How to Fix American Health Care

What Other Countries Can—and Can't—Teach the United States

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Best practices: a doctor's office in Minden, Germany, July 2016
Maurizio Gambarini / AP images

There are many statistics that illustrate the flaws of the U.S. health-care system. One in particular stands out. In 2017, Americans spent an average of $10,224 per person on health care, according to a Kaiser Family Foundation study. The equivalent figure across similarly wealthy countries that year was just $5,280. Yet despite spending almost twice as much as Australians, Canadians, Japanese, and many Europeans, Americans suffer from lower life expectancy, higher infant mortality rates, and a higher prevalence of heart disease, lung disease, and sexually transmitted infections.

This reflects the deep dysfunction in the U.S. health-care system. Experts estimate that around 30 percent of the money spent on health care in the United States—around $1 trillion a year—is wasted on

inefficiencies, excessive administrative expenses, the duplication of services, and fraud and abuse in insurance claims. Meanwhile, huge numbers of Americans remain uninsured or underinsured. The 2010 Affordable Care Act (ACA) attempted to address such problems but has proved insufficient for many reasons—including the Trump administration's efforts to hollow out the legislation.

It is true that some Americans have better access to advanced technologies and drugsthan do most Canadians and Europeans. And in certain fields, such as cancer diagnostics and treatment, the United States offers unsurpassed care. What is more, on average, Americans experience shorter wait times for certain specialty services, such as orthopedic surgery. But the fact remains that when it comes to health care, Americans pay more and get less.

Establishing truly effective and affordable universal health care will require a dramatic overhaul. Just what sort of change will be necessary is the subject of fierce debate right now, especially within the Democratic Party. One alternative would be to shift to a single-payer system along the lines of the Medicare for All proposals introduced by Senator Bernie Sanders of Vermont and Senator Elizabeth Warren of Massachusetts, who are running for the Democratic presidential nomination. If properly carried out, such a plan would be cost-effective and would bring about major improvements in U.S. health care. But it is far from certain that it would prove politically possible, since it would require raising taxes and, even more controversial, abolishing most forms of private health insurance.

U.S. policymakers should adapt rather than adopt foreign health-care systems.

A less far-reaching, less cost-effective, but perhaps more politically achievable option would be a gradual transition that would maintain the multiple-payer model for two to three decades while steadily increasing the role and authority of government at the federal and state levels. The ultimate result would be a hybrid system in which a number of insurers, including private ones, would continue to exist but a single payer—a partnership between the federal and state governments—would predominate.

Proponents of major reform often point to the disparity between health-care costs and outcomes in the United States and those in other developed economies and argue that Washington should look abroad to fix what is broken at home. This is indeed a good idea—but only if U.S. policymakers choose the right foreign models. For examples of highly successful single-payer systems, they should look to Canada and Taiwan. For inspiration on a hybrid system that would not require scrapping private insurance right

away, they should consider the German model. The governments and societies of those places differ in important ways from those of the United States, of course; in considering foreign health-care systems, U.S. policymakers should adapt rather than adopt. But any reform effort that ignores these successes would deprive Americans of solutions that would allow them to live longer, healthier lives.

A DIFFERENT KIND OF AMERICAN EXCEPTIONALISM

The United States is the only advanced economy that does not offer universal health-care coverage. For the past five decades, Washington has moved in fits and starts toward that goal but has never quite arrived. In 1965, major reforms to expand insurance coverage led to the establishment of Medicare (to cover the elderly and the disabled) and Medicaid (to cover the poor). That expansion was extended in 2010 by the ACA, or Obamacare, which made coverage accessible to the "near poor" (those making an income between the poverty line and 25 percent above it) and others without health insurance. Today, however, 28 million Americans remain uninsured, and 44 million are underinsured, meaning they spend more than ten percent of their incomes on out-of-pocket health-care expenses.

This has a profound effect on American society. The news media often focus on the more than half a million household bankruptcies that medical bills induce every year, but other substantial harms are less well recognized. The uninsured and the underinsured delay or even forgo treatment when they are ill, and their children often do not receive critical immunizations. This contributes to a pernicious form of inequality: on average, the top quarter of American earners live ten years longer than those in the bottom quarter. Making matters worse, the system is terribly inefficient. The amount spent in the United States on administrative expenses related to health care is three times as high as that in other advanced economies. That is because in a multiple-payer system, insurers offer many different policies, each one featuring distinct benefits packages, premium rates, and claim procedures. At the same time, insurers negotiate separately with hospitals and clinics, which means they pay different prices for the same services. So to file claims, health-care providers have to employ vast administrative staffs to sort out the various plans, rules, and prices.

Fraud and abuse also drive up the price of care, accounting for around $150 billion in unnecessary spending every year, according to the best estimates available. A cottage industry has sprung up to advise hospitals and physicians on how to game the claims system by fragmenting bills and "upcoding" services —exaggerating their complexity—in order to maximize payments. Large providers now employ workers whose main task is to find ways to pad charges. Some hospitals and clinics take a blunter approach: they simply file claims for services they have not actually performed.

ACA supporters in Washington, D.C., June 2017
Aaron Bernstein / Reuters

The structure of the U.S. system also plays a role in driving up prices. Multiple payers lack the market power to negotiate effectively with pharmaceutical companies and providers for reasonable prices. When one insurance plan is able to negotiate a lower price, a company or a provider can adapt by simply charging other insurance plans higher prices. Indeed, the exact same service or medical procedure can vary in price by more than 300 percent. Meanwhile, in some places in the United States, hospitals enjoy a monopoly on most forms of medical care, which allows them to charge high prices. And even in places where competition exists, patients often mistakenly believe that higher prices indicate a higher quality of care.

The root of these problems is that as the United States became a prosperous, industrialized society in the early twentieth century, it chose to treat health care as a commercial product rather than as a social good, such as education. As a result, whereas government-mandated universal schooling had become the norm by the 1920s, health care still remains primarily a private-sector activity driven by the profit motive.

But the markets for health insurance and health care have failed in a number of serious ways. Consider, for example, the effects of the asymmetry of information between buyers and sellers of health insurance, what economists call “adverse selection.” Unhealthy people are much more likely to buy insurance than healthy people, which drives up premiums to unaffordable levels. Insurers, meanwhile, optimize profits by trying to sell coverage only to those they consider “good risks,” such as relatively young and healthy

people, and by avoiding the unhealthy, the disabled, and the elderly. A similar asymmetry distorts the health-care market, because physicians (the sellers) have far superior medical knowledge compared with patients (the buyers), which puts the former in a dominant position in any transaction.

In a hybrid system, private insurers would continue to exist, but a single payer would predominate.

The system of employer-based health insurance that defines the current U.S. system blossomed during World War II. At that time, wages were largely frozen, and employers found that offering health insurance was one way to compete for scarce workers. After the war, the United States did not follow European countries in establishing universal health insurance programs owing in part to institutional opposition from powerful special interests that took advantage of the politics of the early Cold War period. In the late 1940s, President Harry Truman made a concerted effort to introduce national health insurance. But the deep-pocketed American Medical Association opposed the program, hoping to protect physicians' superior market power and professional autonomy. The AMA mobilized its nationwide network of county medical societies to stir up fear that the plan would lead to "socialized medicine." The AMA went so far as to call the plan "un-American" and deride the Truman administration as following "the Moscow party line." Opponents of universal coverage have relied on variations of the same playbook ever since.

Slowly but steadily, however, public sentiment has shifted, resulting first in the advent of Medicare and Medicaid and later in the passage of the ACA. According to public opinion polls conducted by the Kaiser Family Foundation, between 2000 and 2019, the proportion of Americans with a favorable opinion of a single-payer, government-run health insurance system rose from 40 percent to 53 percent. The question, it seems, is no longer whether the United States will establish a single-payer system, or at the very least a hybrid system radically different from the one it has now. The question, instead, is how that change will take place and what kind of system it will produce. To help find answers, Americans should look to three places: Canada, Taiwan, and Germany.

HEALTHY, WEALTHY, AND WISE

Canada established single-payer universal health insurance in 1968. The Canadians opted for a one-tiered system built on the principle that coverage should be not just universal but also equal. Canada thus forbids private insurers from duplicating the benefits offered by the government and prohibits physicians and hospitals from serving both publicly insured patients and those with private insurance. Providers must choose to serve one group or the other.

In the Canadian system, the federal government sets national standards and funds 50 percent of the cost. The country's 13 provinces fund the other half and run their own programs, acting as the single payer for

their residents, determining payment rates to providers, and negotiating with pharmaceutical companies. This arrangement vastly reduces the potential for fraud and waste because the single payers maintain uniform records of each medical transaction and closely monitor every provider's behavior. In 2018, Canada spent $4,974 per person on health care. Administrative expenses related to insurance accounted for just six to eight percent of overall spending because there is only one set of rules and procedures for filing claims. Likewise, hardly any fraud or abuse occurs because a comprehensive data-collection system allows authorities to monitor the performance of all providers. And the system is highly effective: life expectancy in Canada is 82 years, and the infant mortality rate is 4.5 deaths per 1,000 births—better on both counts than in the United States, where life expectancy is 79 years and the infant mortality rate is 5.8 deaths per 1,000 births.

Sanders visits a hospital in Toronto, Canada, October 2017
Aaron Vincent Elkaim / The New York Times / Redux

Canada served as the most important model for Taiwan, which established universal health insurance in 1995. Like the Canadians, the Taiwanese set up a single-payer system in which people freely choose their providers, which encourages clinics and hospitals to compete on quality and efficiency. But there are some significant differences between the two approaches. As a small, densely populated island, Taiwan opted to centrally administer its program. Patients also have modest copayments to deter the overuse of services and drugs. In Canada, government budgets finance the program, which means that the level of support fluctuates, depending on the agenda of the political party in power at any given time. Taiwan, in contrast, adopted a more stable financing arrangement that relies on earmarked taxes, insulating the

system from changes in the political landscape. Taiwan also took inspiration from the actuarial methods used by the U.S. Medicare program to assure its long-term sustainability.

Taiwan leapfrogged other countries with single-payer systems by developing innovative data technology to monitor patients' care and to detect and deter fraud and abuse. For example, in the initial years of its program, Taiwan found that several physicians were submitting suspicious bills that, had they been accurate, would have required them to work 24 hours a day, seven days a week. Administrators turn over such suspect claims to a local committee of practicing physicians, which deals with fraudsters by applying sanctions—including, in serious cases, stripping them of their licenses to practice. During the first year in which this process was followed, the overall amount that physicians and hospitals charged the system fell by eight percent.

The Taiwanese system is remarkably cost-effective: in 2016, Taiwan spent $1,430 per person on health care, and only between five and six percent of that spending related to the administrative costs of the single-payer system. As in Canada, there is hardly any fraud or abuse. And as in Canada, life expectancy (81 years) is better than in the United States, as is the infant mortality rate (3.9 deaths per 1,000 births).

Should the United States treat health insurance primarily as a commercial product or as a social good?

Germany offers a different model—not least because its system has evolved over a long period of time. In 1883, German Chancellor Otto von Bismarck declared that industries, occupational guilds, and agricultural cooperatives would have to form nonprofit health insurance programs, called "sickness funds," for their members. Numerous funds were established, each one offering distinct benefits packages, premium rates, payment rates to providers, and claim procedures. People could enroll in the fund of their choice. But many opted out and remained uninsured. Eventually, in 1914, Germany passed legislation compelling all workers in selected industries earning less than a certain amount to obtain coverage; those who earned more could voluntarily enroll or purchase private insurance. After World War II, West Germany continued that system, which was extended to the former East Germany after reunification.

Germany's multiple-payer system, however, suffered from inefficiency and waste because separate groups of people were pooling their health risks, which led to highly variable premium rates. So in the 1990s, Germany's legislature began requiring all funds to offer a standard benefits plan. The various funds pool the premiums they receive, which the central government then allocates to the funds based on the health risks of the people enrolled in them. Meanwhile, associations of sickness funds in each state negotiate with that state's medical association to design a single set of claim procedures and a uniform payment rate for physician services. Likewise, all hospitals in a given state negotiate one uniform set of

rules, procedures, and rates with that state's hospital association. One result of these reforms has been a vast reduction in the number of sickness funds, from around 1,200 in 1993 to just 115 today.

Germany's hybrid system now relies on doctors in private practice for physician services and a mixture of public and private hospitals for hospital care. Patients can freely choose their providers. The federal government sets the rules and negotiates with pharmaceutical companies, allowing Germany to keep drug prices relatively low. In 2017, Germany spent $5,728 per person on health care. Some fraud and abuse exist, but at far lower levels than in the United States. Life expectancy is better than that in the United States (81 years), and the infant mortality rate (3.4 deaths per 1,000 births) is lower.

THE PERFECT AND GOOD

A number of clear lessons for the United States emerge from these three places. Perhaps the most basic one is the need for a broad public consensus about the values that should shape any reform. Should the United States continue to treat health insurance primarily as a commercial product shaped by market forces and one that everyone can choose to either acquire or do without? Or should health insurance be understood more as a social good akin to primary and secondary education: guaranteed by the state, paid for primarily by taxation, and mandatory for everyone?

If Americans do decide to shift away from a market-based system, the cases of Canada, Taiwan, and Germany show that Washington would need to mandate that every citizen and permanent resident enroll in a health insurance plan that offers a standard benefits package. Otherwise, health risks would not be pooled across the healthy and the unhealthy, the rich and the poor. The U.S. federal government could fund universal coverage through a payroll tax on both employers and employees; the poor and the near poor would receive subsidies to offset the tax burden. A better method, however, would be taxes on income and wealth, which would be more progressive and therefore fairer. Moreover, payroll taxation is less effective than in the past because in contemporary economies formal employment has become less common as companies increasingly hire independent contractors rather than staffers. It's for these reasons that Taiwan and Germany gradually shifted away from payroll taxes to fund their systems and adopted earmarked income taxes instead.

Proponents of Medicare for All should take a careful look at the German model.

Would Americans have to pay more for health care under a single-payer system similar to those in Canada and Taiwan? A definitive study published in 2018 by a team of researchers led by the economist Robert Pollin has determined that they would not. In fact, Americans would see a net reduction in overall health expenditures. According to the report, the United States could save more than $250 billion each year by establishing a single-payer system.

The plans put forward by Sanders and Warren incorporate many features of the Canadian and Taiwanese approaches: a single payer with one comprehensive standard benefits package for all, free choice of providers, uniform payment rules, and procedures that would vastly reduce administrative expenses and limit fraud and abuse. The savings would be great enough to pay for covering uninsured and underinsured Americans while still giving most Americans a reduction in their health expenses. The plans would raise taxes: some payroll, income, and wealth taxes would have to increase. But those increases would be offset by reductions in other taxes and by a vast drop in premiums.

Medicare for All, or a plan similar to it, would encounter strong opposition. People's fear of a major change would be a paramount obstacle. Americans who are currently insured might worry that their benefits would be reduced. Physicians, nurses, and hospitals might see a threat to their incomes. The public would resist higher taxes, even though they would be paying less for health care overall. And insurance companies, pharmaceutical firms, and powerful interest groups such as the AMA and the American Hospital Association would lobby hard against a shift to genuine universal coverage. Although Americans have begun to take a more favorable view of single-payer systems in recent years, it's far from clear that the idea has enough popular support to clear such hurdles.

Warren speaking in Washington, D.C., September 2017
Yuri Gripas / Reuters

Perhaps a more practical approach would be for the United States to follow Germany's lead and to undertake reforms that would allow for multiple insurers but create a uniform system of payments and

electronic records to help control waste and fraud. Such a system would also let insurers collectively bargain with major pharmaceutical companies for reasonable drug prices. These measures alone could save somewhere between $200 billion and $300 billion each year—savings that, along with modest tax increases, could be used to expand existing public coverage for the uninsured.

Over time, the United States could go further, as Germany did, and pool the enrollees of various private insurers into a state-level or federal-level risk pool and then introduce regional health budgets to control costs. This gradual approach might take two to three decades and would likely require additional taxes along the way, since the savings available under this hybrid system would not be sufficient to cover the uninsured and the underinsured. But the German alternative would not require the abolition of private insurance in the near term, thus sidestepping one of the most politically problematic aspects of Medicare for All.

It's possible that public sentiment will continue to shift and that support for a straightforward single-payer system will gain enough momentum to overcome the institutional and political obstacles that stand in its way today. In the meantime, however, proponents of Medicare for All and other sweeping reforms should take a careful look at the German model. It may not achieve all their goals as quickly as they would like. But the perfect should not be the enemy of the good, and such an approach would put the United States on the road to an equitable, sustainable, and affordable system of health care for all Americans.