with the price cut, that monetary commitment can be a significant financial decision for Americans.

Beyond the differences in treatment for minority groups in the US, the federal government also fails to contain healthcare expenditures at reasonable prices that would follow similar procedural expenses in other countries. One of the attempts made by the US government was signed into law in March 2010 by President Obama. Colloquially known as Obamacare, the Affordable Care Act (ACA), according to the US Department of Health and Human Services, has three primary goals. The first of these goals is to grant access to affordable health insurance to more significant numbers of people. In states where the Medicare expansions have been implemented, the ACA allows consumers to take advantage of subsidies that lower insurance costs for household incomes between 100 and 400 percent of the federal poverty level (FPL).[16,17] The

[13] Rakesh Khurna, "The Drive for Women's Health Equity," *Harvard T.H. Chan School of Public Health* (blog), March 22, 2023, https://www.hsph.harvard.edu/deans-office/2023/03/22/the-drive-for-womens-health-equity/.
[14] "Cost of Tonsil and Adenoid Removal by State | Sidecar Health," Sidecar Health, 2022, https://cost.sidecarhealth.com/ts/tonsil-and-adenoid-removal-cost-by-state.
[15] "How Much Does a Tonsillectomy Cost? – Amino," Amino, 2019, https://help.amino.com/hc/en-us/articles/360009877533-How-much-does-a-tonsillectomy-cost-.
[16] Assistant Secretary for Public Affairs and William Russo, US Department of Health and Human Services § (2022), https://www.hhs.gov/healthcare/about-the-aca/index.html.
[17] In the 48 continental states the 2023 FPL for a single person is an income of 14,580 USD. For an average family of four the FPL income is 30,000 USD. Each additional person is worth 5,140 USD. If a household's income falls between 100 and 400

second intention of the ACA was to grow the Medicaid program to cover all adults beneath 138 percent of the FPL.[18] Since it was left up to the government of each state to determine whether or not these expansions would be implemented, as of 2023, ten states have refused to adopt Medicaid expansions, and two states have adopted the expansions but have yet to implement them. As a result of failing to implement these expansions, millions of citizens have fallen into the coverage gap. An estimated 1.9 million individuals fall into the coverage gap in the ten states yet to adopt the expansions. Adults within the coverage gap have incomes that fall above their state's eligibility for Medicaid but below the FPL.[19] When the ACA was first enacted, it was not anticipated that individual states could opt out of any future Medicaid expansions; therefore, no subsidies are available for people with incomes below the FPL. The final goal of the ACA was to "support innovative medical care delivery methods designed to lower the costs of healthcare generally."[20]

Despite the intentions of the ACA, as stated by the HHS, in 2018, eight years after the ACA was signed into law, health expenditures in the US were $11,172; however, costs increased annually between 4.2 percent and 5.8 percent over the past five years.[21] Despite the measures taken to reduce expenditures, in 2021, the United States' health consumption expenditures per capita rose to $12,914.[22] Further, the ACA required all adults in the US to obtain health insurance or pay a hefty tax fine.[23] This mandate isolated low-income families and individuals in many ways. First, low-income citizens would suffer either way in this system because if an uninsured individual or any family member has a chronic illness, an insurance agency could refuse to offer them coverage. Second, low-income families who can obtain a health coverage plan often struggle to raise the necessary funds. If for-profit insurance agencies repeatedly turn down low-income citizens, there will be no way for them to obtain health insurance, leaving them with a hefty

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percent of the FPL that household would qualify for Medicaid. (https://www.healthinsurance.org/glossary/federal-poverty-level/)

[18] Assistant Secretary for Public Affairs and William Russo, US Department of Health and Human Services

[19] Tikkanen et al., "United States."

[20] Assistant Secretary for Public Affairs and William Russo, US Department of Health and Human Services § (2022), https://www.hhs.gov/healthcare/about-the-aca/index.html.

[21] M. Hartman et al., "National Health Care Spending in 2018: Growth Driven by Accelerations in Medicare and Private Insurance Spending," *Health Affairs* 39, no.1 (Jan. 2020): 8–17.

[22] Matthew McGough et al., "Health Spending in the US"

[23] Matthew Fiedler, "The ACA's Individual Mandate in Retrospect: What Did It Do, and Where Do We Go from Here?," *Health Affairs* 39, no. 3 (March 1, 2020): 429–35, https://doi.org/10.1377/hlthaff.2019.01433.

fine for which they will also be unable to obtain the money. In 2017, Congress eliminated the ACA insurance mandate, deeming it unconstitutional; however, at the end of the mandate, in a healthcare system managed only by for-profit insurance agencies, there are too many risks for low-income Americans when the government imposes such strict mandates.

Rooted in the Past: Americans' Current Fears of a Socialized Healthcare System

While most Americans are eager for a new healthcare system, a segment of the population fears what universal coverage would entail in the US. These fears include new and sudden heavy costs, system inefficiency, and potentially excessive government control. Americans developed these fears by looking to existing sources of universal healthcare that are already in practice around the globe. American critics of universal healthcare say that introducing a universal coverage system is impractical for the country.[24] Furthermore, Americans already hold certain stigmas about the efficiency and capability of the existing bureaucracy. Currently, government agencies are associated with low-ambition employees putting in minimum effort to help clients. Translate this ideology to healthcare, and Americans fear these disgruntled employees will manage the healthcare system. Moreover, Americans tend to pursue their medical choices through a series of emotional responses; this is why the US alone spends more money on life-prolonging technology than most industrialized countries worldwide.[25] These same emotional responses drive up the predicted costs of universal health coverage.

In the past, proposals for universal healthcare in the US have called for increased taxes to implement a new system. One of these proposals included a 7.5 percent payroll tax increase and a 4 percent income tax increase on all Americans; however, higher-income Americans would be faced with higher taxes.[26] It was determined that if the US were to implement entirely universal health coverage, the costs

[24] Gabriel Zieff et al., "Universal Healthcare in the United States of America: A Healthy Debate," *Medicina* 56, no. 11 (November 30, 2020): 580, https://doi.org/10.3390/medicina56110580.
[25] Neumann, Peter J., and Milton C. Weinsten. "The Diffusion of New Technology: Costs and Benefits to Health Care." US National Library of Medicine, January 1, 1991. https://www.ncbi.nlm.nih.gov/books/NBK234309/.
[26] Zieff et al., "A Healthy Debate."

would range from $1.1 to $2.1 trillion a year over the next ten years.[27] With these projections, however, the US would still not be able to cover the cost of an entirely socialized healthcare system even with the money obtained through increased taxes.

Furthermore, Americans fear that a completely universal coverage system would significantly increase hospital and emergency room wait times.[28] These arguments stem from US perceptions of Canada, where in 2013, patients waited 14-40 weeks to receive an operation or consultation.[29] If the US were to implement universal health care, wait times would likely increase in the short term as there is predicted to be a steep increase in primary care visits once the economic barrier is removed.[30] This fear is most likely rooted in the reality behind the current government-run agencies in America. For example, American post offices and DMVs are traditionally characterized by long wait times and impersonal care. To replace private and personalized healthcare with a model designed to function strictly under government control leaves Americans with the impression that receiving medical care would become the same as waiting a long period just to be greeted at the post office by a disgruntled government employee.

Despite the cost projections, implementing universal healthcare can potentially lower the predicted wait times. In the US, 55 percent of emergency room visits are made by the uninsured diabetic population, accounting for significantly more care time and emergency room visits than their insured counterparts.[31] Furthermore, similar to diabetes, patients diagnosed with hypertension spend $2,000 more than the average American without hypertension.[32] The final most common chronic disease in the US is obesity. In 2022, experts estimated that the costs of loss of productivity are $66 billion annually.[33] Each uninsured sector of the population affected by diabetes, hypertension, and obesity

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[27] Office of the Actuary, Centers for Medicare & Medicaid Services § (2022), https://www.cms.gov/files/document/national-health-expenditure-projections-2021-30-growth-moderate-covid-19-impacts-wane.pdf.
[28] Donald W. Light, "Universal Health Care: Lessons from the British Experience," *American Journal of Public Health* 93, no. 1 (January 1, 2003): 25–30, https://doi.org/10.2105/ajph.93.1.25.
[29] Bacchus Barua and Nadeem Esmail, "Waiting Your Turn: Wait Times for Health Care in Canada, 2013 Report," *Social Science Research Network* (2013), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2346373.
[30] Zieff et al., "A Healthy Debate."
[31] Zieff et al., "A Healthy Debate."
[32] Zieff et al., "A Healthy Debate."
[33] Ross Hammond and Ruth Levine, "The Economic Impact of Obesity in the United States," *Diabetes, Metabolic Syndrome and Obesity: Targets and Therapy*, 2010, 285–95, https://doi.org/10.2147/dmsott.s7384

almost entirely consists of people from a low socio-economic status without access to quality healthcare, which ultimately lowers life expectancy and other health outcomes.[34,35] Universal health coverage in the US would enable prevention methods with capabilities to lower the risks associated with these chronic diseases, increasing the overall public health and economic productivity of the US. Furthermore, preventive measures provided to the general public would limit the costs associated with an unhealthy, uninsured population.[36] One recent study conducted under the National Health and Nutrition Examination Survey shows that if an estimated 18 percent more of the population of elementary school children in the US were to participate in just 75 minutes of exercise per week, these children will be able to save over $21.9 billion in medical costs and productivity over their lifetimes.[37] Another possible preventive measure would include investing just $10 per person annually into community-based educational programs to combat poor nutrition, the side effects and consequences of smoking, and physical inactivity in the US is estimated to save more than $16 billion annually within the first five years, returning $5.60 for every dollar spent.[38] If the US were to implement an entirely universal healthcare system, it was estimated that the costs would equal about $1.1 to $2.1 trillion.[39] Additionally, if the US were to enact the projected educational programs above, these estimated costs would drop from the trillions of dollars to the billions.

Hypothetically, a few years after universal healthcare is implemented, Americans could reap significant economic benefits. One of these benefits is increased profitability among hospitals that pay for the treatment of the uninsured. In America's current healthcare system, all hospitals are required to provide emergency care to uninsured patients and others who cannot pay the fees; because of this, hospitals must increase the prices of smaller operations or lower other expenditures. In a universal healthcare system, hospitals would no longer have to raise prices if all emergency patients could afford the operations they

[34] Bing Leng et al., "Socioeconomic Status and Hypertension," *Journal of Hypertension* 33, no. 2 (February 2015): 221–29, https://doi.org/10.1097/hjh.0000000000000428.
[35] Fred C. Pampel, Patrick M. Krueger, and Justin T. Denney, "Socioeconomic Disparities in Health Behaviors," *Annual Review of Sociology* 36, no. 1 (April 1, 2010): 349–70, https://doi.org/10.1146/annurev.soc.012809.102529.
[36] Center for Disease Control and Prevention, CDC § (2022), https://www.cdc.gov/chronicdisease/programs-impact/pop/diabetes.htm.
[37] Bruce Y. Lee et al., "Modeling the Economic and Health Impact of Increasing Children's Physical Activity in the United States," *Health Affairs* 36, no. 5 (May 1, 2017): 902–8, https://doi.org/10.1377/hlthaff.2016.1315.
[38] Lee et al., "Increasing Physical Activity in the United States," 902–8
[39] Lee et al., "Increasing Physical Activity in the United States," 902–8

receive.[40] Universal healthcare also has the potential to increase the profitability of small businesses by eliminating what companies must spend on health coverage for employees.

Finally, Americans have always opposed the interference of some higher power of control, whether a monarchy or some other clerical power. These are the ideals on which the country was founded; as said in the Declaration of Independence, "To secure these rights, Governments are instituted among Men, deriving their just powers from the consent of the governed."[41] Therefore, Americans naturally fear government interference with healthcare and coverage, which has ultimately led to an absence of the traditional class system. Therefore, because of the absence of an aristocracy and its resulting social hierarchies in America, there is no self-identified working class. If Americans were to form a laboring class, it would function similarly to labor unions. These unions have the potential to hold immense political influence over the country for a few specific reasons. The first is that labor unions are composed of vast numbers of members with high levels of functionality and organization; because of this, unions can and do force externalities on the public, for example, through strikes, pickets, and protests. In the past, strikes, pickets, and protests organized by labor unions have forced employers to meet their demands: higher wages, safer working conditions, and especially universal health coverage.[42] Suppose a working-class party could be formed with the same significant quantity of members and high levels of organization. In that case, this party could direct its power in the political realm to equally represent its members' well-being, including increased wages, safe working conditions, and even universal health coverage.

Without any laboring class to identify their political party, America has fallen into a two-party system, focused almost entirely on the self-identified middle class, which consists of the low socio-economic Americans that make up a typical labor class. Because of the excess of free land at the nation's founding, many low-income Americans own their land; the number of low-income Americans who

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[40] Research Department and Donald Hirasuna, Universal Health Coverage: An Economist's perspective § (2007).
[41] Thomas Jefferson et al., "The Declaration of Independence," *National Archives* (2023), https://www.archives.gov/founding-docs/declaration-transcript#:~:text=We%20hold%20these%20truths%20to,their%20just%20powers%20from%20the
[42] Horacio A Larreguy, Pablo Querubin, and Cesar E Montiel Olea, "The Role of Labor Unions as Political Machines: Evidence from the Case of the Mexican Teachers' Union," *Harvard* (2014), https://www.iq.harvard.edu/files/iqss/files/updated_march_6_paper.pdf.

own their land is substantially greater than that in most industrialized nations worldwide.[43] Another possible explanation for the absence of a working class in America lies in the nation's deep-rooted history of racial segregation. The country's inability to bring Black and Hispanic laborers together with their white counterparts has left the laboring portion of the population divided and unable to gain the political enthusiasm necessary to form a political party. These low-income, blue-collar Black, white, and Hispanic Americans make up an estimated 34.3 percent of the uninsured population of 27.5 million US citizens.[44,45] It is also reported that people of color who are insured receive worse care than most white Americans, often receiving care that is an estimated 35 percent worse than their white counterparts.[46] Forming a working-class party would allow this historically underrepresented segment of the population to advocate in the world of politics for what they need to ensure that they can stay healthy: universal health coverage.

Healthcare Systems around the Globe: The Three Models of Universal Healthcare

Skeptics in the United States argue that the country is too large with too many distinct cultural identities to implement a universal healthcare system; however, many developed countries, which also have diverse populations, have been able to implement healthcare systems that encompass each unique culture represented in their own country. Understanding how these diverse nations have each been able to put variations of socialized healthcare into practice is crucial. Great Britain, Germany, and Canada are all home to an array of ethnic groups benefiting from their countries' different health coverage systems.

Great Britain, Spain, and New Zealand utilize the Beveridge Model of health coverage, which was founded and initially implemented in Great Britain.[47] The Beveridge Model, named after Sir William Beveridge, is a system in which the government finances and provides healthcare through tax payments, similar to local American police forces

[43] Zieff et al., "A Healthy Debate."
[44] "Census Bureau Releases New Report on Health Insurance by Race and Hispanic Origin."
[45] Tikkanen et al., "United States."
[46] Tikkanen et al., "United States."
[47] Mimi Chung, "Health Care Reform: Learning from Other Major Health Care Systems – Princeton Public Health Review," Princeton University, December 2, 2017, https://pphr.princeton.edu/2017/12/02/unhealthy-health-care-a-cursory-overview-of-major-health-care-systems/.

and libraries.[48] The government is the single-payer in the Beveridge system, eliminating competition between insurance companies and keeping costs relatively low. This system eliminates out-of-pocket fees, making services free at the point of service. Furthermore, this system guarantees that everyone who is a citizen is given access to free, quality healthcare, as the Beveridge system prioritizes health as a human right.

In a system such as the Beveridge Model, Americans' fears are likely to become a reality. In Great Britain, the average wait time for hospital-based care is 46 days; however, some patients wait up to a year to receive a consultation.[49] Because every citizen is guaranteed access to healthcare, many citizens over-utilize the system, often receiving unnecessary operations and procedures at no cost.[50] If a single-payer system were to be implemented in the US, this problem would likely begin in the US, causing the demand for all operations, even unnecessary ones, to increase and also cause the price of healthcare to increase because patients would believe that at the point of service, the operation would be free when it would end up costing the country even more money. Another potential issue with the Beveridge Model is that if a war, natural disaster, or any change in priority were to occur in the country, the government could potentially divert funds from healthcare to aid in the event impacting the country.

In regions of Europe where the Beveridge Model has not spread, developed countries often choose to implement the Bismarck Model of healthcare. Near the end of the nineteenth century, this model was created by the Prussian Chancellor Otto von Bismarck. Since the model's creation, it has been implemented in Germany, Belgium, Japan, and Switzerland.[51] The Bismarck model employs an insurance system funded jointly by employers and employees through compulsory payroll deductions, making this system multi-payer.[52] Citizens who are employed have access to "sickness funds" created by these payroll deductions. Additionally, private insurance companies must cover every employed

[48] T. R. Reid, *The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care*, *PBS* (Thorndike Press/Gale, Cengage Learning, 2010), https://www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/countries/models.html.

[49] Light, "Universal Health Care: Lessons from the British Experience."

[50] Chung, "Major Health Care Systems."

[51] Chung, "Major Health Care Systems."

[52] Compulsory payroll deductions are mandatory tax deductions taken out of an employee's paycheck. In the US, compulsory payroll deductions include federal income tax, state income tax, local tax, court-ordered child support payments, or the social security tax. (Mike Kappel, "What Are Payroll Deductions?: Mandatory & Voluntary Deductions," Patriot Software, December 16, 2022, https://www.patriotsoftware.com/blog/payroll/an-overview-of-payroll-deductions/.)

person, regardless of any pre-existing conditions. The government controls insurance prices, leaving insurance companies to make no profit. This allows governments to exercise a similar amount of control over costs as those in the Beveridge Model. However, the Bismarck Model was not founded to be a form of universal healthcare because it does not cover unemployed citizens who cannot contribute to the system, leaving a potentially large uninsured population vulnerable to high medical expenses on their own.[53,54]

If the Bismarck model were to be employed in the US, many Americans' fears would not accompany it; however, the system does raise several issues, as well as several possible benefits. One issue with the Bismarck Model is that the system would fail to cover 5.7 million unemployed US citizens.[55] While this is a significantly smaller number than the currently uninsured population, the Bismarck model would leave the poorest and most in need of the medical care sector of the population uncovered. However, an argument can be made that the employment of the Bismarck system would urge Americans to seek employment opportunities and potentially encourage business owners to seek out new ways to create these employment opportunities. If this were to become true, the unemployment rate would drop from its current rate of 3.7 percent.[56] Another potential issue raised with the Bismarck Model would be how to cover citizens who cannot work due to an existing medical condition or old age, as the Bismarck system would not cover these sectors of the population. If this system were to be implemented in the US, one possible solution would be to maintain disability coverage and the Medicaid aspects, which cover retired Americans.

Canada, Taiwan, and South Korea all employ a National Health Insurance Model, which is a mix of both the Beveridge and the Bismarck Models, taking the single-payer aspect from the Beveridge system and the private providers from the Bismarck Model. Universal insurance, like in the Bismarck model, collects no profit and cannot deny a citizen based on an existing health condition. Countries with a National Health Insurance model can negotiate and severely decrease the shelf prices of pharmaceuticals. Countries with this model also lower costs by limiting the specific medical services they will provide, allowing space for a

[53] Chung, "Major Health Care Systems."
[54] Reid, *The Healing of America.*
[55] "The Employment Situation – April 2023," *Bureau of Labor Statistics*, May 5, 2023, US Department of Labor, https://www.bls.gov/news.release/pdf/empsit.pdf.
[56] "The Employment Situation – April 2023," *Bureau of Labor Statistics.*

private sector within the country.[57] The inclusion of a private sector within the US is essential to not only eradicate Americans' fears of long wait times but also allow for an additional economic boost within the country.

Furthermore, within the National Health Insurance Model, many Americans' fears of system inefficiency, high costs, and excessive government control are all addressed and resolved. Whereas in a Beveridge system, patients may wait up to a year for care, the National Health Insurance Model would allow those who can afford private health services to do so, freeing up wait times for those who cannot afford to pay out-of-pocket prices at private institutions. While the government would pay some significant upfront costs, the impact of these prices would be cushioned by an increase in taxes that would go towards funding a private insurance mechanism. With a National Health Insurance Model applying both private and public health institutions, Americans would have the choice of whether or not to receive care from the government, thus eliminating the fear of too much government control by letting each taxpayer choose what type of care they want to receive.

In a 2010 study, the Commonwealth Fund found that nations that implemented these three systems of healthcare, outrank the US tenfold.[58] In comparison to six countries – Australia, Germany, the Netherlands, Canada, New Zealand, and Great Britain – the US consistently underperforms in general health outcomes. The research was based on access to care, quality of care, efficiency, equity, and the quality of the lives of citizens. Because of the high costs of healthcare in the US, many citizens will go without care far more frequently than in the other six countries. Americans with health issues were the most likely to report that their lack of access to care was due to high costs, however, in other countries, such as Great Britain which employs the Beveridge Model, citizens are faced with no financial burden but instead faced with long wait-times to receive care.[59] However, in a Bismarck country such as Germany, these wait times are limited and are simultaneous with little to no out-of-pocket fees. As for the quality of care, the US fares the best on provision. However, the country scores significantly low on chronic care management and coordinated, safe care pulling down the overall

[57] Reid, *The Healing of America.*
[58] Karen David, Cathy Schoen, and Kristof Stremikis. "Mirror, Mirror on the Wall: How the Performance of the US Health Care System Compares Internationally, 2010 Update." Commonwealth Fund, June 23, 2010. https://www.commonwealthfund.org/publications/fund-reports/2010/jun/mirror-mirror-wall-how-performance-us-health-care-system.
[59] Karen Davis, et al., "Mirror, Mirror on the Wall"

score for the US in this category. Australia, New Zealand, and Great Britain can maintain a higher ranking than the US in quality of care because they have been able to utilize information technology for a longer period, enhancing physicians' care of patients.[60] In the efficiency category, the US ranks last overall because of the nation's poor performance on measures of national health expenditures, use of information technology, rehospitalization, administrative costs, and duplicative medical testing. In Germany and the Netherlands, survey respondents showed that citizens in each country are less likely to be admitted to emergency rooms for a condition that could have been treated by a regular physician.[61] As for equity, the US continues to maintain the lowest ranking. Beyond the apparent racial disparities in the American healthcare system, below-average income citizens in America are more likely than their foreign counterparts to not visit a physician when sick, not receive a recommended test, treatment, or follow-up care, not fill a prescription, or not see a dentist when needed all because of the costs in America.[62] The US again ranks last overall for the quality of life their citizens lead based on healthcare, boasting death rates 25 to 50 percent higher than the other six countries in 2010, yet similar rates continue into 2024.[63,64] American hospitals and healthcare centers are dedicated to improving care in the US as well as safety and quality, however, the US could learn from the innovations of universal healthcare in foreign developed nations.

The Beveridge, Bismarck, and National Health Insurance Models, if implemented in the US, would all provide improvements to the current healthcare system. The Beveridge and Bismarck Models would standardize healthcare nationwide, giving every citizen equal quality of care. The National Health Insurance Model would also standardize care across public and private institutions respectively. Most likely, the citizens willing to pay more at a private institution would receive higher quality care than citizens who opt to go to a public institution to receive care. Furthermore, each healthcare model can potentially provide economic benefits for America. The Beveridge Model would control the costs coming from the general population based on income bracket, standardizing what citizens would contribute. However, under this system, there is a vast opportunity for Americans to overutilize the

[60] Karen Davis, et al., "Mirror, Mirror on the Wall"
[61] Karen Davis, et al., "Mirror, Mirror on the Wall."
[62] Karen Davis, et al., "Mirror, Mirror on the Wall."
[63] Karen Davis, et al., "Mirror, Mirror on the Wall."
[64] Bradley Sawyer and Daniel McDermott. "How Do Mortality Rates in the US Compare to Other Countries?" *Peterson-KFF Health System Tracker*, November 16, 2021. https://www.healthsystemtracker.org/chart-collection/mortality-rates-u-s-compare-countries/.

system, receiving unnecessary operations and causing taxes to increase. In the Bismarck Model, the government would standardize the federal payroll deductions to ensure every citizen pays a fair amount based on income level. Furthermore, the Beveridge Model, which employs private insurers, does not allow for unnecessary operations, as the Bismarck Model does. Therefore, payroll deduction under the Bismarck system would only increase due to natural inflation. The National Health Insurance Model would also provide economic benefits to both the American people and their government. An increase in taxes collected by the federal government would allow citizens to face zero costs at the point of service and also cushion the upfront costs the government would face. Further, these taxes would also provide for a national non-profit private insurance system for citizens who choose to go to a private institution. Beyond economic elements, each model would provide an increase in overall healthcare outcomes for Americans. Standardized access to healthcare would allow citizens previously unable to visit a physician to do so regularly while also allowing for government-funded education-based platforms to help the populace understand common chronic diseases and how to prevent/remedy them.

Conclusion

"Inequitable" and "non-inclusive" are the two best words that could be used to describe the current American healthcare system. Public and private policies have repeatedly excluded members of the low-income and minority populations in the US. Even with these disparities, which leave 27.5 million citizens uninsured, American citizens spend more on often low-quality healthcare than any other industrialized nation.[65] Because of the system's poor outcomes, Americans label it as broken and in need of change. Yet, most Americans still hold profound reservations about a universal healthcare system that has worked very well in every other developed nation around the globe. American skeptics claim that implementing a universal healthcare system would be expensive, inefficient, and allow the government to take too much control over people's lives. Americans have learned these fears by focusing only on the worst aspects of healthcare systems in other developed countries; however, many countries do not have these issues because there are several types of universal healthcare that each must be modified to fit a nation's economic standing and diverse population. The Beveridge Model, the Bismarck Model, and the National Health Insurance Model are all effective forms of universal healthcare. The National Health Insurance Model, a combination of both the Beveridge and Bismarck Models, answers all of America's fears about universal

[65] US Census Bureau et al., US Census Bureau §

healthcare. If the National Health Insurance Model were to be enacted in the US, high up-front costs for the government would be softened by an increase in taxes; citizens could avoid and decrease wait times by opting to go to a private practice instead of a public, government-owned institution; and all citizens would be able to be covered by a private, non-profit insurance company in a single-payer manner. In conclusion, the US. could implement a universal healthcare system. To do so, however, the US government would need to put the matter to a national vote and slowly but surely implement a healthcare system that would provide equal care and opportunities for the entirety of the American population.

Bibliography

Agency for Healthcare Research and Quality, and William Russo, US Department of Health and Human Services § (2022). https://www.hhs.gov/healthcare/about-the-aca/index.html.

Assistant Secretary for Public Affairs, and William Russo, US Department of Health and Human Services § (2022). https://www.hhs.gov/healthcare/about-the-aca/index.html.

Barua, Bacchus, and Nadeem Esmail. "Waiting Your Turn: Wait Times for Health Care in Canada, 2013 Report." *Social Science Research Network*, 2013. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2346373.

"Census Bureau Releases New Report on Health Insurance by Race and Hispanic Origin." *United States Census Bureau*. Patricia Ramos, November 22, 2022. United States Census Bureau. https://www.census.gov/newsroom/press-releases/2022/health-insurance-by-race.html#:~:text=The%20U.S.%20uninsured%20rate%20in,in%20the%20nation%20at%2017.7%25.

Center for Disease Control and Prevention, CDC § (2022). https://www.cdc.gov/chronicdisease/programs-impact/pop/diabetes.htm.

Chung, Mimi. "Health Care Reform: Learning from Other Major Health Care Systems – Princeton Public Health Review." Princeton University, December 2, 2017. https://pphr.princeton.edu/2017/12/02/unhealthy-health-care-a-cursory-overview-of-major-health-care-systems/.

"Cost of Tonsil and Adenoid Removal by State | Sidecar Health." Sidecar Health, 2022. https://cost.sidecarhealth.com/ts/tonsil-and-adenoid-removal-cost-by-state.

Davis, Karen, Cathy Schoen, and Kristof Stremikis. "Mirror, Mirror on the Wall: How the Performance of the US Health Care System Compares Internationally, 2010 Update." Commonwealth Fund, June 23, 2010. https://www.commonwealthfund.org/publications/fund-reports/2010/jun/mirror-mirror-wall-how-performance-us-health-care-system.

Fiedler, Matthew. "The ACA's Individual Mandate in Retrospect: What Did It Do, and Where Do We Go from Here?" *Health Affairs* 39, no. 3 (March 1, 2020): 429–35. https://doi.org/10.1377/hlthaff.2019.01433.

Gendler, Robert. "An American Physician's Foray into Scandinavian Healthcare." *Scandinavian Journal of Public Health* 44, no. 3 (May 15, 2016): 225–27. https://doi.org/10.1177/1403494815627385.

Gupta, Anil. "Universal Access to Healthcare: Threats and Opportunities." *Economic and Political Weekly* 46, no. 26/27 (June 25, 2011): 27–30. https://www.jstor.org/stable/23018636.

Hammond, Ross, and Ruth Levine. "The Economic Impact of Obesity in the United States." *Diabetes, Metabolic Syndrome and Obesity: Targets and Therapy*, 2010, 285–95. https://doi.org/10.2147/dmsott.s7384.

"How Much Does a Tonsillectomy Cost? – Amino." Amino, 2019. https://help.amino.com/hc/en-us/articles/360009877533-How-much-does-a-tonsillectomy-cost-.

Kappel, Mike. "What Are Payroll Deductions?: Mandatory & Voluntary Deductions." Patriot Software, December 16, 2022. https://www.patriotsoftware.com/blog/payroll/an-overview-of-payroll-deductions/.

Kennedy, Robert M. "Healthcare for All Americans ." *Human Rights* 25, no. 4 (1998): 6–7. https://www.jstor.org/stable/27880116?seq=2.

Khurna, Rakesh. "The Drive for Women's Health Equity." *Harvard T.H. Chan School of Public Health* (blog), March 22, 2023. https://www.hsph.harvard.edu/deans-office/2023/03/22/the-drive-for-womens-health-equity/.

Larreguy, Horacio A, Pablo Querubin, and Cesar E Montiel Olea. "The Role of Labor Unions as Political Machines: Evidence from the Case of the Mexican Teachers' Union." *Harvard*, 2014. https://www.iq.harvard.edu/files/iqss/files/updated_march_6_paper.pdf.

Leng, Bing, Yana Jin, Ge Li, Ling Chen, and Nan Jin. "Socioeconomic Status and Hypertension." *Journal of Hypertension* 33, no. 2 (February 2015): 221–29. https://doi.org/10.1097/hjh.0000000000000428.

Light, Donald W. "Universal Health Care: Lessons from the British Experience." *American Journal of Public Health* 93, no. 1 (January 1, 2003): 25–30. https://doi.org/10.2105/ajph.93.1.25.

Lyon, Sarah M., Ivor S. Douglas, and Colin R. Cooke. "Medicaid Expansion under the Affordable Care Act. Implications for Insurance-Related Disparities in Pulmonary, Critical Care, and Sleep." *Annals of the American Thoracic Society* 11, no. 4 (May 11, 2014): 661–67. https://doi.org/10.1513/annalsats.201402-072ps.

McGough, Matthew, Matthew McGough, Imani Telesford, Shameek Rakshit, Emma Wager Twitter, Krutika Amin Twitter, and Cynthia Cox Twitter. "How Does Health Spending in the US Compare to Other Countries?" Peterson-KFF Health System Tracker, February 15, 2023. https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#GDP%20per%20capita%20and%20health%20consumption%20spending%20per%20capita,%202021%20(U.S.%20dollars,%20PPP%20adjusted).

Office of the Actuary, Centers for Medicare & Medicaid Services §§ (2022). https://www.cms.gov/files/document/national-health-expenditure-projections-2021-30-growth-moderate-covid-19-impacts-wane.pdf.

Pampel, Fred C., Patrick M. Krueger, and Justin T. Denney. "Socioeconomic Disparities in Health Behaviors." *Annual Review of Sociology* 36, no. 1 (April 1, 2010): 349–70. https://doi.org/10.1146/annurev.soc.012809.102529.

Reid, T. R. *The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care. PBS*. Thorndike Press/Gale, Cengage Learning, 2010. https://www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/countries/models.html.

Sawyer, Bradley, and Daniel McDermott. "How Do Mortality Rates in the US Compare to Other Countries?" Peterson-KFF Health System Tracker, November 16, 2021. https://www.healthsystemtracker.org/chart-collection/mortality-rates-u-s-compare-countries/.

Sen, Amartya. "Universal Health Care: The Affordable Dream." *HPHR Journal* 2015, no. 5 (2015): 1–8. https://doi.org/10.54111/0001e/2.

"The Employment Situation — April 2023." *Bureau of Labor Statistics*, May 5, 2023. US Department of Labor. https://www.bls.gov/news.release/pdf/empsit.pdf.

Tikkanen, Roosa, and Melinda K Abrams. "US Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes?" US Health Care from a Global Perspective, 2019 | Commonwealth Fund, January 30, 2020. https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019?gclid=Cj0KCQjw7pKFBhDUARIsAFUoMDbVZBN2PrzOlYBZvEe8qGs1PvCiAAxHemHZb_FjjCnAbSdQ0LSPChYaAmLYEALw_wcB.

Tikkanen, Roosa, Robin Osborn, Elias Mossialos, Ana Djordjevic, and George A Wharton. "United States." The Commonwealth Fund, June 5, 2020. https://www.commonwealthfund.org/international-health-policy-center/countries/united-states#reducing-disparities.

US Census Bureau, Edward R. Berchick, Jessica C. Barnett, and Rachel D. Upton, US Census Bureau § (2019). https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf.

Vladeck, Bruce. "Universal Health Insurance in the United States: Reflections on the Past, the Present, and the Future." *American Journal of Public Health* 93, no. 1 (February 2003): 16–19. https://doi.org/10.2105/ajph.93.1.16.

Zieff, Gabriel, Zachary Y. Kerr, Justin B. Moore, and Lee Stoner. "Universal Healthcare in the United States of America: A Healthy Debate." *Medicina* 56, no. 11 (November 30, 2020): 580. https://doi.org/10.3390/medicina56110580.