ABSTRACT

Addressing Healthcare-Related Bankruptcy: A Comparative Analysis of Healthcare Systems in the United States, United Kingdom, Germany, the Netherlands, Japan, Australia, and Canada

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This thesis examines the United States healthcare system as the leading cause of personal bankruptcy, despite attempts to mitigate financial burdens. It investigates the system's financing mechanisms and evaluates the United States initiatives to address these challenges. By comparing the United States' system with those of the United Kingdom, Germany, the Netherlands, Japan, Australia, and Canada, this study identifies successful strategies these countries have implemented to alleviate financial burdens on their citizens. Drawing lessons from these comparisons, this thesis proposes potential solutions that could be adapted to enhance the U.S. healthcare system's affordability and accessibility. This research aims to provide insights into how the U.S. can address the issue of healthcare-related financial hardship, offering policy recommendations to enhance the affordability and accessibility of healthcare for all citizens.

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ADDRESSING HEALTHCARE-RELATED BANKRUPTCY: A COMPARATIVE ANALYSIS OF HEALTHCARE SYSTEMS IN THE UNITED STATES, UNITED KINGDOM, GERMANY, THE NETHERLANDS, JAPAN, AUSTRALIA, AND CANADA

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TABLE OF CONTENTS

LIST OF FIGURES……………………………..……………………………..……...….iii

ACKNOWLEDGEMENTS…………………………………………….…...…………iv

INTRODUCTION………………………………………..………..……………...1

CHAPTER ONE……..…………………………...……….………..………...……3
Introduction to the Healthcare Financing System in the United States………………3
Medical Care as a Leading Cause of Personal Bankruptcy…………………………..7

CHAPTER TWO…………………………………………………….……………..12
The Affordable Care Act………………………………………………………13
Managed Care……………………………………………………………………17
Federally Qualified Health Centers……………………………………………20

CHAPTER THREE…………………………………………………………...24
The United Kingdom…………………………………………………………..24
Germany…………………………………………………………………...……..27
The Netherlands……………………………………………………………….29
Japan…………………………………………………………………………...30
Australia…………………………………………………………………….....33
Canada…………………………………………………………………………34

CHAPTER FOUR………………………………………………………………….36
Universal Health Coverage……………………………………………………36
Regulation of Supply and Prices………………………………………………38
Equitable Systems……………………………………………………………..39
Strengthen Primary Care………………………………………………………40
Streamlined Payment System…………………………………………………41
Autoenrollment……………………………………………………………...43

REFERENCES……………………………………………………………………..45

LIST OF FIGURES

Figure 1……………………………………………………………..…………………..6
Percentage of Americans by type of health insurance coverage and change from 2021 to 2022

Figure 2………………………………………………………………………………8
Distribution of medical collections balance amounts in the CFPB's Consumer Credit Panel as of 2020

Figure 3…………………………………………………………………...……14
Medicaid expansion by state

Figure 4……………………………………………………………………..…16
Health insurance marketplaces enrollment – predictions vs. reality

Figure 5……………………………………………………………….………22
Percent of FQHCs reporting budgeted, unfilled positions

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INTRODUCTION

A great national healthcare system is one that provides universal access to high-quality healthcare services for all its citizens, regardless of their socioeconomic status. Such a system ensures that everyone has access to essential healthcare services, including preventative care, primary care, and treatment for acute and chronic conditions, without facing financial hardship. It should also prioritize patient-centered care, focusing on the individual's health needs and preferences.

Additionally, a great national healthcare system promotes health equity by addressing disparities in health outcomes and access to care among different population groups. It strives to ensure that everyone, regardless of race, ethnicity, gender, or geographical location, has equal access to healthcare services and receives the same standard of care. This includes addressing social determinants of health, such as education, income, and housing, that can impact health outcomes.

Furthermore, a great national healthcare system is sustainable and efficient, utilizing resources effectively to provide cost-effective care. It should incorporate innovative approaches to healthcare delivery, such as telemedicine and digital health technologies, to improve access to care and reduce costs. Additionally, it should prioritize preventative care and public health initiatives to reduce the burden of preventable diseases and promote overall population health.

Lastly, a great national healthcare system is characterized by transparency, accountability, and continuous improvement. It should involve stakeholders, including

healthcare providers, policymakers, and patients, in decision-making processes and be responsive to the evolving healthcare needs of the population. By prioritizing these principles, a great national healthcare system can serve as a benchmark for other countries seeking to improve their healthcare systems.

The United States falls short of achieving the characteristics of a great national healthcare system in several key areas, leading to financial hardship for many individuals. One major issue is the lack of universal access to healthcare, as millions of Americans remain uninsured or underinsured. This results in many people forgoing necessary medical care or facing extreme costs for treatments, leading to financial strain and potentially worse health outcomes. The fragmented nature of the United States healthcare system, with its reliance on private insurance and employer-based coverage, further exacerbates disparities in access to care and health outcomes.

Moreover, the high cost of healthcare in the United States is a significant barrier to achieving a great national healthcare system. Healthcare expenditures in the United States are among the highest in the world, yet health outcomes lag those of many other developed countries (Wager et al. 2024). The high cost of healthcare, including premiums, deductibles, and out-of-pocket expenses, often leads to financial hardship for individuals and families. Medical debt is a common issue, with many Americans facing bankruptcy due to healthcare costs (Rakshit et al. 2024). The lack of a comprehensive, affordable healthcare system in the United States contributes to these financial challenges, highlighting the need for reform to ensure access to quality care for all.

CHAPTER ONE

Navigating the U.S. Healthcare Financing Landscape: From Policies to Personal Bankruptcy

Introduction to the Healthcare Financing System in the United States

The United States' healthcare financing system does not provide universal coverage, a contrast to systems in other countries. Healthcare expenses are covered through a combination of public payers, private insurance, and individual payments (De Law, Greenberg, and Kinchen 1992). Both public payers and private insurance serve as forms of health insurance, providing varying levels of benefits to individuals. Each finance type operates as a distinct funding source with different payment methods compared to the others.

Public payers can be categorized into the Federal, State, and local governments. The most significant form of publicly funded healthcare is Medicare, established in 1965 as a federal health insurance program aimed at providing coverage to individuals who are at least sixty-five years old, who have a disability, or have end-stage renal disease (Medicare n.d.). Medicare consists of three parts, Part A, Part B, and Part D. Part A serves as hospital insurance, covering hospital stays, hospice care, and care in specific nursing facilities. Part B acts as medical insurance covering certain medical services, outpatient care, and medical supplies. Part D focuses on covering the cost of prescription drugs (Medicare n.d.). Initially, individuals enrolled in Medicare receive Part A and Part B, with the option to add Part D as a separate drug plan. Beneficiaries pay for services as

needed, including a deductible at the beginning of the year and approximately 20% of the cost of each service thereafter (Medicare n.d.). Medicare's financing comes from a mix of taxes, federal revenues, and premiums, primarily funded by taxes from employed individuals. The financing is divided into two parts, Part A, funded by a 1.45% payroll tax on both employers and employees, and Part B, which requires a premium payment once enrolled in Medicare (De Law, Greenberg, and Kinchen 1992).

The second largest form of publicly funded healthcare is Medicaid, a joint federal and state program established in 1965 alongside Medicare. Medicaid aims to provide health coverage to low-income individuals and families in the United States. To qualify for Medicaid, individuals must have low-income and be elderly, blind, disabled, pregnant, or have a child under eighteen years old. Medicaid benefits differ from those provided by Medicare. Each state has the flexibility to establish its own Medicaid programs and determine the type, amount, duration, and range of services provided within the federal guidelines. Federal guidelines mandate coverage for inpatient and outpatient hospital services, laboratory services, x-ray services, and home health services, while benefits such as prescription drugs, physical therapy, and case management are optional (Medicaid n.d.). Medicaid is funded jointly by the federal and state governments through a federal matching program, where the federal government matches a percentage of the state's Medicaid expenditures (De Law, Greenberg, and Kinchen 1992).

Private health insurance, provided by private companies, is the most common means for individuals to obtain health insurance in the United States. It encompasses various types, including employer-sponsored health insurance, Affordable Care Act (ACA) marketplace plans, individual health insurance, TRICARE for military personnel,

short-term health insurance for temporary coverage, and catastrophic health insurance with high deductibles (Borrelli 2024). Employer-sponsored health insurance occurs when an employer offers a health insurance plan within the benefits package to their employees. With these insurance packages, the ACA requires that businesses with fifty or more full-time employees cover at least 60% of health insurance costs, or face tax penalties (Borrelli 2024). The ACA also established insurance marketplaces for individuals to compare and enroll in a variety of health insurance plans and enroll in one that best suits their needs. TRICARE provides coverage for military members and their families, offering several plans to help cover health costs (Tricare n.d.). Short-term health insurance serves as interim coverage, often used when transitioning between jobs. Catastrophic health insurance plans, which require qualification based on age or hardship, feature high deductibles but similar coverage to ACA plans (Borrelli 2024). These plans typically cover hospital services, medical services, prescription drugs, specialist care, and rehabilitative care. Private insurance plans create an agreement between a health insurance company and an individual. Usually, individuals pay an annual premium, which accumulates in a figurative pool. Since most individuals are not constantly ill, this pool can be tapped to cover the medical costs of those who are currently unwell (Stanford Vaden Health Services n.d.).

Some Americans lack health insurance, leaving them uninsured and without coverage. This group typically includes individuals who lack employer-sponsored health plans, do not qualify for Medicare or Medicaid, and cannot afford private insurance without financial assistance (Rakshit et al. 2023). The lack of insurance impacts their access to care and overall health, often leading them to delay or forgo healthcare due to

cost concerns. Public hospitals, community clinics, and local providers play a crucial role in providing health care to uninsured individuals (Tolbert, Drake, and Damico 2023). However, when uninsured individuals do seek care, they often face high medical bills that can quickly accumulate into medical debt.

Each year, the census gathers data on health insurance coverage. Amongst these payment options, private health insurance covers the largest percentage of Americans at 65.6%. Breaking this down further, employer-sponsored health insurance plans cover 54.5% of Americans, direct purchases cover 9.9%, marketplace insurance plans cover 3.6%, and TRICARE plans cover 2.4%. Public payments cover 36.1% of the American population. Medicare covers 18.7%, Medicaid covers 18.8%, and the VA and CHAMPVA plans cover 1.0%. The uninsured population of Americans sit at around 7.9% (Census 2022). These figures are summarized below in Figure 1.

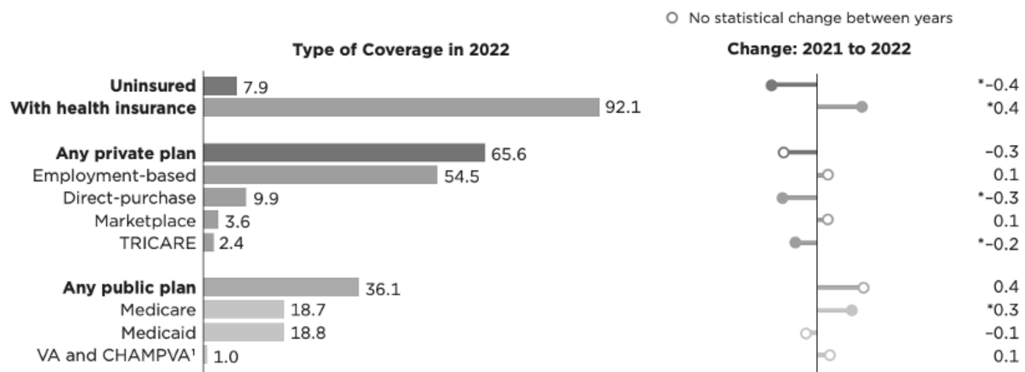

Figure 1: Percentage of Americans by type of health insurance coverage and change from 2021 to 2022. (Census 2022).

This data reveals that in the past year, there was a 0.4% decrease in the uninsured percentage of the population and a 0.3% decrease in the percentage of the population with a private health insurance. Conversely, there was a 0.4% increase in the proportion

covered by public health insurance plans, largely due to a notable rise in Medicare enrollment. One possible explanation for these shifts is the aging population and the retirement of individuals from the workforce, making them eligible for Medicare. Additionally, job scarcity may have led to more unemployed individuals qualifying for employer-sponsored health insurance.

The healthcare financing system in the United States is intricate, aiming to provide financial protection against significant medical expenses. It relies heavily on private health insurance, government-funded programs, and out-of-pocket payments. Despite this array of funding sources, escalating healthcare costs remain a significant financial burden for many Americans.

Medical Care as a Leading Cause of Personal Bankruptcy

The escalating costs of healthcare pose a significant challenge for many Americans, and it is crucial to understand that these costs will continue to rise due to factors such as inflation, changes in supply and demand, and market forces. This trend often makes healthcare unaffordable for individuals, leading them to accumulate medical debt. Despite having a median savings cushion of only $985 per month, the typical American can easily fall into medical debt even after a relatively small bill (Renter 2023). Medical debt is a leading cause of bankruptcy in the United States and can have far-reaching negative impacts on individuals' life lives (Rakshit et al. 2024).

Medical debt is the most frequently reported form of debt on an individual's credit report. According to a 2022 report by the Consumer Financial Protection Bureau (CFPB), the estimated amount of medical debt in collections ranges from $81 billion to $140 billion, with $88 billion estimated to be in collections by the CFPB. This wide

range stems from differing estimates, such as a 2020 study by the Journal of the American Medical Association estimating the medical debt balance at $140 billion, and a 2018 study by Health Affairs estimating it at $81 billion (Batty, Gibbs, and Ippolito 2018; Kluender et al. 2021). It is important to note that in some cases, individuals may pay off their medical debt by incurring other types of debt, like credit card debt, making the true amount of medical debt uncertain (Lopes et al. 2022).

Similarly, the percentage of Americans with medical debt ranges from 17.8% to 35% (Consumer Financial Protection Bureau 2022). This variation is due to the tendency for Americans to report higher amounts of medical debt in surveys compared to what is reflected in credit report data (Consumer Financial Protection Bureau 2022). The cost of an individual's medical debt can vary depending on a variety of factors. The distribution of medical debt amongst individuals based on credit report data in 2020 is shown below in Figure 2.

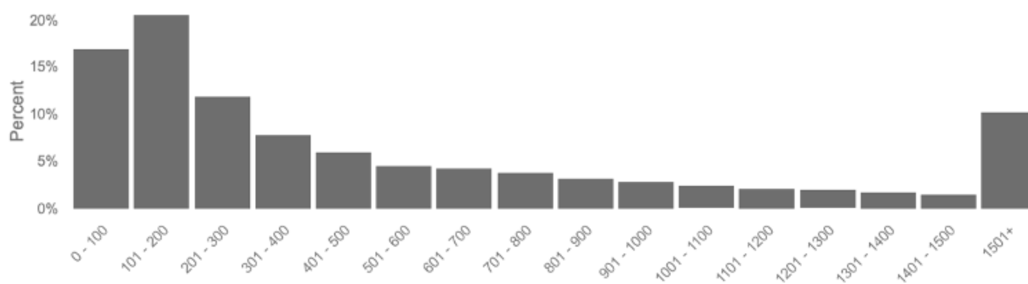

Figure 2: Distribution of medical collections balance amounts (in United States Dollars) in the CFPB's Consumer Credit Panel as of 2020. (CFPB).

This data indicates that 62% of medical debt in credit report data is less than $490, with a median of $310 and a mean of $773. Over 10% of medical debt exceeds $1,500 (Consumer Financial Protection Bureau 2022). While most medical debt is low-

dollar amounts, a significant portion is substantial, and any amount of debt can profoundly impact an individual's life and limit opportunities.

Healthcare is a leading cause of personal bankruptcy due to several factors. One primary reason is the steep increase in healthcare costs. An analysis by KFF, a source for health policy research, in July 2023 revealed that inflation in medical expenses has consistently outpaced inflation throughout the rest of the economy, particularly for outpatient care and hospital services (Tolbert, Drake, and Damico 2023). These escalating costs can quickly deplete savings and push individuals into financial turmoil. Insufficient insurance coverage is another significant factor. Despite the purpose of health insurance to shield individuals from financial distress related to healthcare, many individuals have inadequate health care coverage. A 2022 study conducted by the Commonwealth Fund found that 43% of Americans were inadequately insured (Collins, Haynes, and Masitha 2022). Inadequate coverage often translates to high deductibles, co-pays, and limited coverage for specific services or medications, leading to substantial out-of-pocket expenses that can overwhelm individuals. Medical emergencies, which can occur unexpectedly regardless of a person's health, also contribute to financial stress and potential bankruptcy. These emergencies can disrupt an individual's ability to work and earn income, further exacerbating financial challenges. Serious illnesses or injuries may require extended periods away from work, resulting in a loss of wages, and creating a significant financial burden. This combination of factors can create a perfect storm, pushing many individuals towards bankruptcy.

Medical debt can have severe financial repercussions for individuals. Unpaid medical bills may be sent to collections, leading to decreased credit scores, reduced

access to credit, and an increased risk of bankruptcy (Consumer Financial Protection Bureau 2022). Any medical debt appearing on an individual's credit report can lower their credit score, affecting their ability to secure credit, receive favorable terms, or access certain financial services. Credit scores play a critical role in decisions related to loans, mortgages, and renting, potentially influencing housing and transportation options. Medical debt can also elevate the likelihood of bankruptcy. A study by the American Journal of Public Health examining bankruptcy filings from 2013 to 2016 found that most respondents cited medical debt as a contributing factor to their bankruptcies (Himmelstein et al. 2019). Additionally, wage garnishment can occur, when creditors can legally deduct money from an individual's paycheck to repay debts after obtaining a court order (Consumer Financial Protection Bureau 2022). To manage medical debt, individuals often resort to drastic measures such as cutting back on necessities, depleting savings, taking on additional debt, borrowing money, seeking additional employment, or skipping payments on other bills (Lopes et al. 2022). These actions can significantly impact an individual's financial well-being and continue to pose threats in the future.

Medical debt extends beyond financial implications, profoundly affecting mental health and quality of life. One significant impact is the avoidance of medical care due to cost concerns. Many individuals will choose whether to receive health care based on the estimated cost and whether they can afford it (Lopes et al. 2022). In a study conducted on health care utilization, researchers discovered that 46% of individuals who have medical debt will purposely refuse to go get care due to the high costs (Adams et al. 2021). The weight of medical debt can also cause significant distress, with debtors three times more

likely to experience mental health issues such as anxiety or depression (Richardson, Elliot, and Roberts 2013). An anonymous individual wrote in a complaint to CFPB:

> "Receiving these communications made me feel anxious, afraid, frustrated, exposed, helpless, confused and offended every time I saw their company name… and [agency] gave me severe emotional and mental stress thinking I would lose my job… I felt embarrassed, less confident, and depressed…" (Consumer Financial Protection Bureau 2021).

Numerous complaints to the CFPB highlight the impact of debt collections on overall health and well-being. A 2021 study found that debt is linked to poor health outcomes later in life, including reports of increased joint pain and stiffness (Frech, Houle, and Tumin 2021). Stress resulting from medical debt can lead to a range of health problems, including ulcers, insomnia, high blood pressure, heart disease, and strokes. Additionally, a 2016 study by the Sycamore Institute found that medical debt is positively correlated with early death, indicating that higher levels of medical debt are associated with a greater likelihood of premature death (Spears 2021).

Overall, medical debt profoundly impacts individuals' lives, leading to financial instability, increased stress and anxiety, and poor physical health. The burden of medical debt limits the opportunities an individual has, creating a cycle of hardship that is extremely difficult to end.

CHAPTER TWO

Balancing Acts: U.S. Efforts to Alleviate Healthcare Financial Strain and Their Ambiguous Outcomes

Because healthcare costs are a pressing concern for many Americans, the United States has pursued various strategies to reduce these costs. A key milestone in this effort was the enactment of the Affordable Care Act (ACA) in 2010, representing the most significant expansion of health care coverage since the establishment of Medicare and Medicaid in 1965 (The Professional Society for Health Economics and Outcomes Research n.d.). The ACA was designed to expand access to healthcare insurance as well as make affordable health insurance available to all Americans. Another pivotal approach to cost containment is managed care, which was introduced to oversee the cost and quality of services provided under Medicaid. Additionally, the establishment of Federally Qualified Health Centers (FQHCs) has played a crucial role. These community-based centers offer affordable healthcare to underserved populations. These strategies collectively contribute to the overarching objective of enhancing the accessibility and affordability of healthcare for all Americans.

Despite these efforts, the results have been mixed, and the goal of making healthcare more affordable remains elusive. The United States still faces significant barriers in achieving its objective of making healthcare for accessible and affordable for everyone.

The Affordable Care Act

The Affordable Care Act (ACA) is a health care reform law that was enacted in the United States in 2010. The ACA had three primary goals: (1) make affordable health insurance available to all Americans, (2) expand the Medicaid program, and (3) support methods that ultimately reduce the cost of healthcare (U.S. Department of Health and Human Services 2021). To achieve these goals, the ACA focused on three main areas: (1) expanding public programs, (2) establishing health insurance marketplaces, and (3) altering aspects of private insurance (The Professional Society for Health Economics and Outcomes Research n.d.).

The ACA sought to expand Medicaid eligibility by requiring states to offer Medicaid to individuals at or below 138% of the federal poverty level (Lyon, Douglas, Cooke 2014). Currently, this threshold stands at $41,400 for a family of four (California Department of Public Health 2023). The federal government would provide funding to assist states in expanding Medicaid coverage. The ACA also made it possible for individuals without dependents to be eligible (The Professional Society for Health Economics and Outcomes Research n.d.). However, a 2012 Supreme Court ruling deemed it unlawful to mandate states to expand Medicaid, granting them the choice to expand instead. To date, forty states have opted to participate in Medicaid expansion as seen below in Figure 3.

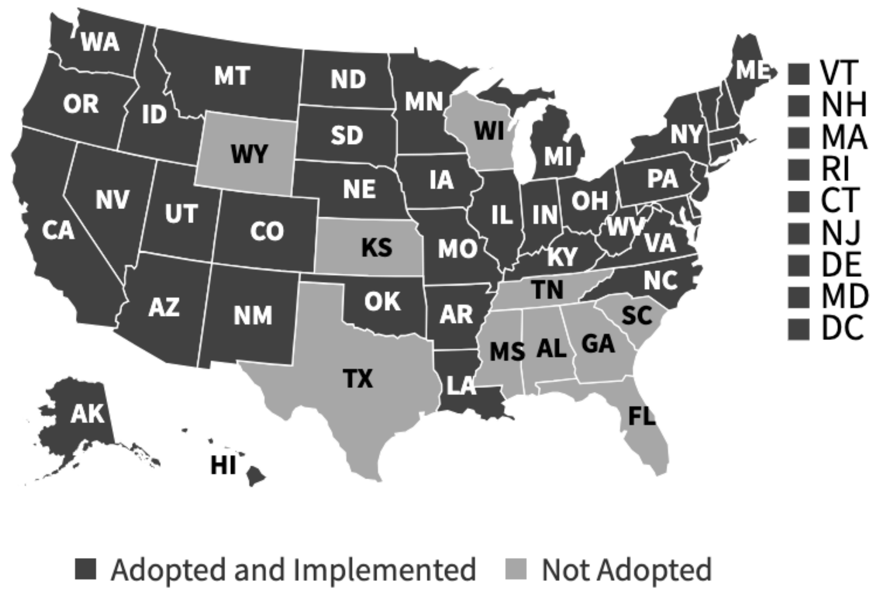

Figure 3: Medicaid expansion by state. (KFF 2024).

In states that chose not to expand Medicaid, many Americans fell into a "coverage gap" where their income was too high to qualify for Medicaid but too low to receive subsidies for private insurance (Lyon, Douglas, Cooke 2014). To address this, the ACA established health insurance marketplaces, which act as centralized platforms where individuals can shop for and compare various health insurance plans (Centers for Medicare and Medicaid Services 2023). Users input personal information and receive insurance plan recommendations best correlated to their needs. The plans are divided into four tiers – bronze, silver, gold, and platinum – each offering different levels of coverage and cost-sharing. These tiers vary in terms of premiums, deductibles, and out-of-pocket expenses (HealthCare n.d.).

The ACA also implemented significant changes in the realm of private health insurance. It introduced regulations preventing health insurers from denying coverage to individuals based on factors such as pre-existing health conditions, gender, or age.

Additionally, the ACA allowed dependents to stay on their parents' health insurance until they reach the age of twenty-six. Moreover, the ACA increased affordability by eliminating copays for many preventative health services (The Professional Society for Health Economics and Outcomes Research n.d.). Overall, the ACA expanded public health insurance programs, established health insurance marketplaces, and improved the realm of private health insurance in hopes of increasing access to healthcare, improve the quality of healthcare, and reduce the overall cost of healthcare within the United States.

The ACA has achieved considerable success in expanding insurance accessibility. Through the establishment of health insurance marketplaces and Medicaid expansion, millions of Americans gained health insurance coverage. A study conducted by the U.S. Department of Health and Human Services in 2024 revealed that since the opening of health insurance marketplaces, nearly 45 million more Americans have acquired some form of health insurance (U.S. Department of Health and Human Services 2024). Health insurance marketplaces have improved access to healthcare by simplifying the process of selecting a health insurance plan and facilitating enrollment. They have also enhanced transparency regarding pricing and benefits. Additionally, the ACA established consumer protections to ensure that Americans can obtain health insurance without facing discrimination. Furthermore, the ACA has helped reduce healthcare costs by lowering copayments for certain preventative services. These measures have collectively made healthcare more accessible, affordable, and equitable for the American population.

While the ACA brought several benefits to the American healthcare system, it has also faced significant criticism and challenges, leading many to consider it fundamentally flawed. One major criticism is the failure to control the escalating costs of healthcare.

Premiums have continued to rise, making health insurance less affordable for many families (Oberlander 2020). This increase in premiums has forced over 4 million individuals, who did not qualify for subsidies, to forgo health insurance due to unaffordability (Blase 2020). Additionally, as seen above in Figure 3, a few states opted not to expand Medicaid, creating a "coverage gap" for low-income individuals in these states (Lyon, Douglas, Cooke 2014). Moreover, the ACA has not succeeded in lowering healthcare costs for those who already had insurance before its implementation. Many individuals have faced significant increases in deductibles, particularly in employer-sponsored health insurance plans (Oberlander 2020). Furthermore, the ACA has fallen short of its enrollment projections. The Congressional Budget Office initially expected the health insurance marketplaces to have over 25 million enrollees by 2019 due to mandated penalties, subsidies, and increased awareness and outreach efforts (Blase 2020). However, as shown in Figure 4, average enrollment has remained below this target since inception, with around 10 million enrollees.

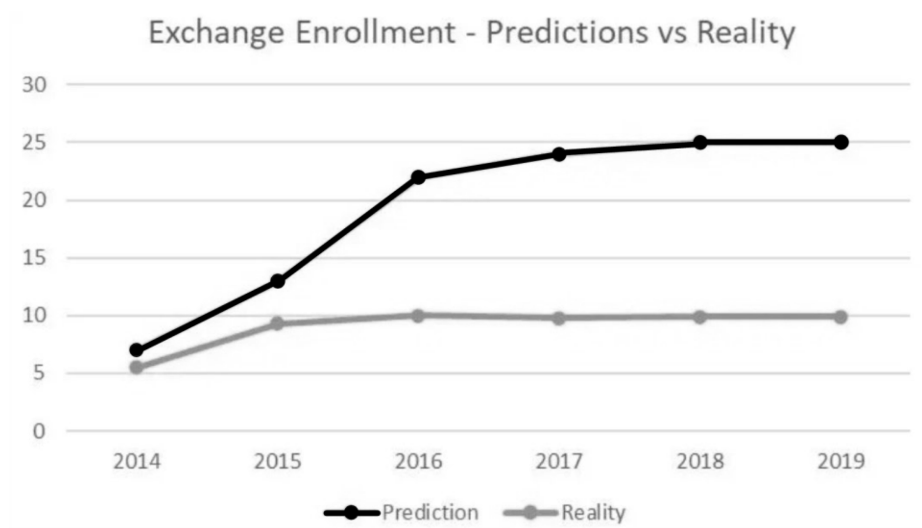

Figure 4: Health insurance marketplaces enrollment – predictions vs. reality. (Blase 2020).

As indicated, actual enrollment has hovered around 10 million people since 2015, approximately 60% lower than the Congressional Budget Office's expectations. This is because some individuals will opt to purchase their own healthcare insurance outside of the marketplaces and that the plans in the marketplaces are too expensive for individuals to afford (Levitt et al. 2016). One of the ACA's significant shortcomings is its failure to effectively control healthcare costs. While it did reduce the number of uninsured individuals, it also resulted in many being underinsured. While the ACA achieved several important objectives, its perceived shortcomings and political challenges have sparked further debates on the best approach to healthcare reform is in the United States.

The ACA stands as one of the most transformative healthcare reform laws in the United States, with both positive and negative consequences. On the positive side, it provided millions of Americans with access to health insurance, implemented consumer protections in the private insurance sector, and enabled individuals to receive preventative care at no additional cost. It also contributed to a reduction in healthcare costs, albeit not to the extent initially hoped for. However, the ACA has faced criticism for its perceived failures, including ongoing concerns about healthcare costs, disparities resulting from states that chose not to expand Medicaid, the rise in underinsured individuals, and lower-than-expected health insurance marketplace enrollees.

Managed Care

Managed care is another approach the United States has taken to lower the cost of healthcare. Managed care is a comprehensive and integrated approach to healthcare delivery and financing that was established as part of the Health Maintenance Organization Act of 1973 (Heaton and Tadi 2023). It has since become a predominant

model in response to escalating healthcare costs and the need for more coordinated care systems. While the concept of managed care has evolved over time, many definitions share five common features: a limited network of providers, quality management, utilization management, financial incentives for the patient, and financial incentives for the type of care provided (Giardino and De Jesus 2022). Managed care organizations (MCOs) aim to strike a balance between affordability and access to high-quality healthcare (Medicaid n.d.). These organizations take various forms, including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Point of Service Organizations (POS), and Exclusive Provider Organizations (EPOs) (Heaton and Tadi 2023).

Each form of managed care operates by establishing contracts with specific healthcare providers. These contracts require providers to offer care at a reduced cost based on the chosen form of managed care (Giardino and De Jesus 2022). HMOs typically offer the most cost-effective option, requiring individuals to select an in-network primary care provider who can then refer them to specialists if needed. PPOs are more expensive than HMOs due to their increased flexibility. With PPOs, individuals can choose from a list of providers, both in-network and out-of-network, though seeing an out-of-network provider incurs higher costs. POS organizations blend aspects of HMOs and PPOs, requiring individuals to choose an in-network primary care provider while permitting them to consult a specialist without a referral. EPOs provide the greatest flexibility, allowing individuals to select both in-network providers and out-of-network providers without referrals. However, costs are not covered for out-of-network services in EPOs (Heaton and Tadi 2023).

Managed care organizations offer several benefits that enhance the quality and efficiency of healthcare services. One significant advantage is their emphasis on preventative care (Falkson and Srinivasan 2023). By encouraging patients to receive vaccines and screenings, MCOs promote early detection of health issues, leading to better health outcomes and potentially lowering costs by preventing costly hospitalizations. MCOs also help reduce costs by negotiating pricing with health care providers (Stone 2013). This negotiation can result in lower out-of-pocket expenses for patients. Additionally, MCOs improve the coordination of a patient's care. Care coordination, according to a study conducted in 2017, is a key part of managed care due to its effectiveness in lowering overall cost and improving health outcomes (Gilchrist-Scott, Feinstein, and Agrawal 2017). Better coordination reduces wait times between healthcare services, thus minimizing the repetition of care and potentially lowering costs. Furthermore, MCOs offer a network of healthcare providers (Giardino and De Jesus 2022). This defined network, which includes primary care providers and specialists, enhances access to healthcare and increases efficiency by reducing wait times for appointments. Overall, managed care organizations have been effective in making healthcare more affordable and accessible for a larger portion of the United States population.

While managed care offers several benefits, such as increased utilization of preventative care and negotiated lower costs with healthcare providers, it also has several drawbacks. One major concern is the restriction of healthcare providers, limiting individual's freedom to see providers outside of their network. This can be challenging for individuals who have established relationships with specific doctors. Additionally,

managed care can lead to care rationing, where individuals are denied necessary healthcare services to limit expenses. This can make it difficult for individuals to receive the care they need, which they were previously able to access before managed care (Friedman and Chase 1997). Another downside of managed care is its administrative complexity, which is challenging for both providers and patients. Requirements such as pre-authorization for treatments or referrals can delay or deny healthcare services, placing a burden on patients (Gold and Mittler 2000). Furthermore, managed care's use of financial incentives can compromise the quality of care patients receive. With MCOs, physicians can lose money if they provide more services or referrals than the MCO allows. Physicians may economize care to ensure profitability, potentially harming patients' health (Rodwin 1998).

MCOs have reshaped the healthcare landscape in significant ways, offering both advantages and disadvantages. On the positive side, MCOs have increased utilization of preventative care, negotiated lower costs with healthcare providers, and helped increase the coordination of their care. However, MCOs have their drawbacks, specifically with the limitation in providers, care rationing, the complexity of the administration, as well as incentives for physicians that ultimately lowers the quality of care individuals are receiving. While MCOs have undoubtedly brought efficiency and cost control, it also has drawbacks that end up harming the health of many individuals.

Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) play a crucial role in providing medical services to underserved populations in the United States (HealthCare n.d.). Established under federal law in 1965, these community-based healthcare centers receive

federal funding to ensure that individuals can access care regardless of their ability to pay. FQHCs typically offer sliding fee scales, where the price depends on an individual's income (Myong et al. 2020). These centers provide a wide range of medical services, with a focus on care coordination and improving health outcomes through preventative care and chronic health management, thus reducing health disparities.

With the establishment of FQHCs came many successful outcomes. One of the largest positive outcomes from FQHCs is the increase in amount of people covered. As of 2013, FQHCs were providing care to 20 million people in the United States who otherwise would not have received healthcare (Center for Healthcare Research and Transformation 2013). Another benefit that came from FQHCs was an improvement in the quality of healthcare being provided. A study found that the quality of care being delivered in FQHCs was directly comparable to the care given in private practices (Falik et al. 2006). FQHCs also foster community engagement by conducting community needs assessments (Lopez 2023). These assessments allow the center to tailor the services given to provide more of what a certain community needs most. FQHCs provide accessible and affordable healthcare services and improve health outcomes by emphasizing preventative care and chronic disease management.

While FQHCs offer healthcare services to underserved communities, they do have certain downsides. One of the biggest challenges FQHCs face are the capacity constraints (Brandt et al. 2015). These constraints often lead to longer wait times as well as making it difficult for individuals to access the care they need. Since FQHCs are funded by federal grants, these funds could potentially limit the number of services provided as well as the quality of healthcare. Because they rely on government funding, FQHCs are also subject

to changes in policies and budget. Changes can impact the ability of a FQHC to provide quality healthcare and can impact the stability of the center (Lewis et al. 2019). Another significant barrier that FQHCs must overcome is workforce shortages. Retaining staff members is difficult for FQHCs since they are predominately in underserved areas as seen below in Figure 5.

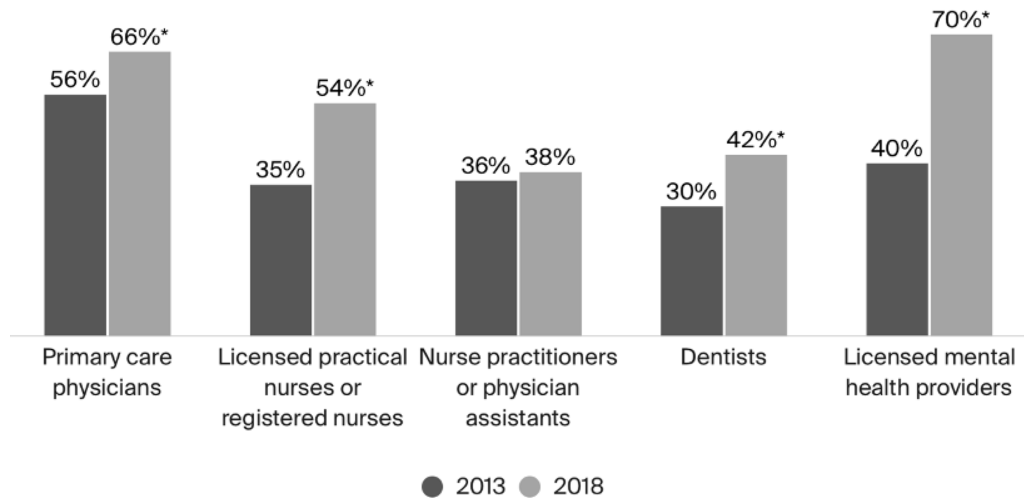

Figure 5: Percent of FQHCs reporting budgeted, unfilled positions. (Lewis et al. 2019).

Over time, there has been a significant increase in staffing shortages at FQHCs. From 2013 to 2018, the number of unfilled positions grew by at least 10% for every type of job except for nurse practitioners and physician assistants (Lewis et al. 2019).

FQHCs play an important role in the United States healthcare services, offering many benefits to underserved communities. These centers increase health outcomes by focusing on preventative care as well as chronic disease management. FQHCs contribute to reduce health disparities. However, FQHCs have their downsides including capacity constraints, workforce shortages, and limited funding (Southwick 2022). Despite these

drawbacks, FQHCs are still an essential component of the healthcare system in the United States.

While the Affordable Care Act, managed care, and Federally Qualified Health Centers have made major contributions to improving healthcare access and affordability, challenges remain in achieving comprehensive and sustainable solutions to address the high cost of healthcare in the United States. Given that the United States has not achieved significant reductions in healthcare costs, it is crucial to explore what other countries have done to search for potential solutions to this crisis.

CHAPTER THREE

Global Perspectives: Strategies to Mitigate Healthcare Costs for Citizens

The rising cost of healthcare has become a global concern, with many countries dealing with the challenge of providing affordable healthcare to their citizens. As the United States navigates its complex healthcare landscape, various countries have found innovative measures to create both a more sustainable and inclusive healthcare system. From Europe to Asia, countries have experimented with diverse policy frameworks, technological advancements, and community-driven initiatives to mitigate the economic strain imposed by the cost of healthcare. By examining the measures of these countries, we can find valuable insights and potential solutions that may offer a blueprint for addressing similar challenges within the United States' healthcare system.

The United Kingdom

The United Kingdom (UK), comprised of England, Scotland, Wales, and Northern Ireland, is well-known for its National Health Service (NHS), a publicly funded healthcare system that provides comprehensive medical services to residents at little to no cost at the point of use (National Health Service 2023). The NHS is made up of the NHS, NHS Scotland, NHS Wales, and the Health and Social Care in Northern Ireland. With this system, citizens are entitled to healthcare, but are also allowed to purchase private health insurance if they choose. With a focus on universal healthcare coverage, the UK's healthcare system serves as a prominent example of a government-led initiative aimed at ensuring healthcare affordability and accessibility for all citizens.

The NHS is primarily funded through general taxation, in which the government collects taxes from individuals and businesses and then a portion of these is allocated to the NHS to cover the cost of healthcare. Around 18% of an individual's income tax goes toward healthcare, meaning that around 4.5% of the average individual's income will go toward healthcare (Chang et al. n.d.). Additionally, the NHS is also funded by National Insurance contributions. These contributions are paid by individuals and employers. The government sets a budget for the NHS on an annual basis. For 2022-23, the NHS spent a total of 181.7 billion. This money was used to cover the costs of healthcare services, including hospitals, general practitioners, and other healthcare providers (The Kingsfund 2023).

The NHS has played a crucial role in easing the burden of healthcare costs on its citizens. One of the main ways this burden is lessened is through the NHS's principle of providing healthcare services free at the point of use. What this means is that individuals can access a wide range of medical services, including but not limited to consultations, treatments, and surgeries, without having to pay large out-of-pocket fees (Delamothe 2008). By removing the financial barrier to healthcare, the NHS ensures that individuals can seek medical attention when needed, without fear of incurring additional and significant costs.

Additionally, the NHS has started focusing more on preventative care and public health initiatives which has helped reduce the burden of healthcare on its citizens. The NHS provides a range of preventative services, such as vaccinations, screenings, and health education programs, with the primary goal of reducing the incidence of illness and promoting healthy lifestyles among all citizens. By investing in preventative care, the

NHS not only improves the health outcomes of its population but also reduces the need for costly treatments and interventions in the long run. One initiative introduced in 2009 was the health check program, which encouraged healthcare professionals to assess healthy individuals for cardiovascular risk factors. This program had outstanding success and millions of people were screened for the risk factors (U.K. Government 2021).

The NHS also emphasizes comprehensive and integrated care by providing a wide range of services, including primary care, specialist care, mental health services, and social care, all under one umbrella (National Health Service 2023). This integrated approach ensures that individuals receive holistic and coordinated care, which can help to improve health outcomes and reduce the need for costly hospital admissions. By ensuring that individuals receive the right care, in the right place, at the right time, the NHS ultimately eases the burden of healthcare costs on its citizens.

Despite these successes, the NHS also faces challenges and criticisms, particularly in areas such as long waiting times and financial constraints. One of the biggest criticisms of the NHS has to do with the long waiting times for certain treatments and procedures. Due to high demand and limited resources, patients may experience delays in accessing non-urgent care, such as elective surgeries or specialist consultations. Based on the analysis of data that is released by the NHS, there was an average waiting time of fifteen weeks for treatment in December 2023 (British Medical Association 2024). These waiting times can lead to increased discomfort and anxiety for patients and may have a negative impact on their health outcomes.

Another downside is the strain on the NHS finances and resources. As healthcare costs continue to rise, the NHS faces budgetary constraints that have led them to

experience staff shortages and rationing of care. In late 2022, the Health and Select Committee within Parliament confirmed that almost every profession within healthcare is experiencing major shortages, with a minimum of 105,000 vacancies across all professions (NHS Support Federation n.d.). The increased demand for healthcare services, coupled with limited funding, has put pressure on the NHS to find cost-effective solutions, which can sometimes result in a lesser quality or availability of care.

Germany

Germany, a country in Central Europe, has implemented several measures to ease the burden of healthcare costs on its citizens, with a healthcare system known for its universal coverage and emphasis on high-quality care.

One aspect of Germany's approach is its system of statutory health insurance (SHI). SHI is required by law for individuals who earn up to 60,750 euros (77,985 USD) per year, covering around 88% of the total population. For individuals who earn over 60,750 euros per year, they can choose to remain a part of SHI (Tikkanen et al. 2020). SHI is primarily funded through payroll taxes, with contributions made by both employers and employees. Since 2016, the legally set contribution has been 14.6% of gross income. In 2019, however, the rules about contributions changed. Individuals earning more than 54,450 euros (69,897 USD) have the option of opting out of SHI for private insurance, at an increased cost (Tikkanen et al. 2020). SHI guarantees that healthcare costs are distributed fairly among the population, with individuals paying according to their ability to contribute, and helps to ensure the sustainability of Germany's healthcare system.

Furthermore, Germany has implemented various cost-containment measures to ensure the sustainability of its healthcare system. For starters, the country has a system of regulated fees for medical services. For example, hospital stays in Germany cost ten euros per day with a maximum of two hundred and eighty euros per year for individuals insured through SHI (Matz-Townsend 2022). This fee regulation helps control the costs and prevent overcharging by healthcare providers. Additionally, Germany has a strong emphasis on preventative care, with a range of programs directed at promoting healthy lifestyles and early detection of illness. For example, a preventative health check-up that takes place every other year has been available for individuals since 1989. This check-up looks for cardiovascular disease risk factors as well as looks for symptoms of diabetes mellitus type two and kidney disease (Schülein et al. 2017). By investing in preventative care, Germany hopes to reduce the need for costly treatments and hospitalizations, ultimately easing the financial burden on its citizens.

Moreover, Germany's healthcare system encourages competition among private health insurers and providers. For example, sickness funds and ambulatory care are made up of competing, not-for-profit health insurance plans (Kifmann 2017). Patients are allowed to choose their physician, their general practitioner, and even their specialists. This competitive environment incentivizes insurers and providers to innovate and improve their services (Tikkanen et al. 2020). Having competition not only fosters innovation but also improves quality by having care that is more patient centered.

Despite these efforts, Germany's healthcare system is not without its challenges. The country faces an aging population and rising healthcare costs, which put pressure on the system. Rising medical costs are said to leave the system 7.5 billion euros (11.1

billion USD) short next year (Fuhrmans 2009). What this means is that the government will likely have no choice but to raise mandatory contributions. Additionally, there are disparities in access to care between different regions of the country, with rural areas often facing shortages of healthcare providers. Recent estimates show a lack of 1.8 million healthcare professionals by 2035 (Sax Dos Santos Gomes 2023). Addressing these challenges will require additional investment in the healthcare system.

The Netherlands

The Netherlands, a country in Europe that borders Germany, has taken various steps to help relieve citizens of the financial burden of healthcare.

The Dutch healthcare system is well-known for its universal coverage, while still maintaining high-quality care and accessibility (Government of the Netherlands 2016). One of the main aspects of this system is the mandatory social health insurance program. This program was created in 2006 after there were inefficiencies and long-wait times within the old system where individuals could choose between public and private health insurance. Under this new program, individuals are given a choice between several different insurance policies and are then required to choose a policy that fits their needs. All policies are required to cover certain healthcare services, such as general practitioner visits, specialty care, prescription drugs, and hospital visits (Tikkanen et al. 2020). Although health insurance is provided by private health insurers, it is still heavily regulated by the government to ensure affordability.

This mandatory health insurance is financed in three ways. 45% of the funding comes from an annual income tax of 6.9% up to a certain amount. Another 45% of the funding comes from insurance premiums that are set by each insurer. The other 10%

comes from a government grant that pays for anyone under the age of eighteen (Tikkanen et al. 2020). Individuals with health insurance pay a fixed premium to the insurance company they chose as well as an income-related contribution, referred to as the ZVW contribution (Government of the Netherlands n.d.). To maintain affordability, the government offers a series of income-based subsidies to help individuals with lower incomes afford health insurance. For example, low-income households can be provided with monthly healthcare allowances anywhere from two to two hundred euros (three to two hundred and fifty USD) (Tikkanen et al. 2020). These subsidies operate on a sliding scale, with higher subsidies for individuals with lower incomes. This system ensures that healthcare remains affordable for all individuals, regardless of their financial situation.

Similar to Germany, the Netherlands has also implemented a system of regulated competition among health insurers. This competition was implemented with the goal of improving both the efficiency and quality of care. Health insurers can negotiate with healthcare providers about the price of care as well as use financial incentives to influence the general public to visit that insurer's preferred provider (Schut and Varkevisser 2017). While the law requires health insurers to provide a basic insurance package, they can also offer additional coverage options at an increased price to those who are interested (Tikkanen et al. 2020). This competitive environment incentivizes insurers to provide high-quality and cost-effective care to attract customers, which would ultimately benefit the general public.

Japan

Japan, a country in East Asia, has been working toward the goal of affordable and accessible healthcare, given its rapidly aging population and the increase in the costs of

healthcare. The Japanese government has implemented various strategies to mitigate these challenges and ensure that healthcare remains affordable for its citizens. From its elderly fee adjustment to innovative cost-optimizing plans, Japan serves as a compelling case study in the quest to provide high-quality healthcare while managing costs effectively.

In Japan, the elderly fee has been adjusted to reduce the burden on younger workers and to address the increasing healthcare costs associated with an aging population. This adjustment was implemented in 2022 and raised the medical fee individuals 75 and older pay by 10%, bringing the current payment to 20% of the medical fees (The Asahi Shimbun 2020). The rationale behind this adjustment is to shift some of the healthcare costs from younger, working-age individuals to the elderly, who are more likely to utilize healthcare services. In fact, the Japanese government estimates that this adjustment will ease the younger individual's burden by 88 billion yen, or 587 million USD (The Asahi Shimbun 2020). By implementing this adjustment, Japan effectively prevents younger workers from bearing an unfair burden of healthcare costs associated with an aging population.

Another way Japan has reduced the costs associated with healthcare is by making improvements in the technology. Due to its rapidly aging population, Japan has turned to healthcare innovations that focus on preventative measures, early diagnosis, and general healthy living while keeping healthcare costs generally low (The Economist Intelligence Unit 2017). These innovations primarily revolved around technological improvements. For example, Japan started using electronic health records in the early 2000s. Based on evaluations of how these records work, the government has determined that these

electronic records have streamlined administrative processes, reduced paperwork, and eliminated duplicate tests (Yoshihara 1998). Besides electronic health records, Japan has also used telemedicine, robotics, and artificial intelligence to assist with diagnostics. These technological advancements have allowed for more cost-effective healthcare delivery and led to shorter hospital stays and fewer complications, ultimately reducing overall healthcare expenditures (The Economist Intelligence Unit 2017).

Finally, Japan actively implements cost-optimization plans to help stop the growth in medical expenses. One plan is resource allocation, in which the Japanese government assesses the distribution of medical facilities, specialists, and equipment to balance supply and demand (Hiki 2004). The Japanese government is actively checking for duplication of services, overprovision of medical facilities, and other things, allowing Japan to optimize resource allocation and save money. Another plan Japan has implemented is quality-adjusted life years (QALYs). QALYs are a measure used to assess the value of healthcare interventions by considering both the quantity and the quality of life that they provide (Igarashi, Goto, and Yoneyama-Hirozane 2019). QALYs help policymakers and healthcare providers make decisions about resource allocation, ensuring that limited healthcare resources are used effectively to improve overall health and well-being of the population. Furthermore, Japan also can negotiate pharmaceutical pricing with pharmaceutical companies to ensure affordability. The government reviews and adjusts the prices periodically (Chen and Cheng 2023). This helps ease the financial burden on Japan's citizens by ensuring that medications are priced competitively and accessible to those who need them.

Japan has implemented a variety of strategies to alleviate the financial burden of healthcare costs on its citizens. These efforts underscore Japan's commitment to providing high-quality, affordable healthcare for all.

Australia

Australia's healthcare system is renowned for its universal coverage and efforts to provide accessible and affordable healthcare for all citizens. Australia has tried many different strategies and initiatives to lower healthcare costs in their country.

One of the main approaches Australia has lowered healthcare costs is through its Medicare system. This system provides universal access to essential healthcare services, such as emergency care, surgery, general visits, medication, and more (Department of Health and Aged Care 2023). Another benefit to the Medicare system is the bulk billing. Bulk billing occurs when the hospital or healthcare professional will bill Medicare directly for an individual's medical service (Australian Government 2024). Bulk billing ensures that individuals are not paying any out-of-pocket fees for services they need, allowing affordability for all the services covered under Medicare. Medicare also provides safety nets designed to help individuals who have high out-of-pocket costs. Once a set threshold is reached, additional services are subsidized (Department of Health and Aged Care 2023). This ensures that for services not covered by Medicare, individuals will still be able to access the care they need, at an affordable cost.

Australia has also made efforts to reduce out-of-pocket fees and promote affordability. The Australian government actively tracks trends revolving around out-of-pocket healthcare spending, such as high-cost areas (Callander, Fox, and Lindsay 2019).

Based on the collected data, the government then can target interventions to eliminate those high costs, thus alleviating the burden on patients. Outside of out-of-pocket fees, policymakers ensure that the healthcare policies in place ensure that healthcare, specifically services not covered by Medicare, remains at an affordable price for all citizens, regardless of income level (Callander 2023). The Australian government also enhances transparency about fees to the general public, which allows them to make more informed choices, and negotiates with healthcare providers to ensure reasonable fees (Tikkanen et al. 2020). Healthcare professionals in Australia also encourage patients to use generic medications, which are equally effective but often more affordable than brand-name equivalents (Beran 2021).

Australia continues to refine its healthcare policies, aiming for equitable access, cost containment, and improved health outcomes for its citizens.

Canada

Canada is actively pursuing strategies to reduce healthcare costs while maintaining the quality and accessibility of its healthcare system.

One of the main ways they have tried to lower healthcare costs is with Health Technology Assessment (HTA) agencies. HTAs are designed by the government to evaluate the cost-effectiveness, safety, and efficacy of new drugs, medical devices, and procedures (Haas and Moskowitz 2007). By assessing the clinical success and cost-effectiveness of new treatments, HTAs help to ensure that limited healthcare resources are allocated efficiently. HTAs are also integral to promoting transparency and accountability in healthcare decision-making, as they involve input from various stakeholders. The use of HTAs has also led to the development of guidelines and

standards for the adoption of new health technologies, further enhancing the efficiency and effectiveness of the healthcare system (Haas and Moskowitz 2007).

Another strategy Canada has taken was to improve end-of-life care solutions. Canada has worked on improving accessibility to palliative care. Instead of receiving palliative care, most Canadians go to hospitals, receiving more expensive care (C.D. Howe Institute 2021). This increases the cost of healthcare delivery in the final months of an individual’s life. Canada has worked on improving accessibility by informing individuals in acute care who are near the end of their life, supporting those who chose to receive end-of-life care at home, creating processes for shifting towards a palliative approach, and tracking metrics relevant to end-of-life care (C.D. Howe Institute 2021). By improving end-of-life care solutions, Canada has been able to lower the overall cost of healthcare.

In conclusion, several countries around the world have implemented innovative strategies to lower the cost of healthcare and alleviate the financial burden on their citizens. From the universal healthcare systems of countries like the United Kingdom and the Netherlands to the targeted approaches of countries like Germany and Japan, these efforts have focused on improving efficiency, promoting preventative care, and enhancing access to affordable treatments. While each country’s approach is unique, they all share a common goal of ensuring that healthcare remains accessible and affordable for all, offering valuable lessons and insights for policymakers in the United States to address similar challenges in healthcare affordability within the United States healthcare system.

CHAPTER FOUR

Learning from Global Models: Enhancing Affordability and Accessibility in the U.S. Healthcare System

The United States can learn valuable lessons from other countries' approaches to lowering healthcare costs. By studying successful strategies implemented elsewhere, the United States can identify effective solutions to its own healthcare challenges. While the United States has a strong healthcare system, there is still room for improvement to enhance accessibility, affordability, and effectiveness for all citizens to become a great, high-functioning national healthcare system.

Universal Health Coverage

As seen in Chapter 3, many countries with successful healthcare systems prioritize universal health coverage. The United States should consider implementing universal health coverage to ensure that all citizens have access to essential healthcare services without facing financial hardship. The NHS in the United Kingdom provides universal coverage. It is a publicly funded system where the government directly provides healthcare services. The United States could consider a similar approach, ensuring that every citizen has access to essential medical care without financial barriers. Or the United States could pursue options like the Dutch system, which combines private health insurance with regulated competition. Citizens choose from private insurers and the government provides subsidies for those who need financial assistance. Universal

health coverage would help address current disparities in access to healthcare, ensuring that everyone, regardless of income or employment status, has access to necessary medical care. It would also promote health equity, as it would provide a baseline level of care for all citizens, reducing the impact of socioeconomic factors on health outcomes.

Universal health coverage could work in the United States by expanding existing public programs, like Medicare and Medicaid, to cover additional individuals. It could also involve implementing a single-payer system, where the government acts as the sole insurer for healthcare services. This could streamline the healthcare financing system, reduce administrative costs, and simplify the billing process for both patients and providers. Additionally, universal health coverage could be funded through a combination of taxes, premiums, and cost-sharing mechanisms, ensuring that the financial burden is distributed fairly among the population.

To implement universal health coverage in the United States, several changes would need to occur. First, there would need to be political will and bipartisan support for such a system. This would require overcoming ideological differences and engaging stakeholders from across the healthcare industry. Additionally, there would need to be a significant investment in healthcare infrastructure, including expanding the healthcare workforce and improving access to medical facilities in underserved areas. Finally, there would need to be a shift in public perception, with a greater emphasis on the value of healthcare as a human right rather than a commodity (Williams 2021).

Regulation of Supply and Prices

The United States should also consider regulating the supply and prices of healthcare to address the rising costs and ensure affordability for all citizens. By regulating the supply, the government can prevent overutilization of healthcare services, which can drive up costs. Canada can negotiate drug prices through the HTAs and the United States could adopt similar agencies to negotiate lower drug costs with pharmaceutical companies. Additionally, regulating prices can help control healthcare spending and ensure that essential services remain accessible to everyone. This approach would also help reduce the financial burden on individuals and families, making healthcare more affordable in the long run. HTAs in Canada also evaluate the effectiveness of medical treatments and interventions. If the United States had agencies like these in place, they would help guide decisions on which treatments to cover while assessing the comparative effectiveness of different medical interventions. While cost-effectiveness measures are typically based on averages, they serve as guidance rather than strict rules. Healthcare decisions can still be individualized based on specific patient needs even when considering cost-effectiveness.

One way to regulate the supply and prices of healthcare in the United States is through a system of price controls and a utilization review. Price controls would set limits on how much healthcare providers can charge for their services while utilization reviews would assess the appropriateness and necessity of healthcare services to prevent unnecessary treatments. This approach would require collaboration between the government, healthcare providers, insurers, and other stakeholders to establish fair and effective regulations. Additionally, implementing transparency measures, such as

requiring providers to disclose their prices upfront, can help empower consumers to make informed decisions about their healthcare.

Implementing supply and price regulations in the United States would necessitate significant changes. Firstly, there would need to be political consensus and bipartisan support for such regulations, overcoming potential opposition from stakeholders like healthcare providers and insurers concerned about the impact on their revenue. Secondly, substantial investment in healthcare infrastructure and workforce would be required to ensure that regulations do not lead to shortages or delays in care. Finally, there would need to be a cultural shift towards prioritizing value-based care and patient outcomes over profit-driven healthcare practices.

Equitable Systems

The United States should consider making its healthcare system more equitable by reducing cost sharing and expanding benefit coverage to ensure that all individuals, regardless of income or socioeconomic status, have access to necessary healthcare services. The United States can learn from healthcare systems in countries like Germany, who have minimal out-of-pocket expenses, and Australia, who covers a wide range of services from dental care to mental health services. Cost sharing would reduce the financial burden on individuals, making healthcare more affordable and accessible. Broad benefit coverage would ensure that essential healthcare services are included in insurance plans, preventing individuals from facing barriers to care due to limited coverage. This approach would help address disparities in access to care and improve health outcomes for all Americans.

To achieve a more equitable healthcare system, the United States could implement policies that reduce or eliminate out-of-pocket costs for essential healthcare services, such as preventative care, prescription drugs, and chronic disease management. This could be done through legislation that mandates comprehensive coverage for these services or through subsidies that offset the cost for individuals with low incomes. Additionally, expanding benefit coverage to include services that are currently excluded, such as dental, vision, and mental health care, would further improve access to care and reduce disparities in health outcomes.

Implementing these changes would require a shift in how healthcare is financed and delivered in the United States. This would involve increasing public funding for healthcare programs, such as Medicare and Medicaid, to cover the costs of reducing cost sharing and expanding benefit coverage. It would also require collaboration between the government, insurers, healthcare providers, and other stakeholders to develop and implement policies that prioritize equity and accessibility in healthcare. Additionally, there would need to be public education and outreach efforts to inform individuals about the changes and ensure that they are able to access the care they need.

Strengthen Primary Care

The United States should consider strengthening primary care services, following the example set by countries like Japan, to improve access to healthcare, enhance coordination of care, and reduce healthcare costs. Strengthening primary care can help individuals receive timely and appropriate care for their health needs, leading to better health outcomes and lower healthcare spending in the long term. By investing in primary

care, the United States can address disparities in healthcare access and improve the overall quality of care for Americans.

To strengthen primary care services in the United States, several steps could be taken. This could include increasing funding for primary care providers, such as family physicians, nurse practitioners, and physician assistants, to ensure there is an adequate workforce to meet the needs of the population. Additionally, implementing policies that incentivize primary care providers to deliver comprehensive, coordinated care, such as through value-based payment models, can help improve the quality and efficiency of care. Expanding access to primary care services, particularly in underserved areas, through telehealth and other innovative approaches can also help improve access to care for all Americans.

Implementing these changes would require a significant shift in the healthcare system in the United States. This would involve reallocating resources to prioritize primary care, such as increasing funding for primary care training programs and expanding access to primary care services in underserved communities. Additionally, there would need to be changes in payment models to incentivize primary care providers to focus on preventative care and chronic disease management, rather than on volume-based care. This shift would require collaboration between the government, insurers, healthcare providers, and other stakeholders to develop and implement policies that support a stronger primary care system.

Streamlined Payment System

The United States should consider adopting streamlined payment systems for healthcare, like those used in countries like Australia, to improve efficiency, reduce

administrative costs, and enhance the overall quality of care. Streamlined payment systems can simplify the billing process for healthcare providers and insurers, reducing paperwork and administrative burdens. This can lead to cost savings and allow providers to focus more on patient care. Additionally, streamlined payment systems can help improve transparency and accountability in healthcare pricing, making it easier for patients to understand and compare costs.

To implement streamlined payment systems for healthcare in the United States, several pathways emerge. This might include transitioning to a single-payer system, where a single entity, such as the government, acts as the sole insurer for healthcare services. This would simplify the payment process, reduce administrative costs, and ensure that all Americans have access to affordable healthcare. Another approach could be to standardize billing practices and codes across healthcare providers and insurers, making it easier to process claims and track payments. Additionally, implementing electronic health records and other digital tools can help streamline payment processes and improve communication between healthcare providers and insurers.

Implementing streamlined payment systems for healthcare in the United States would require significant changes to the current healthcare system. This would involve overcoming resistance from various stakeholders, including healthcare providers and insurers, who may be reluctant to change existing payment systems. It would also require investment in healthcare infrastructure, including electronic health record systems and other digital tools, to support streamlined payment processes. Additionally, there would need to be public education and outreach efforts to inform individuals about the changes and ensure that they are able to access the care they need.

Autoenrollment

The United States should consider adopting an autoenrollment system for health insurance, like Australia's approach, to enhance healthcare coverage and reduce the uninsured population. Autoenrollment can help overcome barriers to enrollment, such as lack of awareness or confusion about the enrollment process, by automatically enrolling eligible individuals in health insurance plans. This can lead to higher rates of coverage and improved access to healthcare services for those who may otherwise remain uninsured. Additionally, autoenrollment can help stabilize insurance markets by increasing the number of participants, which can help reduce costs for everyone.

Implementing an autoenrollment system for health insurance in the United States could work by using existing data sources, such as tax records or enrollment in other social programs, to identify individuals who are eligible for coverage but not currently enrolled. These individuals could then be automatically enrolled in a basic health insurance plan, with the option to opt out or choose a different plan if they prefer. This approach could help simplify the enrollment process and ensure that more people have access to health insurance coverage. Additionally, outreach and education efforts could be used to inform individuals about the autoenrollment process and their options for coverage.

To implement an autoenrollment system for health insurance in the United States, several changes would need to occur. This would include updating existing laws and regulations to allow for autoenrollment and ensure that individuals' privacy rights are protected. Additionally, there would need to be collaboration between the government, insurers, employers, and other stakeholders to develop and implement the autoenrollment

system. Public education campaigns would also be needed to inform individuals about the benefits of autoenrollment and how to opt out or change their coverage if desired.

In conclusion, implementing a comprehensive set of reforms modeled after successful healthcare systems in other countries could transform the United States into a great healthcare system that eliminates the financial burden on its citizens. Universal health coverage would ensure that everyone has access to essential healthcare services, while regulation of supply and prices would control costs and improve affordability. A more equitable system with cost sharing and broad benefit coverage would address disparities in access to care, while strengthening primary care and implementing streamlined payment systems would improve the quality and efficiency of care. Additionally, autoenrollment for health insurance would increase coverage rates and reduce the number of uninsured individuals.

However, the biggest barriers to implementing such reforms include political resistance, unconditional interests in the current system, complex regulatory frameworks, and the sheer scale and complexity of transitioning to a new healthcare system. Overcoming these barriers will require bipartisan cooperation, stakeholder engagement, public education, and careful planning. Demographic factors such as the aging population, increasing diversity, and varying healthcare needs across different regions of the country will also need to be considered to ensure that the reforms are tailored to meet the unique needs of all Americans. By adopting these reforms, the United States could create a healthcare system that prioritizes the health and well-being of its population, without imposing undue financial hardship on individuals.

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