# The many roads to universal health care in the USA

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**Health-care systems in different countries have evolved along different paths, with some countries offering private insurance, some universal health care, and some a mixture between the two. In most high-income countries, health care is considered a human right and is provided universally, typically free at the point-of-care. The USA has developed a fractured for-profit system that is substantially more expensive than those of its European counterparts and delivers poorer outcomes than the health-care systems in other high-income countries, while leaving a substantial proportion of Americans without health coverage. This Personal View discusses the current health-care system in the USA and offers a roadmap towards the achievement of universal health care for the USA. Three key components of the roadmap are: support and improve the Affordable Care Act; maintain the existing private insurance system; offer in parallel a government-sponsored health-care insurance, or gradually expand Medicare to more people, and ultimately to all Americans not covered under existing health-care insurances.**

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## Introduction

As of 2019, the EU and the UN recognise health care as a human right,[1] but the USA does not. Over time, most high-income nations have developed successful universal health-care programmes, but, by contrast, the USA has developed a fractured for-profit system that is substantially more expensive and delivers poorer outcomes compared with other high-income countries.[2,3] The original driving triad for the US for-profit system was the idea of American exceptionalism, the for-profit nature of our health-care industry, and physicians' concerns over income.[4] Medicare, Medicaid, and the Patient Protection and Affordable Care Act (ACA) have aided the progress of the American health-care system, covering the most vulnerable Americans[5,6] and reducing the number of people who are uninsured by half. However, because of political ideologies, the ACA have been weakened, leading to increasing costs, rising premiums, and leaving 29 million Americans without coverage.[7]

The US health-care system is the most expensive in the world (valued at US$3·4 trillion in 2016; 18% of national GDP *vs* 5–12% in Europe and Canada).[1] The for-profit nature of US health care has introduced perverse market incentives such as high costs of drugs, high deductibles, and out-of-product expenses. However, rather than working to improve coordination of care and reduce total costs and individual spending, health-care entities (insurers, drug companies, hospitals, physicians) leverage their powers to increase their own market share and profitability.

## Effect of health care on patients with cancer

The dynamics and particularities of a health-care system affect patients with cancer disproportionately. Since 1900, the global average human life expectancy has more than doubled to about age 70 years today.[8] Consequently, more people live longer and, as a result, more people develop and die of cancer. According to the American Cancer Society, one in three Americans are expected to have cancer in their lifetimes,[9] and it is the second most common cause of death in the USA. In 2019 alone, more than 1·7 million Americans will be diagnosed with cancer and 600 000 will die of their disease.[10] Several factors explain why patients with cancer are affected by the dynamics of the health-care system to a greater extent than other patients. Unlike many reversible medical conditions (eg, pneumonia, urinary infection, allergies) or less serious chronic conditions (eg, arthritis, hypertension, diabetes, coronary artery heart disease), cancer is a chronic condition and can be fatal if left untreated, requiring a multi-disciplinary approach and therapy over the course of several years. These cases of cancer, together with the high cost of patented cancer drugs, inpatient and outpatient care, multiple frequent testing, and high out-of-pocket expenses and deductibles, results in a higher proportion of debts, bankruptcies, abandonment of care, and mortality, than observed for patients with other medical conditions.

A single complete blood count, which might be required 2–3 times weekly for several years for some cancers, can cost an average of $300 per test.[11] Scientific advances in detection and treatment have also led to increased costs and increased financial burdens. In 2015, total direct health-care expenditures for cancer were more than $80 billion, with about $4 billion being out-of-pocket expenses.[10] The indirect costs of a cancer illness, disability, and early death are greater than $130 billion.[12] The price of newly approved cancer drugs has increased from less than $10 000 per year before 2000, to at least $170 000 per year in 2017.[13] New anti-cancer drugs, such as checkpoint inhibitors—now widely used across multiple cancer types, either alone or in combination with other treatments—can cost even more. One chimeric antigen receptor (CAR) T-cell infusion, for example, (soon to be widely used in acute lymphoblastic leukaemia, lymphomas, and multiple myeloma), costs about $500 000; however, the total cost of this treatment, including pre-infusion and post-infusion care, can cost up to $2 million.

Out-of-pocket expenses in private and employer-based insurance plans have increased insidiously and substantially over the past 5 years and can be as much as 25% of the total cost. Deductibles in such plans have quadrupled over the past 12 years. Notably, two decades

ago, cancer therapy mostly involved surgery, radiotherapy or intravenous chemotherapy, or a combination, and were delivered in hospital settings and covered by Medicare for older patients. As a result of the cancer therapeutic revolution (advent of targeted and immunotherapies), numerous highly effective and expensive oral targeted therapies are now available. Because these therapies are oral and can be self-administered, they are not covered by the major medical part of commercial plans or Medicare Part A, but are covered under prescription plans instead (for older patients, Medicare Part D). Even if the prescription benefit managers agree to cover the drug, deductibles and out-of-pocket expenses frequently cause financial problems for patients and their families.

Financial hardship in patients is often divided into three domains: material (problems paying bills or bankruptcy), psychological (stress), and behavioral (delaying treatment because of cost). New research shows that more than half of patients with cancer in the USA report issues in one or more of these areas.[14] Medical bills contribute to 60% of personal bankruptcies, even though three quarters of these individuals are insured.[15] Laws limit annual out-of-pocket spending, but in 2017, the maximum spend was $7150 for an individual and $14 300 for a family of four (two parents, two children)—a substantial amount for many consumers who are living paycheck to paycheck. These costs do not include monthly premiums and only apply to services covered under individual plans.

Considering that the probability of developing cancer increases with age, is more common among senior Americans, and that the average family income of seniors is about $26 000 per year, deductibles for cancer care can easily cause bankruptcy or force patients to abandon their cancer care altogether.[15] Patients with cancer who declare bankruptcy also have a greater risk of death than those who do not. In 2016, out-of-pocket spending on health care tipped more than 11 million Americans into poverty. In 2018, an income of US$25 100 was considered to be on the poverty line for a family of four.[16]

## The origins of universal health care

The evolution of health care has been shaped by various historical (post World Wars), political (capitalism, socialism, communism), and economic (poor *vs* rich nations) events and conditions, and diverged into different but successful universal health-care models with unique benefits and limitations. Understanding the progress and status of these universal and affordable health-care systems offers ideas as to how the US health-care system can progress in 2019 to provide optimal universal health care to Americans.

In the late 1800s, European nations began developing national insurances, primarily to address income stabilisation and wage loss resulting from illness. These national insurances culminated in successful universal health-care plans.[17] During the 1930s, American physicians and hospitals established prepaid, multi-specialty groups, and charged consumers monthly fees for services.[18] Labour unions, farmers' associations, and mutual aid societies followed similar models. Fearing loss of physician autonomy and earning potential, the American Medical Association (AMA) lobbied against these models and advocated for the so-called fee-for-service system through private insurances.[19] These efforts, along with wage controls and tax exemption for health-care benefits during World War II, led to the expansion of the private, employer-based insurance model.[20] The AMA also lobbied against universal health-care legislation, and backed efforts to brand proposals by Presidents Truman and Roosevelt as so-called socialised medicine and a communist plot.[1,4] As the private insurance company model expanded, many older and impoverished Americans were not considered eligible for insurance coverage. In 1965, President Lyndon Johnson established Medicare and Medicaid to provide the additional coverage needed. Over the next five decades, there was no further progress toward universal health care until the ACA was passed in 2010.[5,6]

## The universal health care debate

The unsustainable system and absence of universal coverage make health care the most important issue to Americans in 2019.[21] In 2013, life expectancy in the USA by age (65 years) ranked last among 17 high-income countries.[22] When Americans became eligible for Medicare, their life expectancy ranked highest among the same 17 high-income countries, suggesting that patients can receive exemplary care when given adequate coverage. Expanding Medicare to cover all Americans (Medicare for All) or more Americans (50–55 years or older; Medicare for More) is a widely popular and highly debated topic among Americans and presidential candidates. However, probing into the details of these two proposals shows they mean different things to different people.

Opponents of Medicare expansion contend it would place an unsustainable financial burden on the federal budget. Although current Medicare for all proposals, such as H.R. 1384 (originally H.R. 676), would raise taxes to the American public to cover additional costs of expanding medicine to all, and reductions in private sector inefficiencies and elimination of out-of-pocket costs for individuals would result in net savings for 95% of Americans.[23] Given the rapidly expanding wealth gap in the USA, and the fact that 45 000 Americans die annually because of no insurance,[24] having the top 5% of income earners contribute more tax is a reasonable proposal to help achieve universal health care.

Some politicians caution that federally funded universal coverage compromises integral American ideals such as freedom of choice and individual responsibility.[25] But in health care, the threats of illness, death, or crippling

expenses create distorted market forces that are distinct from ones that typically guide purchasing decisions of other goods or services that will not effect human life. For most Americans, freedom is already restricted by private entities (including employers, insurers, pharmaceutical companies, and other industries or entities) that dictate coverage plans, providers' networks, and costs. For millions of working Americans, such considerations (freedom of choice in health care) are irrelevant because they cannot afford insurance. Most advanced capitalist economies (ie, Australia, Canada, Europe, Japan) acknowledge this dynamic and have opted to limit profits when providing health care. A similar system in the USA would grant Americans more, rather than less, freedom—the freedom to live without the consequences or fear of illness and death, and the freedom to receive more equitable health care that would reduce the large current average life expectancy gap between the rich and the poor.

Initial estimates of annual cost projections to implement Medicare for All (H.R. 676) in 2013 ranged from $1·3 trillion to $3·2 trillion.[26–28] Several independent studies indicate that the USA can break even or even save money with a single-payer system.[29] Savings from reduced administrative and pharmaceutical costs ($570 million to $616 billion) would offset the costs of covering an additional 27 million Americans ($326 billion).[30]

Health-care costs in the USA have increased from $2·5 trillion in 2011 to $3·4 trillion in 2016. In 2011, so-called health-care cost waste (defined as spending that could be eliminated without affecting overall quality of care) accounted for 34% of total health expenditures.[31] A 2018 analysis showed similar estimates: $0·4–1·5 trillion of $3·4 trillion spent can be wasted in non-patient activities (such as administrative processes and paperwork).[32] Adjusting for health-care inflation, wasteful spending probably exceeds $1 trillion nowadays.[33] Although many factors can contribute, three areas drive the majority of modifiable health-care inflation: hospitals, insurance administration and profits, and prescription drugs.[32–36]

In 2012, a meta-analysis[34] showed that waste accounted for about 31% of Medicare and Medicaid spending compared with 41% in private plans. Administrative costs for private insurance plans average 11·5%. Even among Medicare plans, administrative overheads for government-issued Medicare is 2·4% compared with 12·6% for privately managed sectors of Medicare.[35] Expanding Medicare to all would reduce waste in general administrative costs.

Price transparency and variability play an important role in high hospital costs. In 2018, the federal government began requiring hospitals to be transparent about prices, but experts suggest the complexity of these price lists limits usefulness to individual patients. As market consolidation trends show, a single-payer system would have more leverage to negotiate with hospitals compared with individual insurers. Additionally, lower prices would translate directly into savings for taxpayers rather than generating more profits for private health-care entities.

Empowering government agencies to negotiate lower hospital prices has already proven to be beneficial in reducing costs. In 2011, the California Public Employee Retirement System (CalPERS) capped reimbursements for various procedures (arthroplasty, cataract removal, arthroscopy, and colonoscopy), and used government data to publish a list of hospitals providing these services within their cost parameters. Within 2 years, prices dropped by an average of 26% with no change in quality outcomes, saving nearly $6 million.[36] Although this amount appears small, this example serves as a proof-of-concept, which, when extrapolated to the entire health-care system, could possibly result in substantial savings. Hospitals that did joint replacements at lower costs had market share increases of 28%, forcing surrounding providers to lower their prices for joint replacements.[37]

## Roadmap toward universal health care in the USA

The many health-care plans and proposals (Medicare, Medicaid, ACA, and Medicare for More or for All bills) have one aim: to provide affordable health care to all Americans. Models of successful, affordable, and accessible universal health-care systems already exist in other countries. These models vary from mostly government-based, public single-payer systems (Sweden, Norway), to health-care systems offering side-by-side government-sponsored public options and different degrees of private insurances (Canada, France, the UK), to private insurance plans under government supervision (Germany).

As of 2019, about 29 million of 327 million Americans remain uninsured, down from 50 million following the implementation of the ACA in 2010. This number of uninsured Americans is still unacceptable and arguably immoral in a large, advanced, rich country such as the USA. Among the 298 million Americans insured, 217 million have private insurance (employer-based —181 million; direct purchase—52 million), and 122 million have government-based plans (Medicare —56 million; Medicaid—62 million; military health care—16 million).[38] Under the ACA, Medicaid now covers 75 million Americans, an increase from 50 million who were covered before the law was enacted.

Implementation of the ACA provided major progress in health care. However, rather than garnering subsequent expansion as many had hoped, it was weakened by legislation and by some politically driven and some ideologically driven actions that resulted in fewer patients being insured than one might have hoped, and resulted in an increase in insurance premiums (because of an increased number of unhealthy people choosing to buy ACA insurance and fewer young and healthy people wishing to be covered). Additionally, various decisions weakened the ACA, including the Supreme Court decision in June, 2012, to uphold the constitutionality of

the ACA individual mandate and insurance subsidies, but strike down the requirement for states to accept the ACA Medicaid expansion[39] (in 2019, there are still 14 states that have chosen not to expand Medicaid, if they did, the number of uninsured would decrease by 4–5 million); an executive order issued by President Trump to stop subsidies; an executive order that prevented enforcement of mandate penalties by the Internal Revenues Service; reducing ACA funding by 90% to advertise and support infrastructures for the 2017 and 2018 exchange enrolment periods; and, statements by President Trump and others that the ACA is approaching a downward spiral and will collapse.

In fact, the ACA is a positive and important step in health care. Weakening it for political and ideological reasons serves no good or moral purpose, and results in difficulties for the most vulnerable Americans. However, the ACA is far from perfect, but rather than "Repeal and Replace" the legislation, a policy of "Remedy and Restore" through positive legislative steps could solve the ACA's shortcomings.

How do we change the current US system into a health-care system for all? Many proposals are under consideration. They are broadly described as universal (a single public system that eliminates private insurance) and incremental (gradual expansion of Medicare while preserving private insurance). Proposals include "Medicare for More" (offering existing Medicare to people aged 50–55 years or older who are not insured under other programmes); "Medicare for All" (Medicare offered to all ages—this was proposed as an amendment to the original ACA but removed as a condition by private insurers for their support of the ACA, because they would only provide support if the "Medicare for All" clause was not included); and repairing the existing ACA.

Accounting for the preferences of Americans over decades (American exceptionalism, freedom of choice, anti-socialism), the choice of a single-payer public option that excludes private insurances is a non-starter for many, since 70% of the 180 million people who have employer-based coverage claim they are satisfied with the coverage they receive.[40] The single-payer public health-care system is also highly vulnerable to inflammatory political campaign slogans (eg, "socialised medicine", "medical communism") that could sway many Americans against a public health-care system. In order to have the approval of the majority of Americans, health-care proposals should keep the current private insurance system and offer government-sponsored Medicare and Medicaid to more people instead. Additionally, any reform must also remove restrictions on the abilities of government programmes to negotiate bulk drug prices, and must cap premiums, out-of-pocket expenses, and deductibles to affordable levels that do not lead to an abandonment of care, bankruptcy, and, ultimately, death.

### Search strategy and selection criteria

Published and unpublished data for this Personal View were identified by searches of PubMed, MEDLINE, and references of relevant articles in the English language, done on March 15, 2019.

## Conclusion

The health-care system in the USA results in serious medical, socio-economic, and psychological burdens among American patients, particularly patients with cancer.[41] The direct and indirect costs of cancer continue to rise, as do the number of patients, particularly with an aging American population. The key to making health care better is access to universal affordable insurance (insurance for all rather than Medicare for All). Other necessary improvements include wider access to prevention and early detection services (early cancers are frequently easier and less expensive to treat); price limits on prescription medications; shifting coverage of oral anti-cancer therapies to major medical coverage rather than prescription drug plans; expanding the use of the anti-cancer human papillomavirus vaccination; and more emphasis on campaigns to discourage smoking, sun exposure, and unhealthy diets. Attempts by private-sector entities to reform the US health-care system have not been successful. For-profit strategies consistently result in wasteful spending, more bureaucracy, and greater inequality. Government programmes have already shown promise in containing costs and in improving outcomes. Allowing broader government-sponsored programmes to run in parallel with private insurances is in the spirit of American ideals (capitalism, free-market forces, and freedom of choice) and will, through incremental steps, uncover the best health-care system for the USA.

**Contributors**

HK and GJ contributed equally to the writing of this Personal View.

**Declaration of interests**

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