ABSTRACT

The Political Viability of Universal Health Care in the United States

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Universal health care in the United States is possible, granted that the government incentivizes states to implement Bismarck health care systems, requiring health insurance companies to offer a basic coverage package for no profit, enabling free choice of health care provider, regulating health care costs, maintaining health care coverage during unemployment, and streamlining health care administration systems. This paper will first prove that the United States health care system is broken. The second chapter will describe some key features of the Affordable Care Act and prove that the law does not go far enough to solve our health care problems. The third chapter will explain how the Bismarck system could solve many of the problems of the American health care system, and the fourth chapter will propose a strategy for the United States to follow with regard to its transition from a broken health care system to universal health care. This paper will be employing the method of comparative analysis.

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THE POLITICAL VIABILITY OF UNIVERSAL HEALTH CARE IN THE UNITED STATES

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PREFACE

The Comparative Method

In order to improve the cost, accessibility, and quality problems of its health care system, the United States should implement a Bismarck-style system federally and democratically by passing a national bill that incentivizes states to educate their citizens on the need for health care reform, write health care reform bills that employ the five principles of the Bismarck model, and pass them using referenda rather than elected legislative bodies. In order to prove this conclusion, this thesis will use the comparative method (Lijphart 1971). In accordance with Lijphart's principles of the comparative method, this thesis will mitigate the problems of multiple variables and limited subjects by focusing on key variables when comparing domestic political institutions between different countries. In other words, this thesis will compare the health care system of the United States to those of nations that have similar political values and levels of industrialization. The first chapter will establish the need for the United States to develop a universal health care system by comparing statistics on cost, accessibility, and quality to other industrialized nations. The second chapter will explain that the Affordable Care Act does not go far enough in solving the cost, access, and quality problems of the United States' health care system. The third chapter will argue that the Bismarck universal health care model is the most politically viable option for the United States because it is an alternative to a

single-payer system that is more compatible with American political values. The final chapter will propose a framework for a bill that could be passed at the federal level to incentivize the implementation of the Bismarck model through referenda on a state-by-state basis. The bill proposal in the final chapter is based on an examination of Canada's transition to universal health care using federalism and Switzerland's transition through direct democracy.

CHAPTER ONE

Why Does the United States Need Health Care Reform?

In an interview with *60 Minutes* in 2012, then-presidential candidate Mitt Romney made a comment about the American health care system that reflects a relatively widely-held sentiment today (Weiner 2012). "Well, we do provide care for people who don't have insurance," said Romney. "If someone has a heart attack, they don't sit in their apartment and -- and die. We pick them up in an ambulance, and take them to the hospital, and give them care." This post-Affordable Care Act quote from a prominent politician reveals a pervasive ignorance among many Americans, especially the wealthy (Datz 2011). There seems to be an underlying assumption among Americans that those who are not wealthy enough to afford health insurance will simply receive all the care they need at the emergency room. However, this emergency room myth does not take into account the fact that emergency rooms do not provide preventative care or prescription medication on long-term basis. This myth fails to recognize that had Mitt Romney's hypothetical heart attack victim been insured, he probably could have saved a great deal of damage to his heart, not to mention thousands of taxpayer dollars with preventative care from a general practitioner. If this person was insured, maybe a routine stress test would have caught artery blockage before the heart attack. Maybe his doctor could have put in a stent, a relatively non-invasive outpatient procedure, and prescribed Lipitor to lower his

cholesterol along with a few dietary restrictions. Even though this approach would be less expensive and much less damaging to the body, it is not available to the poor and uninsured in the United States. This story exemplifies all three major problems that infect our health care system on a national level; it shows that the state of our health care system is unacceptable in that it is unfair, too expensive, and ineffective.

Although in recent years more Americans have come to see that the health care system is, if not in crisis, in a state of great inefficiency, a Deloitte report finds that 37% of Americans still believe that the United States' health care system is "comparable to the best in the world" (Deloitte 2011). This is simply not the case. As stated in the Prologue, this thesis will employ the principles of the comparative method and will therefore focus comparisons on key variables. In this chapter, the United States' health care system will be compared to those of similar levels of industrialization, because it follows that the more developed a nation is, the more it should be expected to have a cost-effective, high-quality health care system that results in good health outcomes across a broader spectrum of its population (Reid 2009). The criteria that will be used to determine economic comparability is a given nation's membership status with the Organization for Economic Cooperation and Development. In other words, all nations that will be compared with the United States in this chapter are OECD members, and will therefore be considered at a comparable level of industrialization to the United States. According to a 2014 study by the Commonwealth Fund, a private think-tank that advocates for American health

care reform, the United States health care system ranks dead last overall compared with 10 other industrialized countries. The United States scores very low on some Global Health Indicators set by the World Health Organization, which will be discussed in later paragraphs. To top it off, the United States spends way more on health care per capita than any nation in the world (Davis 2014). This lack of access, unbelievably high cost, and low performance prove that the American health care system is broken and should be completely reformed. Before continuing, it is important to note that these three issues are interrelated. The high cost of health care of leads to accessibility problems, as Americans are wont to deliberately go without seeking the health care they need because of the cost (Collins 2014). When people consistently do not obtain needed medical treatment, their health deteriorates until extreme and expensive emergency room measures are needed to heal them, exponentially multiplying health care costs (Currie 2010). Furthermore, these drastic emergency room measures do not always work. If the hypothetical heart attack patient from the first paragraph survives treatment, he still will have greatly increased his risk for other health problems and possibly reduced the number of healthy years he has left (Center for Disease Control and Prevention 2014). On a national scale, these situations in which patients' health care is neglected until they are on the brink of crisis negatively impacts all of the United States' health care quality indicators. In sum, high cost of health care leads to lack of access, which leads to poor quality.

The Problem of Cost

The most obvious problem with United States health care system is the exorbitant cost. The United States spends 17.6% of GDP on health care (World Health Organization 2014). That is the highest percentage in the world and a full 5% more than any other industrialized country, and it is on the rise (Emanuel 2012). The high cost of health care is mainly due to a lack of transparency in the health care market, inflated health insurance premiums, and inefficient administration practices among health care providers (Anderson 2003). It is a guiding principle of a capitalistic service industry that consumers are presented with an open market of service providers and are free to gather as much information as possible on prices, quality, etc., before purchasing the service. However, American patients are often never given so much as an estimate as to how much their treatment will cost until after the service has been rendered (Emanuel 2012). Doctors often do not even know how much the treatments they prescribe will cost the patient. The price a patient has to pay for health care is the result of back door negotiations between doctors, hospitals, pharmacies, and insurers, to which the patients are not privy. Patients are effectively at the mercy of these other powerful parties, which often are in the primary business of maximizing profits rather than protecting the patients' interests. The American health care market may not be highly regulated, but it is not fair, transparent, or capitalistic either. Unlike most of the other members of the Organization for Economic Cooperation and Development, the "buy side" of the health care economy in the United States is too fragmented to achieve the purchasing power

of a monopsony, making even gathering consistent data on the prices of health care goods and services a challenge (Anderson 2003). Due to the extreme difficulty in obtaining accurate information about health care pricing, there exist only a few feeble attempts by different organizations and government agencies, usually only on a state-by-state basis and limited to a handful of services, to demand any sort of transparency in the health care market (Whitney 2014). A recent report by the *New York Times* reveals what certain doctors across the nation charged Medicaid patients for the same routine procedure, a colonoscopy, and the variation is astounding. Since Medicaid is a large government program, it achieves a degree of monopsony power, and can therefore demand more reasonable prices for health care than private insurers (Anderson 2003). However, depending on what doctor a Medicaid patient visits, a colonoscopy in the United States could cost anywhere from $600 to over $8,000 (Rosenthal 2014). This discrepancy and the blatant obscurity within the health care market are unacceptable. It is clear that the laws of supply and demand are not governing the American health care market, for if they were, prices for such a standard procedure would be much more stable.

Not only are the prices for health care goods and services inflated and shrouded in mystery, health insurance premiums are much higher in the United States than in other OECD countries that still have private health insurance providers (OECD 2012). This is because insurance companies tend to pass rising health care costs onto their customers in order to maintain their profit margins (Kane 2012). In 2014, health insurance companies reported an average rate increase of 13 percent, citing rising health care costs as the main justification for

raising premiums (McCue 2015). Expensive premiums are bad enough, but studies show that thanks to high co-pays and deductibles, many insured Americans end up paying between 5% and 10% of their income on out-of-pocket health care expenses in addition to their premium (Collins 2014). About 3 out of 5 low-income insured Americans reported struggling to pay for health care expenses because of their high deductible, and 46% of middle-income Americans reported financial struggle for the same reason. This means that for many Americans, having insurance does little to protect them from the high cost of medical care. Rising costs are passed onto customers through their premiums, and they still end up paying for much of their care out-of-pocket anyway.

Another obvious area in which health care costs could be cut is in the category of administration of health care records and bills. In the United States, twenty-five percent of health care spending goes to administrative costs alone (Himmelstein 2014). This is one of the main reasons the United States' health care system was ranked last in the category of efficiency (Davis 2014). Even large nations like Canada have been able to minimize administrative costs in the health care sector to below thirteen percent. Clearly a loosely regulated market does not always produce the most efficient or innovative solutions. Medical and insurance records are scattered throughout the nation in rooms of file cabinets staffed by numerous workers whose sole purpose is to maintain the flood of paperwork associated with even the simplest medical treatments. The cost of maintaining this army of paper handlers is $875 billion dollars per year (Munro 2014). The inefficiency of this decentralized non-system also contributes to errors in prescriptions, billing, and other records (Kane 2012). Some Americans actually

employ medical billing advocates, who make a living by combing through their clients' medical bills for errors and taking a percentage of the savings. (Bernard 2012). The American health care industry should value advancements in the electronic transmission of administrative data as much as it values other innovations in medical technology (Emanuel 2012). There is much more that can be done to keep the cost of health care in the United States down to a reasonable level, including opening up the health care market, reducing the cost of health insurance, and streamlining administrative procedures.

The Problem of Access

One problem that makes the United States very unique among industrialized countries is that we have a very low rate of access to health care. In the Commonwealth Fund study cited earlier in the chapter, the United States' health care system ranked last in the categories of accessibility and equity because so many Americans are uninsured (Davis 2014). Even outside of the United States, health care is very expensive by its very nature. Therefore, virtually every other wealthy democracy has universal health insurance coverage of some sort, ensuring that all their citizens can get at least basic preventative care and prescriptions regardless of income or employment status (Reid 2009). In the United States, however, access to health care is inextricably linked to socioeconomic status (Lasser 2006). Accessibility and equity shortcomings in the United States are due to a high number of uninsured and underinsured Americans who cannot afford the exorbitant cost of health care.

Even after the Affordable Care Act provisions that went into effect in 2014, 11.9% of Americans are completely uninsured (Gallup 2015). Eighty-six percent of the uninsured are from low- or middle-income families (Nardin 2013). Thirty-seven percent of Americans report forgoing needed medical treatment in order to avoid out-of-pocket costs (Davis 2014). This means that millions of Americans avoid filling needed prescriptions, going to the doctor, and getting recommended tests because they cannot afford the bills.

Even Americans with insurance report forgoing medical treatment because of costs, especially those from low-income families (Collins 2014). As stated earlier in this chapter, those with insurance are often required to pay exorbitant co-pays and coinsurance out of pocket, sometimes even after they have met their deductible, making affording proper health care a massive burden on many low- and middle-income American families. Furthermore, insurers often exploit their customers for profit by finding ways to furtively limit their coverage (McCarthy 2014). For example, any health insurance plans can put a cap on hospitalization coverage, or limit the number of times their customers can visit the doctor's office. They can also refuse to cover certain brands of medication, services from certain health care providers, or prescriptions filled at out-of-network pharmacies. These are just a few of the ways health insurers take advantage of consumers for profit; Americans reported the highest rate of "negative insurance surprises" out of all the other nations in the Commonwealth Fund study (Davis 2014). Health insurance is not serving its intended purpose if, as studies show, insured Americans are still deliberately forgoing needed medical treatment to avoid the stiff out-of-pocket costs that insurance companies refuse to cover.

Wealthy Americans are much less likely to forgo treatment because of cost, either because they have very expensive, high-quality insurance or because the co-pays and "surprises" are nothing but mild annoyances for them (Davis 2014). However, low- and middle-income Americans often must do without proper health care because of the extortionate costs. The uninsured and the underinsured are forced to choose between forgoing needed care and risking financial ruin, as medical bills are the leading cause of bankruptcy in the United States (Himmelstein 2007). Another complication that often leads to major financial crises is the extent to which health insurance is tied to one's job in the United States. When a person loses his job, he and his family often lose their health insurance as well, effectively exposing families to the risk of health care-related bankruptcy at their most vulnerable moment (Reid 2009). Economic inequity in regards to health care access also leads to extreme ethnic disparities, which can be detrimental to society in countless ways (Lasser 2006). Canada, although its ethnic diversity is comparable to that of the United States, enjoys much less extreme socioeconomic disparities in health care access thanks to their universal health care system. Americans should not be content with the health care accessibility and equity discrepancies in our society.

What many Americans do not know is that it does not have to be this way. Universal health care coverage is possible and is done quite successfully all over the world (Reid 2009). There are a variety of systems used by different countries, but they all prioritize the principal that no one should receive better or more health care services simply because they have more money. In places like Germany, Switzerland, Japan, and France, insurance actually works like

insurance in that you do not lose it at a time of major desperation, like unemployment. In fact, all the citizens of these nations are always insured, period. This means that virtually no one in those countries goes without the health care they need because they cannot afford it. The United States' health care accessibility and equity issues stem from the abundance of uninsured and underinsured Americans who must forgo needed care because they do not have the money.

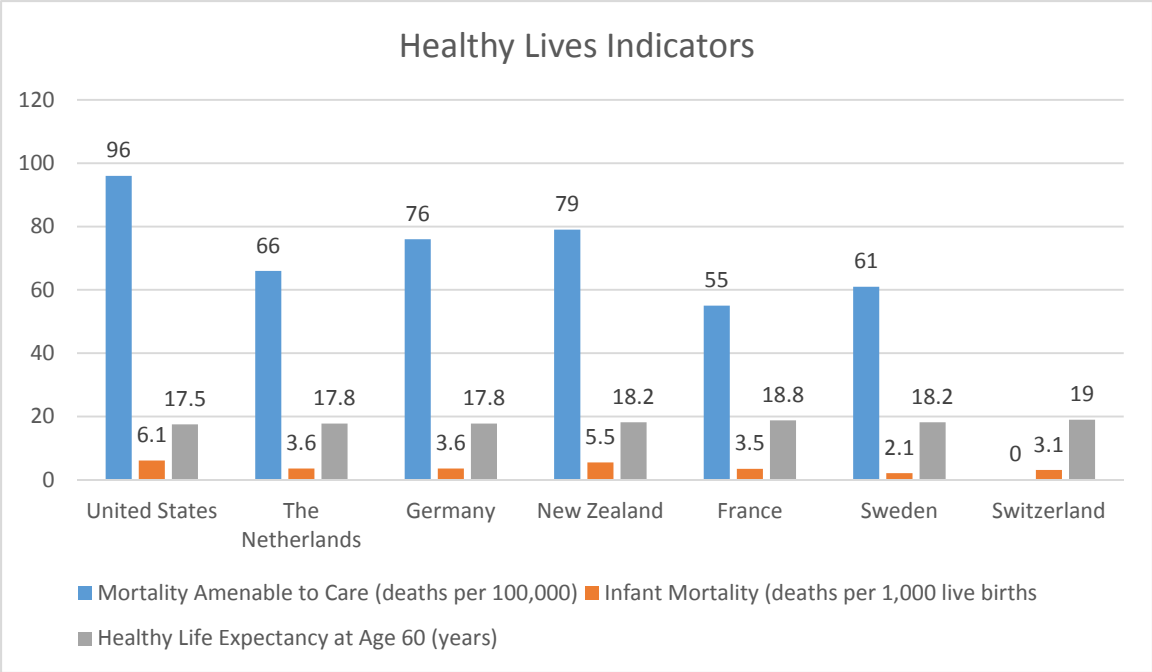
The Problem of Quality

Many Americans object to changing to a universal health care system because they believe that it will require a trade-off in quality of care (Gallup 2009). This erroneous belief is premised on two false assumptions: that the United States has the best quality health care system in the world and that universal systems are flawed in ways that the United States' system is not. Research shows that the United States is not one of those "best systems", contrary to popular belief (Davis 2014). The Commonwealth Fund study of eleven industrialized countries found that the United States ranks fifth in quality of our health care system behind four nations with universal health care and last in health outcome indicators. The quality measurement was based on four categories: effective care, safe care, coordinated care, and patient-centered care. The good news is that the United States scores well on administering preventative care and patient-centered care. The United States scored very low in the categories of chronic care, safe care and coordinated care. Poor scores on chronic care are directly related to the high number of Americans who cannot afford to

pay for medical care on a long-term basis; the study found that 50% of Americans that suffer from chronic diseases did not receive follow-up treatment because of cost. With regard to poor scores in safe care and coordinated care, the study cites a high rate of medical errors due to a lack of pay-related accountability for health care providers and a lack of administrative continuity and technological advancement when it comes to organizing health care data, depriving health care providers access to accurate information needed to monitor and coordinate care for patients. Many countries with universal health care solve these problems by streamlining and integrating their health care data via electronic systems (Reid 2009).

Even more troubling are the United States' health care outcomes. When it came to three overall "Healthy Lives" indicators, including mortality amenable to medical care, infant mortality, and healthy life expectancy at age 60, the United States was dead last (Davis 2014). Mortality amenable to medical care was a rate of 96 deaths per 100,000, infant mortality was a rate of 6.1 deaths per 1,000 births, and healthy life expectancy at age 60 was 17.5 years (World Health Organization 2012). To put these statistics in perspective with other industrialized nations, the median mortality amenable to medical care rate in the Commonwealth Fund study was the Netherlands with 66 deaths per 100,000 (Davis 2014). The median infant mortality rate was a tie between the Netherlands and Germany for 3.6 deaths per 1,000 births, and the median healthy life expectancy at age 60 was New Zealand with 18.2 years. The United States is an outlier in these studies, especially with regard to preventable deaths and infant mortality. As stated earlier, almost 40% of Americans still think our

health care system is one of the best in the world, while their neighbors are needlessly dying of treatable conditions like lupus and diabetes (Reid 2009). These poor statistics are a direct result of the high cost and subsequent lack of



access to care, particularly chronic care, for impoverished Americans (Davis 2014).

FIGURE 1

Moreover, many popular criticisms about nightmarish quality issues of universal health care are simply not true. Opponents of universal health care often claim that those nations that have it experience quality issues like longer waiting times for care, but the United States scored below the median on timeliness against the other ten industrialized countries in the aforementioned study, all with universal health care (Davis 2014). The United Kingdom has had a single-payer universal health care system for decades, and yet their health care

system scored first overall and first in all four quality categories in the study. Also, as previously stated, the ten other nations in the study scored well above the United States on health care outcomes. Nations with universal health care, like Sweden and Australia, have rates of preventable deaths 25% to 50% lower than the United States. Clearly these nations provide their citizens with excellent health care to achieve such dramatically better results. Americans should not be worried about the quality-access trade-off with regard to switching to universal health care. The evidence from other industrialized countries shows no such correlation and there is not a lot of quality to be lost anyway.

The cost, accessibility, and quality of health care in the United States are not as they should or could be. By learning about the way other nations provide health care for their citizens, the United States can improve our own system immensely. Universal health care should not be a taboo topic, but should be a goal that is sought after to the best of the nation's ability. Knowing the statistics, one can see the motivation behind the controversial Patient Protection and Affordable Care Act. However, the next chapter will prove that this law is a stop-gap measure at best and will not solve all of the issues that hold the United States' health care system back.

CHAPTER TWO

Is the Affordable Care Act Enough?

President Obama famously said about his ambitious health care reform goals, "If you like your health care plan, you'll be able to keep your health care plan" (Obama 2009). However, after the implementation of the Affordable Care Act, many middle-class Americans, including Dennie Wright from Indian Valley, California, are left with very limited health insurance options (Bartolone 2015). Major health insurance providers, like Blue Shield California, have stopped selling individual policies in rural areas because they could not find enough providers that would accept payments low enough to allow the company to keep premiums at a competitive level. Therefore, Wright is unsatisfied with his insurance policy, which he bought from the state health insurance marketplace, and has no other options for coverage in his area. This is one example of how the Patient Protection and Affordable Care Act combined with the Health Care and Education Reconciliation Act of 2010, affectionately known together as Obamacare and hereafter referred to as the Affordable Care Act, fails to solve the main problems of the American health care system and unintentionally creates some new ones. As discussed in the previous chapter, the cha major health care system problems in the United States are high cost, lack of access, and low

quality. The Affordable Care Act attempts to address all three of these problems, but research shows that these measures are insufficient. Well after the full implementation of the law, the United States will still spend exorbitant amounts of money on health care, millions of Americans will remain underinsured, and overall health outcomes for our nation will lag behind those of similar levels of wealth and development. This chapter will focus on critiquing the actual content of the law rather than problems with implementation, such as glitches in the health exchange website.

The Affordable Care Act's Response to Health Care Spending Problems

The first main problem with the Affordable Care Act is that it does not adequately address the problem of the high cost of health care in the United States. As stated in Chapter One, there are three main reasons for the United States' out-of-control health care spending: the lack of transparency in the health care market, high health insurance premiums, and the inefficiency with which health care providers handle administration, record-keeping, and billing. The Affordable Care Act makes feeble attempts at resolving all of these issues. With respect to transparency in the health care market, the law establishes one federal agency, the Independent Payment Advisory Board, which is charged with combating inconsistency in health care costs, like those mentioned in the previous chapter with regard to the varying price of colonoscopies across the nation (ACA 2010). However the scope of this board is only limited to "recommending" what doctors and hospitals should be paid for different procedures by Medicaid. This will only further deepen the health care providers'

mistrust of Medicaid and will push the discrepancy in the prices onto the private consumer (Emanuel 2012). The Affordable Care Act cannot significantly lower costs without the power to establish and enforce a competitive, transparent market for medical services and equipment.

Through the Affordable Care Act, there are a few stipulations that attempt to cut costs by containing premium prices. Probably the most effective institution for lowering premium costs is the health insurance exchange, the online marketplace where consumers can compare health insurance plans side-by-side (ACA 2010). Although research indicates that gross premium rates increased from 2014 to 2015, the marketplace increased competition and choice enough that many people were able to change to a cheaper plan (McKinsey Center 2015). There are other attempts to contain premium costs within the law: insurers are now required to justify a premium increase of more than 10% to the government (McCue 2015). Additionally, the government subsidizes premiums for people who cannot find a plan that costs less than 9.5% of their income on the consumer side, and insurers must not spend more than 20% of their premium income on administrative costs (ACA 2010). However, there are no active cost-control procedures established to reduce premium rates. There should be more measures in place to encourage active bargaining for lower premiums on the supply side, rather than just subsidizing rates on the consumer side (Emanuel 2012). The Affordable Care Act does a good job of helping lower-income Americans pay for insurance premiums, but the rates are too high in the first place and the government should work to correct that.

Furthermore, the Affordable Care Act does little to make health care administration practices more efficient. As mentioned in the previous paragraph, the law requires that insurers keep their administrative costs down to 20% of premium income (ACA 2010). It requires that health care providers establish standardized protocol for electronic communications, should they choose to utilize them (Emanuel 2012). However, if the law required that insurance companies make use of such communications, the health care industry could potentially cut administrative costs down to way less than 20 percent (Davis 2014). The Affordable Care Act sets expectations much too low with respect to the amount that could be trimmed from American health administration spending. Many wealthy countries with universal health care systems that retain private insurance companies have much lower administrative costs. For instance, the United States spends $900 per person per year on health care administration costs, while France spends $300, Germany spends $281, and Japan spends $120 (Kane 2012). These other nations employ digital and integrated billing and record-keeping systems, rather than requiring patients and health care providers to handle stacks of paperwork for every office visit and procedure (Reid 2009). The Affordable Care Act should have set much more ambitious administrative spending reduction goals and should have required actors of the health care industry to begin transitioning toward a fully electronic data communication system.

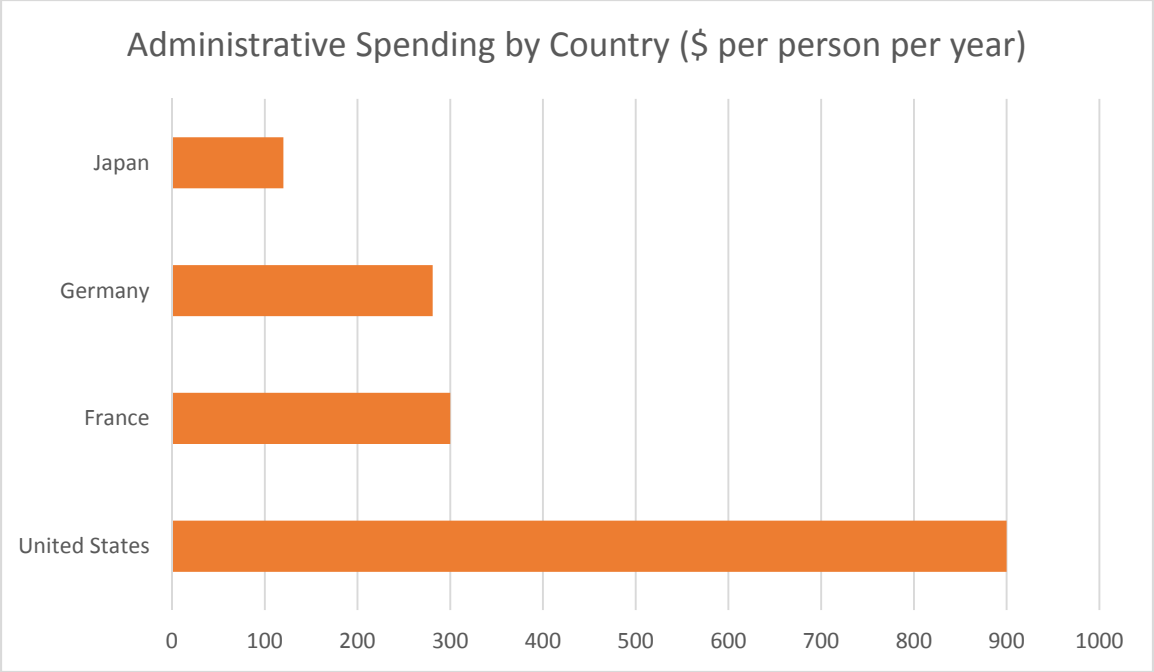


FIGURE 2

The Affordable Care Act's Response to Accessibility Problems

The Affordable Care Act does not fully address the issue of limited accessibility to health care coverage in the United States. The Affordable Care Act tries to improve the problem of lack of access to health care by imposing more patient-friendly regulations on the health insurance industry, creating a health insurance marketplace to help consumers compare cost and quality of coverage and determine whether they qualify for Medicaid or other savings, and incentivizing states to expand Medicaid coverage (ACA 2010). These measures have successfully improved access to health care in that they have resulted in 16.4 million newly insured Americans (Gallup 2015). However, 30 million Americans will remain uninsured, and many will still suffer from various exploitative insurance practices, like high deductibles and co-pays (Nordin 2013).

The health insurance regulations within the law are the best part about it. For instance, insurance companies are no longer able to deny coverage to individuals based on pre-existing conditions, nor are they able to drop people who reach a certain health care spending limit. Furthermore, companies that employ a certain number of people are required to provide health insurance benefits for their employees and their families. These new rules will make affordable health care fairer and more accessible by eliminating some of the more egregious and exploitative tactics used by insurance companies in the past to get out of providing coverage for their customers. However, the Affordable Care Act leaves many loopholes through which insurers can create coverage gaps for their consumers to fall through. As mentioned in Chapter One, the Affordable Care Act does not outlaw caps on hospitalization coverage or limits on the number of times their customers can visit the doctor's office (McCarthy 2014). They can also refuse to cover certain brands of medication, services from certain health care providers, or prescriptions filled at out-of-network pharmacies. Another massive loophole in the American health insurance system are self-funded plans. Not only are they exempt from state regulation and thereby all coverage mandates, they give a tyrannical level of power to employers to find out their employees' private health information and then retroactively revoke coverage when faced with the possibility of expensive claims (Caster 1994). Although the Affordable Care Act's insurance regulations are a step in the right direction, they do not solve the heart of the matter: American insurance companies have more incentive to exploit their consumers for profit than to serve them well (Reid 2009). The Affordable Care Act would have increased health care accessibility

even more if it had reformed the Employee Retirement Income Security Act of 1974 and made self-funded plans subject to coverage mandates and weakened the power they give to employers, but as long as insurance companies are in the business of pleasing their shareholders before their customers, they will continue to find loopholes (Caster 1994).

The Affordable Care Act attempts to maximize health care accessibility, especially for lower-income Americans, with the creation of both a national health insurance exchange and the option for states to create their own exchanges to facilitate consumer access to affordable plans and government savings programs (ACA 2010). Customers can browse the online exchanges and compare plans based on their prices versus their quality, giving them access to information about the most affordable plans. These exchanges can also help consumers determine if they qualify for government subsidies, which make health insurance more affordable for lower-income families. Despite the disastrous initial implementation of this marketplace, the strategy of both subsidizing insurance for low-income enrollees and forcing more competition and transparency in the health insurance market at large has been quite successful (Ungar 2014). Since 2010, the rate of uninsured Americans has dropped from 16.4% to 11.9% (Gallup 2015). As mentioned in Chapter One, the United States' health care access problems are directly related to affordability, and the Affordable Care Act has undoubtedly made insurance more cost-effective for many Americans. However, as in the case of Dennie Wright, private insurers have pulled out of certain ZIP codes in certain states altogether, leaving largely rural residents with extremely limited and sometimes unsatisfactory options for health insurance (Bartolone

2015). These rural areas already have limited options for health care providers, as rural health care access is already dismal in the United States (Hart 2002). This is the main access problem with the health insurance marketplaces: they do not do enough to ensure that all Americans that need subsidies have plenty of options for health insurance no matter where they live (Bartolone 2015). The marketplaces bring more options and competition to consumers that live in metropolitan areas, but they run big insurance companies out of small, rural towns that often house the Americans most in need of improved health care accessibility (Hart 2002).

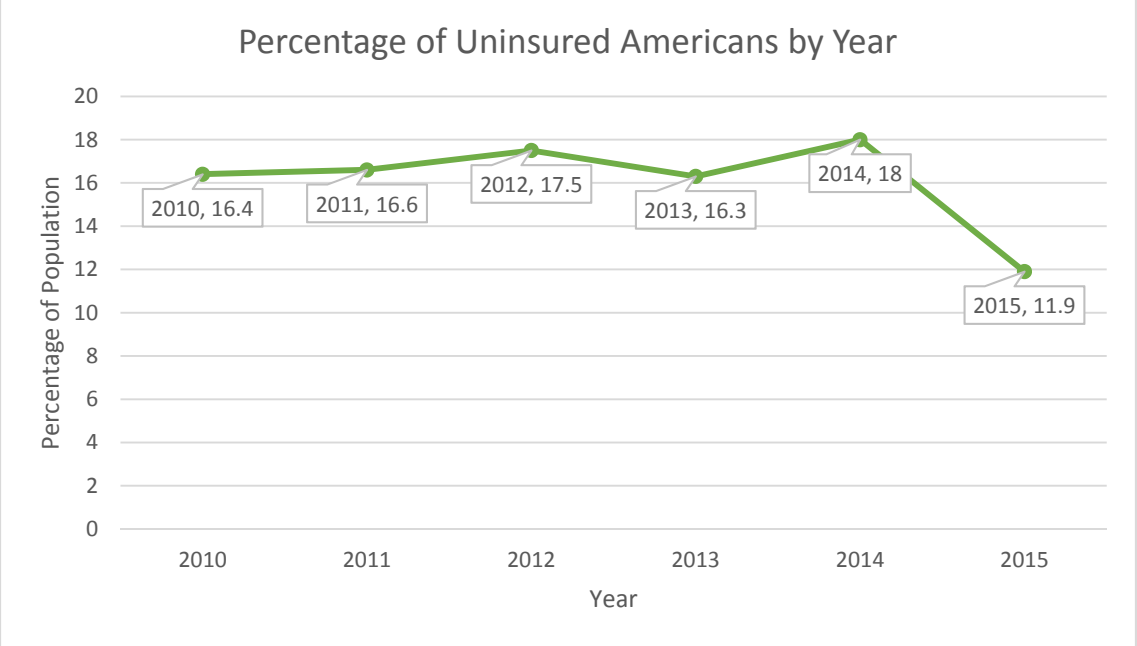


FIGURE 3

The Affordable Care Act also provides incentives for states to expand Medicaid to more impoverished Americans. However, due to the highly emotional and controversial political climate surrounding "Obamacare," twenty-two states have yet to accept the expansion (Kaiser 2015). In states that do not

accept the expansion, especially those which have large low-income populations, a coverage gap exists for those who make too much money to qualify for Medicaid under the old, unexpanded standards but do not make enough money to qualify for the marketplace insurance subsidies (Garfield 2014). It hardly seems fair that four million impoverished people are left without health care coverage simply based on the state in which they live. Over a quarter of those people live in Texas alone. The Congressional Budget Office estimates that over 30 million people will still be uninsured in 2024. Some of those people will be young, healthy people who "do not want to be insured", and they will simply pay the tax that the law requires for those who do not comply with the individual mandate to obtain health insurance coverage (ACA 2010). However, many of those people will be poor men, women, and children who want and need to be insured, but they happen to live in a state, like Texas, that did not accept funding for expanded Medicaid coverage. Even if all states accept the expansion by 2024, there will be many who will not qualify for Medicaid and will not be able to afford health insurance even with the tax credits and subsidies (Nardin 2013). Although the Affordable Care Act is set to cut the number of uninsured by half, it still leaves many people out in the cold, at risk for bankruptcy and avoidable illness (Rosenbaum 2011).

The Affordable Care Act's Response to Problems with Quality

The Affordable Care Act does not do enough to combat low quality care in the United States. As explained in Chapter One, the United States' main quality issues are low performance in chronic care, safe care, and coordinated care, and

overall poor health outcomes (Davis 2014). The Affordable Care Act might indirectly improve chronic care, as if more people are insured, they might be able to more easily afford long-term treatment for chronic conditions, but there is no evidence of an improvement in that area as of yet. At any rate, the Affordable Care Act does not go far enough in addressing the problem of chronic care because it will never be up to its potential if Americans are still uninsured and underinsured as they are even after the full implementation of the law (Gallup 2015). The Commonwealth Fund study suggests that the United States address its poor performance in safe care and coordinated care by switching to electronic health data communications, which result in fewer medical errors and allow physicians to more easily coordinate patient care with data about their personal medical histories, as well as by establishing a health care provider pay scale based on performance (Davis 2014). The Affordable Care Act, as previously mentioned, does not do nearly enough to encourage the health care industry to use electronic communication, but it does expand the use of pay-for-performance programs under Medicare and incentivizes experimentation with them in the private sector (ACA 2010). The Affordable Care Act does not do enough to address the problems of poor chronic care, the safe care issue of medical errors in paperwork, and coordinated care, but due to the mixed results of linking a doctor's pay to his performance on safe care, managed experimentation is the right way to go for now (James 2012). Hopefully these program expansions will result in safer health care and will then spread throughout the country.

The main reason for the United States' poor performance on health outcomes is lack of access (Davis 2014). Cutting the number of uninsured

Americans by half should presumably improve health outcomes, but the 30 million people that will remain uninsured after Obamacare and the underinsured Americans who resist seeking care to avoid co-pays and other out-of-pocket costs will continue to bring those indicators down below where they should be (Collins 2014). A disproportionate number of those uninsured will belong to ethnic minorities (Nordin 2013). The disparities in access to affordable insurance will lead to ethnic and socioeconomic disparities in health outcomes (Lasser 2006). The Affordable Care Act is not able to close these disparities because the only way to do so is to provide universal coverage.

The Affordable Care Act is a start in the right direction on health care reform. However it fails to solve the problems of accessibility, cost, and quality to the extent that it could. We still have the worst health care system among nations of similar wealth and history, which should be unacceptable. In the next chapter, I will explain what the first step toward solving these three issues should be.

CHAPTER THREE

What Should Be Done to Solve the Health Care System's Problems?

Jennifer Hopper of Austin, Texas was well-versed in the provisions of her insurance plan, so when her husband was struck in the eye by a rogue baseball, she drove him to an emergency room that she knew to be in her insurance plan's network (Feibel 2014). Little did she know, none of the doctors working in the emergency room at that time were covered in her network, so she was billed separately by the ER doctor who treated her husband. The bill amounted to $700 that she was expected to pay out-of-pocket, even though her family was insured and she made sure to seek treatment at an in-network hospital. This story reveals the main cause of the high cost, lack of access, and low quality of American health care: insurance companies. If the main goal of American insurance companies was to protect patients from unexpected and exorbitant health care costs, all three of the major issues mentioned in this paper would be considerably improved. Instead, health insurance companies serve shareholders before patients and aim for profits over protection for their clients. The United States should require health insurance companies to provide at least a basic coverage package to the American people for no profit.

The idea of non-profit health insurance providers may seem radical, given the extraordinary power wielded by American insurance companies through their teams of lobbyists and sympathetic political officeholders. However, it is actually

the norm among the other industrialized nations that still have health insurance companies at all (Reid 2009). Germany is the birthplace of the Bismarck model, a universal health care system that preserves competition among private health insurance companies and private health care providers. Variations of this model can be found all over Europe and Asia. It is an individual mandate system as opposed to a single-payer system – all citizens are required to buy a basic coverage plan. However, the key to the success of this model is that insurance companies are not allowed to make a profit from th plan. Other principles of the model include free choice of health care provider, regulation of health care costs, retention of health care coverage during unemployment, and a streamlined health care administration system. This universal health care model is the best option for the United States because it preserves capitalistic values like competition and private business ownership.

Non-Profit Health Insurance

Non-profit health insurance packages would greatly alleviate the high cost and lack of access issues in the American health care system. As Jennifer Hopper learned, American health insurance companies are not in the business of protecting their customers from huge, unanticipated medical bills so much as they are in the business of finding loopholes and excuses not to protect them (Feibel 2014). Health insurance companies are supposed to become the consumer's advocate when they accept his or her premium payment, supposedly giving him or her the peace of mind that comes with knowing you will never be without access to health care due to unexpected high costs. However, for

American health insurance providers, that goal is secondary to making a profit. For this reason, health insurance companies should be required to offer a basic health care package to all Americans for no profit.

How Non-Profit Health Insurance Improves Problems of Cost

Requiring health insurance companies to offer essential health care coverage at no profit would lower health care costs because it would reduce premiums and foster competition in the market. American health insurance companies often inflate their premiums to higher rates than the true market value and pass rising costs of health care directly onto their consumers through higher co-pays, etc., in order to maintain their profit margin (Kane 2012). If insurers had to offer non-profit coverage, health insurance premiums would drop to the true market value. Furthermore, if the profit motive were removed from the health insurance industry, at least when providing essential care to consumers, each company would be made almost completely accountable to the consumer, giving the industry more incentive to offer fair prices and add value to their product (Reid 2009). This is one way in which the Bismarck model is a managed-competition system (Flood 2014). Rather than offering poor coverage at a high price in order to maximize profits and please shareholders, American insurers would have more incentive to offer higher-quality coverage at lower prices in order to please consumers (Reid 2009). Insurers would have more incentive to negotiate fairer prices for health care, rather than just passing rising costs onto their customers through higher premiums and co-pays (Kane 2012). They would also have more incentive to offer generous coverage for a fixed price

rather than charging a premium on top of exorbitant out-of-pocket costs. Mandatory non-profit insurance is how Germany has such a high-quality health insurance industry and fosters capitalistic competition within their health system: insurers are forced to add value to their plans if they want to compete. In fact, competition is so fierce among German health insurers, they tend to offer promotions like free spa treatments in order to attract consumers. In some Bismarck countries, these private insurance companies also offer supplemental coverage packages for profit, which cover nonessential medical expenses like cosmetic surgery and private hospital rooms (Frei 2001). Switzerland's robust health insurance industry subsists on profits from these bonus policies. However, Switzerland enjoys universal health care coverage and spends only 11% of its GDP on health care, as compared to 17.7% in the United States, because it requires health insurance companies to offer a basic care package for no profit (Davis 2014).

How Non-Profit Insurance Improves Problems of Access

Mandatory non-profit insurance would improve access to health care in the United States because it would lower costs and give insurers more incentive to offer good coverage to its consumers. That non-profit insurance lowers health care costs has already been established. If health insurance is less expensive, more Americans will be able to afford it, or at least the government will be able to afford it for them, which will give them the freedom they need to go to the doctor when they are sick (Davis 2014). However, as stated in the previous chapter, the underinsured also suffer from limited access to health care (Collins 2014). The

Affordable Care Act legislates against some of the more egregious practices that insurance companies historically used to exploit customers for profit, like dropping or capping coverage (ACA 2010). However, many Americans, like Jennifer Hopper, still suffer from the loopholes in the system that insurance companies abuse in order to maximize profits (Feibel 2014). If the health insurance industry became a managed-care system, their incentive would shift from pleasing shareholders to pleasing consumers (Flood 2014). This would mean that exploiting customers through loopholes and high deductibles and co-pays would be bad for business (Reid 2009). Fewer insured Americans would forgo treatment for fear of insurmountable out-of-pocket costs, and universal access to health care would be a plausible achievement (Collins 2014). Some Bismarck nations, like Germany, even require that insurers pay all medical claims outright and in full, eliminating the fear of out-of-pocket costs altogether (Reid 2009). This principle will be explored later, but it is unsustainable without eliminating the profit motive for insurers because making a profit in the insurance industry and actually covering all the medical expenses of every customer are fundamentally opposing goals.

Non-profit insurance is the element of the Bismarck system that is most incompatible with American political values. Given that many Americans still cannot accept the individual mandate stipulation of the Affordable Care Act because it involves compelling Americans to purchase something, compelling a private industry to sell their product at no profit is going to be a hard sell (Williamson 2011). This problem will be discussed in a later chapter, but it is worth noting here that mandatory non-profit insurance is key to the Bismarck

system in that it fundamentally shifts the insurance industry's focus from making money to paying for its customers' medical bills (Reid 2009). The United States should alleviate the high cost and lack of access to affordable health care by taking note of the Bismarck system and adopting its policy that all private insurance companies must offer a mandatory non-profit health benefits package.

Free Choice of Health Care Provider

Another excellent principle that some countries incorporate into their Bismarck model system is free choice of health care provider (Reid 2009). If the United States prioritized facilitating an open, competitive health care market, it could greatly improve health care access and quality for all of its citizens (Emanuel 2012). As it stands, most Americans with health insurance are very limited in their options of health care providers. Their insurance companies will only cover their care if they stick to the network of pre-approved physicians, health care facilities, and sometimes even pharmaceutical brands. Not only does this artificially protect health care providers from the competitive market at large, it creates opportunities for people like the Hoppers to fall through the cracks (Feibel 2014). Germany's Bismarck model does away with this inefficient behemoth called "the network". Insurance companies are required by law to pay the bill regardless of what health care provider the patient chooses (Reid 2009). Another element of the managed-competition model, this principle fosters competition throughout the health care industry and ensures that the doctor who gets the most business does so because he is the best, not because he made a deal

with the most powerful insurance company, thereby ensuring access and incentivizing quality (Flood 2014).

How Free Choice of Health Care Provider Improves Problems of Access

Free choice of health care provider improves access to health care because it gives patients the freedom to seek treatment wherever and from whomever is available without fear of out-of-pocket costs. Insurance networks limit access to health care providers outside of their network, sometimes forcing Americans to travel long distances to visit a doctor, especially in rural areas (Hart 2002). Low-income, disabled, and elderly people are especially impacted by these inconveniences. Free choice of health care provider allows patients to seek care freely (Reid 2009). Furthermore, people in emergency situations do not have to worry about which hospital is in the patient's network; they can just rush to the nearest ER and save valuable time (Feibel 2014). When insurers are required to pay the whole bill, no matter what provider is seen, patients are given much better health care accessibility.

How Free Choice of Health Care Provider Improves Problems of Quality

Americans should realize that the government is not the only entity that can stand in the way of a truly free market; the health insurance industry is currently the biggest obstacle to laissez-faire competition among health care providers, and the patients are suffering for it. Health care providers are insulated from competition at large when they are committed to a network (Reid 2009). If Americans had total freedom to choose their health care provider through a managed-competition system, doctors would be rewarded for

practicing medicine effectively, not for joining the right insurance network. This is the purest example of a performance-based pay scale, which is recommended by the Commonwealth Fund to improve quality of health care (Davis 2014). More choice could also directly improve health care outcomes, because research shows that choice builds trust within the doctor-patient relationship and increases the chances that patients will follow their doctors' instructions (Mechanic 1999). American policymakers should recognize that the Bismarck system's principle of free choice of health care providers should be implemented to improve quality of and access to health care in the United States.

Regulation of Health Care Prices

To be fair, one of the main reasons insurance companies have to build a "network" is to avoid wasting time on haggling over prices with infinite numbers of health care providers (Emanuel 2012). By limiting the number of physicians their customers can visit without paying out-of-pocket, the insurance companies can streamline their negotiations, thus saving time and resources. Countries with the Bismarck system solve this problem by regulating prices. However, this can actually be done with very little government involvement (Reid 2009). Insurers and providers send representatives to meet periodically to negotiate prices on every imaginable product and service. They are then published in a massive book, and all health care providers are required to charge nothing more and nothing less than those prices. All health insurance companies in turn must pay the pre-approved price in full when one of their customers receives medical treatment; they cannot deny a claim submitted by a registered doctor. This

method ensures both consistency and transparency in the market, lowering health care costs significantly.

How Regulation of Health Care Prices Improves Problems of Cost

Two of the major reasons for high health care costs in the United States cited in Chapter One are lack of transparency in the health care market and inflated premiums. The Bismarck model's regulation method addresses both of those problems. Insurers and providers agree on one price for every possible medical expense and then publish them for anyone to look up, eliminating the unjust and utterly illogical discrepancy in the pricing of identical health care procedures across the United States (Rosenthal 2013). All payers would be guaranteed a fair price, enjoying the power of a monopsony no matter how much influence they have (Anderson 2003). With this kind of regulation, health care providers could not charge small insurers more than large insurers as they often do, perpetuating the unfairness and exorbitance (Emanuel 2012). The hallmark American distrust of the government is no doubt a huge obstacle to the implementation of this principle, but in Germany, market forces direct price negotiations rather than the government (Reid 2009). Americans should not be content with the way that health care prices are shrouded in mystery just because the obfuscation is done by mostly private entities. A big book of prices would ensure that insurance companies could manage free choice of health care providers for their customers and would eliminate the exploitation of patients that have no way of knowing what a fair price for a colonoscopy would be.

Regulation of health care prices would also lower insurance premiums. Insurance companies would not have to negotiate individually with every health care provider that they do business with, greatly reducing their administrative costs (Emanuel 2012). Since insurers would be required to pay all claims at the published prices, they would not have to inflate premiums to cover expensive claims-review boards, nor would they be able to dump the excess cost of rising prices that they do not want to cover onto the patient, as they often do in the United States (Kane 2012). The United States health care system needs regulation of prices in order to lower health care costs.

Retention of Health Insurance During Unemployment

The Bismarck model would be a great option for the United States because health insurance premiums are paid in much the same way as they are here – the cost of insurance is split between the customer and his or her employer (Reid 2009). However, there are a few key differences. While the Affordable Care Act has required businesses of a certain size to provide health insurance benefits for its employees, the Bismarck model would require all employers to cover a percentage of the cost of their employees' health insurance premiums. Employers also do not get to choose the company or plan that their employees have, and most importantly, when someone loses his or her job, the government pays for their health insurance as part of their unemployment benefits until they get another job. These principles greatly increases access to health care.

How Retention of Coverage during Unemployment Improves Problems of Access

The Bismarck system improves access to health care by weakening the tie between health insurance and one's occupation. Although employers are required to cover a portion of their employees' premiums, every individual is free to choose whatever insurance company and plan they prefer. A percentage of the employee's pay is docked to cover their share of the premium, and the employer pays the bill. This guards against employers taking advantage of access to their employees' health information and revoking coverage for needed treatment to save money (Caster 1994). Furthermore, insurance is not revoked upon unemployment (Reid 2009). At 62.1%, medical expenses are by far the leading cause of bankruptcies in the United States, often because families are subjected to the deadly combination of the loss of a job and a medical crisis at the same time (Himmelstein 2007). It is cruel to expose people to the exorbitant cost of out-of-pocket medical care at such a financially vulnerable time as unemployment. No one in Bismarck system countries goes bankrupt due to medical expenses because everyone has good insurance, and no one loses their health insurance because they lost their job (Reid 2009). Therefore, unemployed people retain access to affordable medical care through the government until they find a new job. The United States should require all employers to chip in on their employees' health insurance premiums, and should ensure that no one loses health insurance coverage because of unemployment.

Administrative Efficiency

For a nation with a political culture that so highly values capitalism and market solutions, the American health care market is mired in opacity. Some of the shadiness is deliberate – as mentioned earlier, the American system is designed to conceal the true market value of health care services and products, protect health care providers and insurers from open competition, and weasel out of paying the medical bills of the insured in order to exploit the consumer for profit. However, the utter madness with which the United States handles its medical record-keeping and billing is inexplicable. The endless ocean of paperwork is not only incredibly expensive, but it causes errors and puts a strain on the doctor-patient relationship as well (Silberner 2009). The United States could improve cost and quality of care with an electronic storage and communication system for medical billing and record-keeping.

How Administrative Efficiency Improves Problems of Cost

Virtually every other industrialized nation has figured out a way to digitize record-keeping and billing in the health care industry, cutting their administration costs to half or less of what the United States pays (Kane 2012). In France, every individual's medical records including billing and insurance information are stored on their very own microchip card, called a *carte vitale* (Reid 2009). One has only to bring your card to any doctor's office or hospital in the country and all of your records are made available to the health care provider with one swipe. There is no need to fill out extensive and redundant forms or request records from other doctors. With this system, only 3% of France's health

care spending goes toward administrative costs, as opposed to the United States' 17.7 percent (Davis 2014). In Sweden, all prescriptions are sent from doctors to pharmacies digitally (Kane 2012). This system saves pharmacists 1-2 hours of paperwork per day. Nations with streamlined administrative systems have no need for businesses like athenahealth, which charges health care providers to sort through truckloads of boxes filled with paperwork – checks, bills, records, and forms (Kestenbaum 2010). If the United States implemented a standardized medical record and billing system, billions of dollars would be saved annually.

How Administrative Efficiency Improves Quality

As stated in Chapter One, one of the main problems with the quality of American medical care is the rate of medical errors. The Commonwealth Fund study reports that the United States scores last on the rate of medical billing errors and third from last on the rate of lost or unavailable medical records (Davis 2014). This problems could be solved with a streamlined administrative system. Furthermore, electronic medical records could improve doctor-patient relations, help doctors better coordinate care with patients' medical histories, and help researchers mine data for health trends related to certain medicines or conditions (Silberner 2009). Without doubt, provisions to protect privacy, both from rogue thieves with computer-hacking skills and from the prying eyes of the government, would be necessary. Nonetheless, no concern for privacy should cost so many billions of dollars. The United States should eliminate waste by creating an efficient system to manage administrative functions in the health care industry.

The United States' health care systems could solve many of its access, cost, and quality problems by making insurance companies provide a basic health care plan for no profit, allowing free choice of health care provider, regulating health care pricing, ensuring that everyone receives health insurance regardless of their employment status, and updating the current chaos of medical administration. Of course, it costs employers and the government quite a lot of money to sustain the Bismarck model. The United States government's history of inefficiency is a legitimate drawback to initiating another massive overhaul to the health care system. However, any notions that guaranteeing health care coverage to Americans would necessarily lead to less productivity are ludicrous. Japan and Germany both use the Bismarck model and rank 3 and 4 for highest GDP, despite their relatively small sizes (IMF 2014). Moreover, they spend a much smaller percentage of their GDPs on health care (Davis 2014). Americans are already paying too much for health care, and, as mentioned previously, switching to the Bismarck model would actually cut costs by reducing the price of premiums, fostering transparency and competition in the industry, and making the administration of health care much more efficient. There is no reason to pay so much for a system that is so ineffective, and Americans should realize that the Bismarck model could be a much-needed solution. The next chapter will propose a plan that could make the United States' transition to universal health care politically feasible.

CHAPTER FOUR

How Could the United States Transition to Universal Health Care in a Politically Viable Way?

A quote commonly attributed to Abraham Lincoln seems to appropriately characterize the attitude with which an American transition to universal health care should be approached: "I am a slow walker, but I never walk back" (Norton 2015). Between the formidable influence of insurance lobbyists on the government and the entrenching opposition to health care reform found among many conservative Americans, the chances of implementing a universal health care program in the United States any time soon are bleak. That is why advocates of reform should expect a long process of gradual transition, and incorporate the American political principles of federalism and democracy into plans for change. When considering the most politically viable options for the transition to universal health care, the United States can learn from two nations in particular: Canada and Switzerland. Specifically, Canada implemented its national health care reform measures on a province-by-province basis and Switzerland overcame its powerful insurance lobbyists by putting the question of whether to switch to universal health care to a referendum. The United States should implement a Bismarck-style system federally and democratically by passing a national bill that incentivizes states to educate their citizens on the need for health care reform, write health care reform bills that employ the five Bismarck principles delineated

in the previous chapter, and pass them using referenda rather than elected legislative bodies.

Canada's Transition to Universal Health Care

Canada's transition to universal health care is a good model for the United States because the two nations are similar in several important ways. Although the United States is much more populous than Canada, they are both very large geographically (Nations Online 2015). This is important to the cause of health care reform because geographic expansiveness leads to the development of distinct regional political identities. These regional identities manifest themselves generally in the United States as liberal states, conservative states, and swing states, and each category has a different inclination toward health care. Other complications that the two nations share are a rich history of immigration, which necessarily leads to political diversity, and federalism, which can actually facilitate the eventual implementation of controversial policies (Simeon 2010). Bearing these complexities in mind, Canadian Minister of National Health and Welfare Allen J. MacEachen introduced a national bill in 1966 that incentivized provinces to pass their own health care reform legislation, as long as it followed certain guidelines (Charles 1999). By 1971, the guidelines in the Medical Care Act of 1966 had been adopted by all the Canadian provinces. The Canadian national government has since passed a series of bills that centralized Canada's National Health Service and made it a single-payer system, which, unlike the Bismarck system, is closer to what many people mean when they use the term "socialized" medicine (Reid 2009). However, as previously

stated, Canadian universal health care was originally implemented on a state-by-state basis. The United States should take note of Canada's example and pass a bill that incentivizes states to pass their own Bismarck model systems.

Federalism in the United States' Transition to Universal Health Care

The state-by-state approach seems the most achievable for the United States because scholars believe current patterns of political preference the United States will continue to favor the implementation of policy at the state level rather than the federal in the 21st century (Bowman 2002). However, it is highly unlikely that the United States could adopt a universal health care program in every state as quickly as Canada. The Tea Party's crusade against "Obamacare" and anything like it has entrenched many in fear of any type of new government regulation of the health care industry (Williamson 2011). More conservative states would be much less likely to adopt universal health care soon, even with whatever incentives or subsidies are offered in the hypothetical American version of the Medical Care Act of 1966. However, the United States has a long history of state-to-state diffusion of policy (Bowman 2002). A good example is the .08% blood alcohol content driving limit. In 1982, Congress enacted the Section 408 program, which offered grants to states that passed laws criminalizing driving with a BAC of .08% or higher (National Highway Traffic Safety Administration 1982). Utah was the first state to comply with and reap the rewards of this incentive program in 1983. Nineteen states followed suit, until Congress passed a disincentive law in 2000 that revoked any state's federal highway funding if it did not pass a .08 *per se* limit. Soon after, all 50 states had enacted laws that

satisfied the requirements laid out in the Department of Transportation's 2001 Appropriations Act.

If it took almost 20 years and a heavy-handed disincentive bill for all 50 states to adopt such a reasonable law with such obvious life-saving implications, there is no doubt that such a controversial idea as a universal health care program will take a long time and a lot of effort to diffuse throughout the United States. However, with the help of good federal incentive programs, it can be done. If the Bismarck system works as it should, citizens of conservative states, like Texas, will see that their countrymen in other states are spending less on health care, receiving fairer and more widespread insurance coverage, and thus enjoying better health outcomes. State legislatures will eventually have to dispense with their aversion to health care reform and pass universal health care in order to stay competitive with other states (Bowman 2002). Even if some states refuse to accept the benefits of establishing the Bismarck system in their state after its merits have become apparent, the federal government could start passing disincentive bills, like the revocation of essential federal funding for states that do not pass the desired legislation. Canada did not have to go this far to compel each of its provinces to accept universal health care, and hopefully the United States will not either. Achieving universal health care in the United States will be a long, slow walk, but it is doable if we refuse to walk back. The United States should learn from Canada's and its own history of federalism and enact universal health care by incentivizing each state to establish the Bismarck system in their respective governments.

Switzerland's Transition to Universal Health Care

Switzerland also offers a good example for the United States in terms of their transition to universal health care. Although it is a much smaller nation than the United States, it is similar in that the Swiss transition to universal health care was rather late compared to the rest of Europe, and those in favor of non-profit health insurance had to fight powerful lobbyists and a robust private insurance sector (Reid 2009). These obstacles to universal health care stem from political inertia – they cannot be overcome by the political establishment because the establishment itself is the problem. Many members of both state and federal legislative bodies receive massive campaign donations and abundant political support from lobbyists in exchange for protecting the health insurance industry's profits (Open Secrets 2014). Politicians especially conservatives, have benefited from this interest-group liberalism for decades and have much more incentive to protect the insurance companies that can afford to finance their campaigns than to improve their constituents' access to health care by greatly curtailing the insurance companies' profits (Lowi 1979). Therefore, it is highly unlikely that they would be able to pass a health care reform bill that disrupts the insurance industry's profits even more than the Affordable Care Act, such as the Bismarck model incentive bill proposed by this thesis. The Swiss faced similar obstacles in the 1990s, and their solution to these impediments was a national referendum. Switzerland started providing subsidies to non-profit insurance companies that registered with Federal Office for Social Insurance in 1911 (Chaufan 2014). Later, in an effort to reduce health care inequities, the government legislated that

consumers have more flexibility in choosing and switching their health care plans. However this led to a discrepancy – sick people fled to register with insurance companies while healthy people refrained from purchasing health insurance until they became sick. In 1994, the Federal Law on Health Insurance was passed via popular referendum, establishing an individual mandate for citizens to purchase a basic health care package from which health insurance companies were not allowed to profit. Although it only passed by a very slim majority, since its implementation in 1996, most Swiss citizens are very happy with their health care system (Bachmann 2012). Even more remarkable, the Swiss insurance industry has adjusted quite well by pushing for-profit supplemental coverage packages that guarantee things like private hospital rooms (Reid 2009). Based on the Swiss experience, a bill that incentivizes state-by-state referenda would be the best solution for the United States.

Direct Democracy in the United States' Transition to Universal Health Care

The concept of a state-by-state referendum has precedent in American history as well. States holding referenda on controversial issues is far from uncommon. Currently, 24 states have established processes for holding popular referenda (National Conference of State Legislatures 2012). In preparation for the referendum, each state would need to organize a movement. A great example of a very well-organized referendum movement is the 2014 Scottish Independence referendum in Great Britain. In order to prepare the public for the referendum, the Scottish government spent two years holding town hall meetings all over the nation and administering a blog that was open to comments about

Scottish independence from any interested person (The Scottish Government 2014). Next, the government published a "consultation pamphlet" containing the results and responses from the two years of discussion and an evidence-based argument for why it was time for a referendum. Two major political groups formed, one in favor of independence and the other against, and they spent the years leading up to the referendum publishing propaganda, hosting debates, and informing citizens of the pros and cons of independence. Finally, Scotland's First Minister and Great Britain's Prime Minister signed an agreement agreeing that the referendum was legal, that it would be conducted fairly, and that all parties would abide by the outcome peacefully.

Each American state should look to the Scottish Independence referendum as a model for how their universal health care referenda should be conducted. A statewide discussion should be well-facilitated and highly publicized for a long period of time before any formal plans are made. If the discussion in more conservative states does not favor a referendum, states should wait and try again later, after more progressive states have held referenda and hopefully have established the Bismarck system. However, if the conclusion from the discussion is that a referendum is desired, the government should publish its findings and formulate an argument for why a referendum is necessary. The government should facilitate and encourage any and all groups that emerge as advocates for either side of the referendum debate. Finally, the state's leaders should all publicly pledge that they will protect the integrity of the referendum and abide by its results. Then, the referendum can proceed. If after all the education and persuasion, the citizens of the state still vote 'no' to universal health care, the

state will be permitted to refuse it, but the state government will not receive the incentives promised in the original federal bill and it be required to hold another referendum within a certain amount of time, perhaps around fifteen years. That would give the states that did implement the Bismarck system time to gather and publish data on how universal health care has improved its health care costs, access, and outcomes. The citizens of the states that do not implement that system would take the success of the "guinea-pig" states into account when voting in their referendum, based on the principle of state-to-state diffusion of policy (Bowman 2012).

The United States should pass a bill that incentivizes states to hold individual referenda on the implementation of universal health care. The bill will recommend that the system be based on the Bismarck model and should maintain the five principles mentioned in Chapter Three of this thesis: non-profit basic health insurance coverage, free choice of health care provider, regulation of health care costs, retention of health care coverage during unemployment, and a streamlined health care administration system. Each state will be encouraged to hold an extensive public debate before the referendum. If the majority of citizens in that state vote "yes" to universal health care, a program that meets the requirements of the federal incentive bill should be implemented immediately. If a majority votes "no" in the referendum, the state will be required to repeat the public education/referendum process within fifteen years of the original referendum. This process for transition to universal health care is based on the principles of federalism and direct democracy, has historical roots in the transition processes of Canada and Switzerland, and would be the most

politically viable way to implement universal health care, due to the established political culture of the United States.

CONCLUSION

United States Health Care Reform

The United States' health care system suffers from high costs, low accessibility, and low quality. The Affordable Care Act attempts to solve these problems, but even after its full implementation, the United States still spends too much money on low-quality health care that is not accessible to low-income Americans. Using the comparative method, this thesis finds that the Bismarck model, a health care system employed by many countries around the world, including Germany, Japan, and Switzerland, is the best example for the United States to follow for health care reform because it solves the problems of cost, access, and quality while maintaining private industry. The most politically viable way to implement the Bismarck system in the United States would be to pass a bill that incentivizes states to pass universal health care by referendum, drawing from the health care transitions of Canada and Switzerland.

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