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National Health Insurance for the United States

Ashley Herrell
amcgill@murraystate.edu

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Murray State University

Abstract

Approximately 46 million U.S. citizens lack health insurance despite the nation's abundant resources. The imperative for universal healthcare arises, with a proposed solution being mandatory national health insurance. This paradigm shift, championed by the U.S. House of Representatives, Senate, and citizens, aims to eradicate the issue of people foregoing healthcare due to lack of insurance, promising to enhance collective well-being. The U.S. stands out among high-income countries without comprehensive universal healthcare, leading to disproportionately high out-of-pocket expenses and inferior health outcomes. Social determinants like income, race, and rural residence exacerbate the challenge by limiting healthcare access for vulnerable groups. Embracing a 'universal healthcare' paradigm could transform the U.S. healthcare landscape, ensuring quality, economic viability, and the elimination of discriminatory barriers. A preferred model involves a private-sector, government-funded single-payer system, viewed as the clear answer to the healthcare crisis. This robust, publicly funded, non-profit initiative could provide affordable, comprehensive medical coverage for all Americans, making it the only viable option. The bottom line is a single-payer national health program is not only affordable but the only affordable option, poised to deliver on its promise of superior quality, economic viability, and the elimination of discriminatory barriers in fostering a more equitable and compassionate healthcare system.

Table of Contents

Introduction

Many Americans recognize the necessity for the United States to install a national health insurance plan for all citizens. Serious challenges lie ahead unless the United States can install a better model of health care delivery. The nation needs to invent methods to control the rising consumption of healthcare resources, and all the costs associated with the overuse of resources. This abuse of medical resources steals from the American public. That is why I believe installing a national health policy will prevent such criminal behavior and would eliminate the problem altogether. Another reason to reform our healthcare infrastructure and manage our resources fiercely is the shortage of physicians. The United States population is rapidly aging and will require more geriatric care. The future of healthcare will be determined by how certain forces of innovative changes interact. The most serious issues remain in the areas of cost, coverage, access, and affordability. Eventually the nation will have to come to an understanding with what it can afford in terms of healthcare. A national health insurance program would increase wellbeing and in turn reduce the cost of overall healthcare spending for the nation.

Present day in the United States, the country cannot guarantee the right to health care to everyone; The United States stands as one of the scant high-income nations lacking an established universal healthcare initiative. The author, A. Alspaugh, of the article, *Universal Health Care for the United States: A Primer for Health Care Providers,* explains citizens in the United States bear heightened out-of-pocket expenses, yielding increasingly subpar health outcomes. Socioeconomic factors such as limited income, racial disparities, and insufficient resources in rural locales contribute to diminished healthcare access, exposing individuals to a heightened risk of compromised well-being. The term 'universal healthcare' encapsulates diverse healthcare system models designed to provide medical services to every resident of a nation.

Embracing such an approach holds the potential to propel the United States toward healthcare characterized by superior quality, affordability, and impartiality. The imperative for universal healthcare is rooted in principles of procreative justice and human rights. The discourse delves into the historical efficacy of health insurance in the United States, scrutinizing economic rationales for adopting universal healthcare and exploring international frameworks that could be adapted domestically (2021, Alspaugh).

The United Nations has acknowledged attaining universal health coverage stands out as a pressing global imperative. Endeavors directed toward this aim benefit from well-founded research encompassing scientific, technical, and administrative facets of health system design. Regrettably, a significant segment of the global population continues to lack access to essential health services despite these concerted efforts. Universal health coverage is an idea that is increasing recognition that this is a political challenge. The main reason the United Nations believes every country should provide their citizens healthcare is not just because it is a necessity, but because people travel all over the world. This allows diseases to spread worldwide because of exposure to countries that cannot access healthcare. The authors of the text further explain, health literature contains fundamental tenets within the realm of political science, frequently eclipsed by central health discourses, are elucidated (Ho, 2022). This discourse leverages insights from political science research to underscore the manner in which political dynamics can either catalyze or impede policy reform aligned with self-interest. The authors proffer a nuanced analysis delving into the intricate interplay of ideas, interests, and institutions in shaping the landscape of universal health coverage. Subsequently, the text scrutinizes pivotal considerations pertaining to the implementation of pertinent policies. It contends that a political acumen applied to the concept of universal health coverage is imperative for realizing the

overarching goal of health equity and inclusivity. Evidence is indisputably important and should form the basis of health policies. Governments consistently make decisions that are conflicting with scientific and technical evidence. Hence, achieving universal health coverage should also be viewed as a political challenge (Ho, 2022). In summary this article explains why everyone needs universal insurance, and how the government has always shut down the idea for their own selfish reasons.

Economic Costs

The existing healthcare market is fundamentally flawed, showcasing a striking anomaly where the costs of a given product can differ by a magnitude of ten depending on the point of purchase—a peculiarity unparalleled in any other industry. In Elizabeth Rosenthal's work, *An American Sickness: How Healthcare Became Big Business and How You Can Take It Back*, she expounds upon the notion that the pricing of identical healthcare services is indifferent to one's employment status, whether employed, self-employed, or unemployed. Despite living in an era of medical advancements enabling procedures like transplants, gene therapy, life-saving drugs, and preventive measures, the healthcare system remains prohibitively expensive, marked by inefficiency, perplexity, and disparities. Rosenthal contends that we are all susceptible to medical exploitation, a stark reality underscored by alarming and indisputable statistics. The United States allocates one-fifth of its gross domestic product, surpassing $3 trillion annually, to healthcare—equivalent to the entire economic output of France. Remarkably, the U.S. health system yields suboptimal outcomes compared to other developed nations, despite the fact that peer countries spend on average, approximately half of what the U.S. expends per capita. The text summarizes the healthcare market in the United States and it’s how it is seriously damaged. Medical care costs vary depending on not only your coverage but also what providers are

allowed to charge legally, not ethically. The main argument is that we, the U.S., have fallen behind are peer countries in supplying health insurance to citizens as a basic right. Innovators of technology, the United States has no reason not implement a national health policy. The text explains how policymakers are lured by incentives from companies that would benefit from the current insurance marketplace, public and private payers, to remain the same (Rosenthal, 2017). Cost control management in healthcare is imperative to manage utilization of services by patients and reimburse accurate amounts to providers. This is one suggestion to eliminate fraud in healthcare, and several more will have to be considered before reaching a definite answer. A new healthcare reform would have to implement some sort of rationing for the supply of healthcare services.

Positives and negatives of a mandated universal healthcare insurance in the United States will bring joy and irritation for everyone in the nation. The author, Gabriel Zieff, describes in the article, “Universal Healthcare in the United States of America: A Healthy Debate”, that the main tasks to beginning a national health care plan of astronomical size that entails of difficulties but will prove worth the efforts. The initial expenses and practical hurdles represent the predominant challenges in the endeavor, constituting the major share of obstacles that would eventually diminish over time in contrast to the triumphant achievement of establishing widespread, high-quality healthcare for everyone. A nationwide healthcare initiative has the potential to positively impact the economy in the long term by alleviating the economic burdens associated with an unhealthy populace. The largest proportion of the health care labor force is health service professionals. Physicians play a leading role in the delivery of health care services but are maldistributed by geography and specialty in the United States. Shortages of healthcare

professionals are current and foreseen to increase in the future. It is one of the main reasons healthcare needs to be managed more scrutiny (Zieff, 2020).

The United States spends an estimated total of 37 billion dollars annually on patients with chronic conditions. Preventive care would eliminate the majority of poor health outcomes that ultimately lead to chronic conditions (Zeiff, 2020). Patients with routine health exams become aware of health concerns and minor problems, and measures of effort to resolve these health concerns would eliminate the excessive amount of revenue spent of chronic conditions; therefore, it will institute enduring and preemptive health strategies, thereby engendering heightened long-term well-being and fostering a more resilient economic milieu for the United States. Our nation has a current debt of 31 trillion dollars which makes it simple to agree we need to cut costs and prevent unnecessary health services so we can provide healthcare to all.

The view of the author C. Cai of the article, “A systematic review of economic analyses”, explains that the establishment, of a system that prioritizes a nuanced equilibrium on a discerning scale would pave the way for the advantageous evolution of single-payer financing, ultimately resulting in a favorable balance for a financial burdened system—essentially indicating that the accrued savings would surpass the associated costs. The realization of net savings might manifest in a span of 3 to 4 years, if not immediately, estimated to approximately around 3 to 4 percent. The system, utilizing expansive clinical data, would adeptly pinpoint and curtail instances of unnecessary and improper healthcare. Procedures for financial reimbursements ought to mirror those of comparable nations, while pharmaceutical expenses need to be curtailed, rendering prescriptions both accessible and affordable (Cai, 2020). While the main reason for establishing a better healthcare system for America is ultimately to give everyone access to healthcare; Many benefits will evolve from this decision such as improved patient outcomes, controlled financial

costs, and better use and sharing of resources. Any attempt to introduce national health care in the U.S. has been discouraged by the influence of the traditional American values based on capitalism, self-determination, and distrust of the government. I believe healthcare is a right that everyone should have access to when necessary to eliminate the need for the indigent to use the Emergency Department as their only source of healthcare. Preventive care should be accessible due to the fact it would be more cost efficient than the cost of providing care to the millions of Americans with chronic conditions. A decision in our government is thrown on the battleground of politics for the democrats and republicans to challenge each other in debates that never reach a conclusion. Republicans and Democrats will never reach a mutual agreement on how to effectively deliver healthcare. That is precisely why the federal democratic republic form of government that regulates America will have to make enrollment mandatory to every citizen. The rise of popularity of the idea of a national health insurance plan for the United States gives people hope that our economy, and most importantly our lives will improve.

History in Healthcare Insurance

We must be wise to the history of healthcare insurance to avoid errors of the past and to prove some leaders had the right idea all along but without the necessary support. The inception of health insurance dates back to the 1930s, emerging in tandem with the Great Depression. During this period, healthcare providers, including hospitals and physicians, adopted insurance mechanisms to guarantee compensation for rendered services. Simultaneously, both managed care and traditional insurance models took shape. The growth of employee-sponsored coverage ensued with the rise of the labor movement, alterations in the federal tax code, and the unfolding of World War II. Government funded coverage for the elderly provided by Medicare was introduced in 1965. The components of Medicare resembled the private insurance coverage

common during that time. Rivalry among commercial insurance firms intensified as they vied to provide reduced premiums to sizable employers, leveraging the lower frequency of claims submitted by these entities. Company owners would encourage their staff that employees should not utilize the insurance in a frivolous way that will drive up cost, a behavior still common for CEOs present day.

State insurance laws were federally preempted and that led to a significant increase in self-insured employer plans. Managed care was developed in the 1980s and its popularity rose due to rapid increase in healthcare costs. The appeal to selectively contract healthcare revolutionized the marketplace for healthcare from the introduction of price competition which initiated the dislike of managed care. In the 2000s, healthcare expenditures experienced a significant surge as initiatives were introduced to prompt patients to shoulder a greater share of expenses through high-deductible health plans and health savings accounts (ACHE, 2023). Subsequently, in 2010, the Patient Protection and Affordable Care Act (ACA) was instituted with the commitment to bring about substantial transformations in the health insurance landscape for the benefit of the American public.

The presidency of Teddy Roosevelt at the turn of the century occurred during the Progressive Era. The President favored the passage of health insurance legislation, although he assumed that such legislation would come from the states, rather than the federal government, and cover only the working classes. President Theodore Roosevelt supported national health insurance promoted by the American Association for Labor Legislation; he believed that no country could be strong if their people were sick and poor. Employers bore responsibility for injuries transpiring on their premises, contingent upon a court's determination of the employer's negligence. Employers had three strategies of defense against negligence. They would convince

their argument to the court that the worker agreed to take the risk, the worker's negligence was the cause of the accident, or they would argue that the worker was partially responsible.

State workers' compensation laws were created and advocates for workers' rights saw a means to fluctuate the responsibility of the costs of workplace injury to the employer. Legal costs associated with the instances of employer negligence saw a decrease, and the reforms facilitated augmented compensation for injured workers, concurrently diminishing the overall expenditures. Workers' compensation insurance was enacted during the early 1910s. Employers could purchase insurance through their state and were fully liable for all workplace injuries. The physician would receive payment for workman compensation related services until employers opted to hire their own physician so the employer would retain the money for themselves and pay the physician directly. Mining and lumber industries followed suit in firm specific clinics; majority of local physicians experienced a significant decline in their service demand. The design of subsequent health plans makes this background information relevant.

The American Association of Labor Legislation advocated for a scheme that entailed coverage for medical expenses and income loss for all manual laborers' monthly earnings less than $100. This proposal included mandatory contributions from the employee, the employer, and the state government. This plan was considered by 16 states but never was adopted as legislation. The American Medical Association (AMA) favored the idea then opposed it in 1920 due to belief it would interfere with the patient doctor relationship. Hospitals were affected by the Great Depression that began at the end the year of 1929. Justin Kimble is credited for creation of the Bayer Plan during his career as Baylor University Hospital administrator; he enrolled 1,250 Dallas publicly supported educators. The plan only covered hospital services due

to the opposition of the AMA. The model of insurance spread and evolved leading to the birth of Blue Cross.

In 1933, the American Hospital Association (AHA) instituted its Committee on Hospital Service, a body that started sanctioning healthcare plans. This committee evolved into the AHA Hospital Service Plan Commission in 1936 and eventually transformed into the AHA Blue Cross Commission in 1946 (ACHE, 2023). The stipulations for approval necessitated those plans be nonprofit, geared toward enhancing public welfare, exclusively covering hospital expenses, and permitting unrestricted selection of physicians. An additional criterion was introduced in 1937, specifying that there should be no competition among plans. The Blue Cross Commission allocated exclusive geographic market areas to each endorsed plan, a practice that persists for each nonprofit Blue Cross plan today.

The original Baylor single-hospital plan is similar to the modern preferred provider organization. Subscribers only enjoyed hospital coverage if they utilized the sole hospital within the network, presenting consumers with a financial incentive to favor one hospital over others. Soon after, various hospitals in the Dallas area introduced their own hospital service benefit plans. The all-hospital plans eliminated local hospital competition, enabling patients to reap financial advantages by selectively seeking inpatient services across different hospitals.

In 1933, the New York Commissioner made a pivotal ruling, categorizing plans as insurance rather than prepayment. This resolution addressed disputes in numerous states regarding hospital coverage. Consequently, it set the groundwork for new health plans to align with existing health insurance laws, necessitating the maintenance of financial reserves to fulfill future claims from members. The campaign for some form of universal government-funded health care has stretched for nearly a century in the United States. Many times, advocates

believed they were on the verge of success; yet each time they faced defeat. The evolution of these efforts and the reasons for their failure make for an intriguing lesson in American history, ideology, and character (PNHP, 2021).

President Harry S Truman proposed universal health care in 1949. Medicare and Medicaid were created in 1965 from the proposal by Lyndon B. Johnson with the Social Security Act; Ted Kennedy and President Richard Nixon both had proposals that promoted alternate versions of universal health care. Presidential candidate Jimmy Carter also proposed universal health care. President Bill Clinton and headed by first lady Hillary Clinton would be the next leader to try to introduce universal healthcare in 1993 but would ultimately be unsuccessful. When democrats had control of both houses of Congress with the election of President Barack Obama, it led to the passage of the Affordable Care Act (ACA), also referred to as "ObamaCare". The ACA was signed into law in March 2010, and since then, the ACA has become a centerpiece of political campaigning (Manchikanti et al., 2017).

Affordable Care Act

The Patient Protection and Affordable Care Act stated its primary goal was to create universal health coverage for everyone, specifically the uninsured. The efficacy of this act hinges on the implementation of a legal mandate that compels every citizen and legal resident to procure health insurance, under the threat of incurring a tax penalty otherwise. Obamacare’s other objectives was to make healthcare more affordable, increase the quality of care, and reduce unnecessary spending. This was to be achieved primarily by the legislation mandated everyone enrolls to increase the insurance pool which would increase the number of healthy people to lessen the risk percentage for the payer. In simple terms, the mandate distributes the corresponding risk while subsiding coverage for the economically disadvantaged (Isola, S. &

Reddivari, 2023). The fee for not having health insurance (sometimes called the "Shared Responsibility Payment" or "mandate") ended in 2018. This means you no longer pay a tax penalty for not having health coverage (HealthCare.gov, 2023).

It is difficult for anyone to accurately know whether "Obamacare" has been a success or a failure because that is dependent on the individual's situation, but I believe the majority can attest that it has created much needed attention to the healthcare crisis in America. One of the main issues of concern is that some people believe it violates them in the sense of constitutionality because they are forced to purchase a product or pay a penalty. Any time a President or political figure proposed national healthcare in the past it was rejected because people simply do not want the government to have any more control over their lives than they already do. Mandated health insurance is not new to the US; Medicare is mandated health insurance that has been administered by the federal government since 1965.

The opposition to a government role in health care is based on the fact that the vast majority of our citizens do not trust their government. Republicans are much less trusting of the federal government and much less supportive of a government role in health care than Democrats. Yet as noted, most Americans have a favorable view about Medicare, which is administered by the federal government. Some Americans have suggested that the best healthcare delivery system for the US would be "Medicare for All" since Medicare is well accepted by the American public (Dalen et al., 2015).

As has been previously discussed, access, quality, and cost are the key characteristics in healthcare that desperately need improvement. The burden of health insurance coverage is shared between the individual, employer, and the government. Coverage is purchased directly or through your employer; Government funded Medicaid qualifications must be met to enroll in

your state's plan. In the article, *Private Insurance and Universal Healthcare: How can Private Insurance be utilized within a Universal Healthcare System in the United States*, the author Michael Supanick, describes how Medicare is unique in that it provides public coverage but still remains a significant role for private insurance; Options still remain to keep basic or additional coverages by private insurers as well (Supanick, 2021).

The health care delivery model in the United States is undesirable due to it perpetuating unequal access to care, favoring treatment over prevention, and contributing to persistent health disparities and lack of insurance. Members of economically disadvantaged minority groups, encompassing Native Americans, Hispanics, and African Americans, domiciled in precarious and vulnerable communities, constitute the prevailing demographic contending with the onus of preventable diseases and health disparities. Moreover, they find themselves at the forefront of those most predisposed to the absence of insurance coverage. The historical lack of support in the United States for Universal Health Care (UHC) and Primary Health Care (PHC) with their emphasis on health care for all, population health, and social determinants of health requires community health scientists to develop innovative local solutions for addressing unmet community health needs (Dehaven et al., 2021).

The article elaborates how health disparities are currently being addressed in South Dallas Texas. The model posits that for any community health issue, whether chronic, acute, or infectious diseases; or social determinants of health such violence, food scarcity, or housing instability; health promotion and disease prevention can only be effective when clinical treatment, population health, and community organization priorities and actions are aligned. Consistent with asset-based community development, the approach acknowledges that in most communities, resources exist, and activities are already underway for promoting health on

important community issues. Thus, the role of community health science practitioners is to collaborate with those in the community who are already working on any health issues at the clinical, population, or community organization levels, facilitate communication and coordination across the levels, and contribute to partnership-building for creating sustainable solutions for population health improvement (Dehaven et al., 2021).

Social Determinants of Health

The World Health Organization defines social determinants of health (SDH) as the non-medical factors that influence health outcomes. The conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life are SDH. Economic policies and systems, development agendas, social norms, social policies and political systems are the forces and systems that determine a given populations SDH (WHO, 2023). The success of a national health insurance program will require joining efforts with other branches of studies such as Sociology, Economics, Ethnology and Agronomy. Many Americans diets consist of too many fats, carbohydrates and preservatives. Populations in rural areas that lack sustainable farming relay mainly on processed foods. This is especially true during the winter months. Inflation drives up the cost of food and makes it difficult for some to avoid unhealthy options. This is a situation all too common in smaller low-income communities.

A solution to supply affordable food options to communities by government grant funding is to build and maintain greenhouses that provide vegetable staples for a healthy diet year-round. Solar-powered greenhouse domes are an option that could prove to be beneficial for rural areas since they have proven successful in high-populated urban areas. *Reflectix* north wall insulation that helps keep the Growing Dome greenhouse warm during the long winter nights and reflects light evenly onto the plants during the day for maximum growth. Greenhouse

designs including north wall insulation provide shade in the summer and, in combination with the above ground pond, prevent overheating (Growing Spaces, 2023).

Studies reveal that social determinants can have a larger impact on a person's health than healthcare and lifestyle choices. For example, numerous studies suggest that SDH account for between 30-55% of health outcomes. In addition, estimates show that the contribution of sectors outside health to population health outcomes exceeds the contribution from the health sector. Addressing SDH appropriately is fundamental for improving health and reducing longstanding inequities in health, which requires action by all sectors and civil society (Lagasse, 2023).

All factors must be carefully considered when planning for the implementation of national healthcare system. It will be an enormous challenge switching the nation to a universal healthcare system alone while finding the way to pay for it; implementing new ways to care and improve lives will prove to be cost effective in just a shorty period of time. Nearly every overweight adult is instructed by the primary care physician (PCP) to change their diet. Instead of just instructing the patient to eat better their doctor could actually prescribe a healthy diet. This would be a main incentive to showcase how beneficial national health insurance could be for the United States. It could spark a healthy diet revolution that could eventually capture the support of mega fast-food chains to offer more veggies and less fatty carbs for the same price of a burger and fries.

Gym membership and personal trainer sessions would be another radical new prescription that would be a benefit of the national insurance program. Patients seeking laparoscopic surgery would be prescribed exercise therapy sessions to determine the medical necessity of the desired surgery. This is just an example to display how a national insurance system could remodel healthcare for everyone’s wellbeing, and these methods could be ways to

control patients overusing resources. Not every patient can change their health outcomes by diet and exercise alone, there will be some patients with health complications that will prevent much change from their current treatments. The majority's wellbeing will benefit from the prescription of making healthier choices.

Active participation in community initiatives provides a source of empowerment for individuals residing within local communities. This rings particularly true for those citizens who, despite receiving government assistance on account of physical and mental disabilities, retain the capability to contribute to their communities in meaningful ways. Among the myriad opportunities available, the prospect of part-time employment at community greenhouses emerges as a highly rewarding endeavor. By engaging in such initiatives, individuals not only nurture their own sense of fulfillment but also contribute to the flourishing fabric of their community, forging a harmonious synergy that transcends conventional boundaries.

Health Insurance Plan Classification

Today's current health insurance market sells predominantly five different types of insurance plans; Preferred Provider Organization (PPO), Health Maintenance Organization (HMO), Point of Service (POS), Exclusive Provider Organization (EPO), and High Deductible Health Plans (HDHP). Most people struggle to understand the differences between all the health insurance plans available and it is easy to understand why. Everyone wants the most for their money and that especially applies to their wellness and medical care. Why pay high premiums and agree to unreachable deductibles before the insurance benefits actually start to pay? Americans along with their employers are cornered with limited options available to choose from.

It is key to understand all insurance models to ensure no mistakes are repeated and no benefits left out of the National Health Insurance Plan designed for the United States. One of the most favored plans in America is the PPO because it has the most freedom. The Preferred Provider Organization allows the patient to out-of-network physicians and specialists without a referral; It does have higher premiums compared to an HMO and POS. A Health Maintenance Organization is usually the most affordable health plan because it generally has lower copays, premiums, and deductibles; the biggest downside in this plan is you must use a Primary Care Physician (PCP) in the network and referrals are mandatory to seek treatment form a specialist. The Point of Service (POS) plan resembles a mixture of a PPO and a HMO. This type of plan costs a bit more than an HMO, but it provides out-of-network coverage the same as a PPO plan type; the patient must get a referral just like in an HMO plan. An Exclusive Provider Organization (EPO) will only cover in-network care similar to an HMO plan type, but the networks are much larger. Referrals are determined necessary on a case-by-case basis in a EPO plan with premiums similar to those of a POS plan. Another fairly new option is a High Deductible Health Plan (HDHP) that employer's pair with a Health Savings Account (HSA). This plan is currently ideal for a patient who utilizes their insurance frequently due to medical conditions. The patient saves money in the long run due to the fact that once their deductible is paid their insurance benefits will begin to cover all the costs excluding the patient's required coinsurance.

Pharmaceuticals

A reformed healthcare system will have the challenge of financing pharmaceutical research solely on government funding. The majority of funding for clinical trials is currently paid by Big Pharma; National Institute of Health (NIH) only funds less than half of clinical trials

due to budget constraints. It is imperative to underscore the significance of clinical trial data in the approval of novel medications and the exploration of innovative treatments. Notably, the lion's share of clinical trials is financed and supervised by major pharmaceutical entities. This circumstance affords pharmaceutical companies the prospect to manipulate study outcomes or conceal potentially hazardous side effects, either to secure approval for their drugs or to enhance sales figures.

Before obtaining approval from the U.S. Food and Drug Administration (FDA), a prescription medication undergoes a sequence of clinical trials. Data obtained from these trials should ensure the safety and effectiveness of drugs before they make it into the hands of patients. The National Institutes of Health (NIH) experiences a diminishing annual budget for financing clinical trials, elucidating the rationale behind Big Pharma assuming responsibility for and orchestrating the majority of these trials. Subsequently, Big Pharma furnishes data to the FDA for drug approvals and safety evaluations post-market release. This modus operandi introduces the potential for undisclosed risks, all in service of a covetous agenda aimed at expediting drug approvals and hastening treatment availability for patients. The considerable influence exerted by Big Pharma on clinical trials may result in a skewed emphasis on a drug's benefits, while concurrently downplaying associated risks to maximize profits. Such biased information could, in turn, sway physicians to prescribe a drug without comprehensive knowledge of all potential risks involved.

Big Pharma may influence clinical trials in a number of ways, including funding the trials, designing the trials, and selecting desirable trial results. These methodologies jeopardize patient well-being by predisposing trial outcomes in favor of pharmaceutical companies. A notable illustration is presented by the New England Journal of Medicine (NEJM), a globally

esteemed medical journal that has disseminated 73 studies on novel drugs. An investigation by the Washington Post revealed that of these studies, 60 were financially backed by pharmaceutical firms, 50 involved drug company personnel as co-authors, and 37 principal investigators had received remuneration from drug companies. Consequently, this underscores the profound influence wielded by drug companies over a substantial portion of the medical information disseminated to the public. The persistent predicament of unreliable clinical trials, marked by potential bias stemming from the sway of Big Pharma, persists, as underscored by Dr. Michael A. Carome, Director of the Health Research Group of Public Citizens in Washington, D.C., who emphasized that "clinical trials for pharmaceuticals are conducted and funded by the industry" (Llamas, 2015).

A key factor contributing to the substantial sway of drug companies over clinical trials is their active role in both managing and financing a significant number of these trials. The sole current resolution to this challenge lies in augmenting the budget allocated to the National Institutes of Health (NIH) for clinical trials. This augmentation would ensure a greater number of trials maintain independence from external influences. A national health insurance system would change the way all clinical trials would be conducted. Enhanced transparency in clinical trials, reinforced by the government and national health organizations, would be achieved through the implementation of more rigorous guidelines and regulations. Pharmaceutical corporations would have to negotiate in the government’s terms to remain profitable and operational.

Major retail pharmacies are struggling after the pandemic to keep business afloat asides from the megacorporation CVS. The U.S. drugstore sector has been consolidating at an alarming rate post pandemic. In an article posted online this September by the publisher *TheStreet* confirms the inevitable truth; retail pharmacies struggle daily to keep their doors open. Author

Jena Warburton elaborates, “if a U.S. drugstore isn't implementing change, change is being forced on it, and more often than not that spells trouble. And that's before accounting for the sharp spike in shoplifting and other retail crime, which has cut deeply into drugstores' bottom lines and forced some to either shutter or chain up frequently stolen goods” (Warburton, 2023). The economy continues to worsen as prices for daily essentials skyrocket with no relief in sight. This is proof that there are just too many middlemen with their fingers in the pie. The government could control costs of pharmaceuticals from manufacturing to supplying patients directly. This method eliminates the need for pharmaceutical companies to struggle financially when they could be contracted out through the government and be financially secure.

CVS has survived the post-covid recovery with as much ease and grace as is possible in the sector. Author Jena Warburton explains how the franchise plans to stay ahead in the sector. She states, “The largest drugstore in America said in mid-September that it would launch a new company, called Cordavis, which would aim to bring down drug prices for customers by producing biosimilar medications and negotiating directly with drugmakers…CVS is also consolidating, thanks to a recent policy change that will shutter hundreds of locations at a rapid clip” (Warburton, 2023).

CVS is progressively gaining uncharted amounts of power in the health sector. The first most notable change was their purchase of Aetna Insurance; Since November 28, 2018, the company, Aetna Incorporated, has been a subsidiary of CVS Health. SilverScript is a Medicare Part D carrier acquired by CVS Health in 2019. SilverScript Insurance Company, a CVS Health Company, introduced three Medicare prescription drug plan options in 2019. CVS Health has closed its major acquisition of the health services company Signify Health at a deal valued at $8 billion. CVS has offered a new model of integrated care since the beginning of their mergers

back in 2019. Their initial vision was to deliver simple, affordable community-based care with over 10,000 pharmacy locations with a wide network of health care providers. A policy change first put forward in 2021 meant that hundreds of CVS locations would close as the chain worked to cut costs and get ahead of losses. This would demand a new action plan by the mega corporation to stay alive in the struggling post-pandemic economy.

"The company has been evaluating changes in population, consumer buying patterns and future health needs to ensure it has the right kinds of stores in the right locations for consumers and for business. As part of this initiative, CVS Health will reduce store density in certain locations and close approximately 300 stores a year for the next three years," the company said in late 2021.

Opposition

Mega Insurance corporations, lobbyists, and congressmen have monopolized the health insurance sector for several decades. These business moguls fill each other's pockets to maintain leadership in the health insurance industry. Health insurance can be confusing enough for a patient without understanding the politics that dictate current health plans.

Commercial insurance companies fear the idea of a national insurance system that would make them play second fiddle. They would stand to lose millions of dollars some could lose billions if and when the United States does successfully implement national healthcare insurance. The ACA insured millions of citizens and changed Medicaid income qualification levels for some states but not all. It increased the burden for physicians and nurses to care for more patients when the majority of healthcare organizations face the problems of understaffing and overbooking every day. Healthcare organizations must be careful not to overwork physicians which can induce burnout which leads to the physician taking a leave of absence of possibly

changing career paths. The population continues to grow at an alarming rate due to medical advancements which is part of the cause that led to a physician shortage. Physician shortages lead to longer wait times; longer wait times lead to less time to treat patients which lowers overall quality of patient care and satisfaction.

An article written by Janice Hopkins Tanne for PubMed Central from 2005 proves that the insurance market is still monopolized present day by mega corporations that are purely focused on revenue gains. The article clarifies, "Mergers between health insurance companies have created virtual monopolies that limit consumer choice, do not offer savings on premiums, and give doctors little or no bargaining power, a report from the American Medical Association claims. The past decade has seen more than 400 mergers among health insurance companies and managed care organizations, says the report, which analyzed the insurance markets in nearly 300 metropolitan areas" (Tanne, 2005). Mergers between corporations are all too common today with inflation and high malpractice premiums. It is insightful and understandable alarming how the author could forecast the nation would be facing the same issue decades later. The author supports this idea from quoting a board member from the American Medical Association, James Rohack. He stated, "WellPoint and UnitedHealth Group now control a third of the US health insurance market and cover 61 million US citizens, the study says. This trend is likely to continue, as large health insurers take over smaller plans. Large health plans have the power to set prices when they purchase health care for those they insure, and they can ensure competitive prices which are difficult for other health insurers to compete against, or to undercut. "Patients do not appear to be benefiting from the consolidation . . . Health insurers are posting historically high profit margins, yet patient health insurance premiums continue to rise without an expansion of benefits," said James Rohack, a member of the American Medical Association's board." This

statement is a prime example why the American public should support the idea of a single national insurance system, yet the fear remains. The media's power manipulates the people's beliefs that the government only wants to have total control over their lives. Conspiracies such as this with no supporting facts spread panic to the unwise of the true nature of the cold hard facts. Tyrants use the media as their ultimate weapon to trick the public with opinions rather than proven facts and statistics that prove America's Healthcare system is facing hurdles it will not be able to jump.

It is feasible to understand why people believe national insurance would give the government too much power over the nations' lives. Managed care plans can make patients feel trapped with limited options of care. The goal and promise of managed care plans are to reduce costs for members while improving the quality of care. An online article published by Forbes explains just why quality of care is lacking in patient outcomes. The author, Robert Pearl M.D., states, "With rare exception, health insurers don't try to manage medical care or optimize performance. Instead, they take an actuarial approach, calculating how much medical care is likely to cost (given the uncoordinated and inefficient delivery system) and priced accordingly, adding 6-8% for profit" (Pearl M.D., 2023). Citizens would already technically have paid for their healthcare by paying taxes alone. Due to the nature of the economy today it would be necessary for a slight increase in taxes to install the new healthcare system. Once again this is when the media is the tool of choice for all who oppose the idea of national health insurance. Americans must realize that we already pay for Medicare so why not make it Medicare for all (M4A)? This is the mission of the Physicians for a National Health Program (PNHP). The term single-payer health care in this context means Medicare would function as the single payer that covers healthcare for everyone. When discussing M4A, this would be an improved version of

Medicare today. This would be an expanded version that would remove the gaps in coverage and the need for broken systems like Medicare Advantage. In the current model of M4A, the payment system is publicly funded by the government. Hospitals and doctors would remain private, which would allow the delivery system to be private as well. Everyone would be covered be in this system (PNHP, 2023). Many Americans who oppose the idea of national insurance for everyone wonder how it could ever be possible. It is estimated that implementation would take over a two-year period starting with expansion of Medicare, followed by enrollment of different age groups and availability of Medicare Transition program.

Medicare for All

Today, every other major world country in our world provides the basic human right to essential prevention, treatment, and emergency health care. There has been great support and opposition to the implantation of National Health Insurance. ACA is a rough draft to the beginning of a necessary starting point to fixing our broken health care system. Millions of people still are uninsured and lack regular preventive care. Millions of people have minimum coverage that leaves them with high deductibles to meet annually before benefits begin, which results in patients owing thousands in medical bills.

Last year in 2022, the office of Senator Bernie Sanders wrote and published an executive summary titled *Medicare for All Act of 2022*. The article explains why Medicare for All (M4A) would be beneficial for the American population in simple terms and proposes a plan on how to implement the new system. The senator's theory is that the transition would occur in stages over the course of four years instead of a sudden disruptive blow. Medicare would get an extreme makeover in the first year which would expand the eligibility age to 55. Dental, vision, and hearing aids would be newly covered benefits as well. Deductibles would also be eliminated in

the first year. The most notable introduction of the new M4A program would be eligibility for all children between the ages of 0 – 18.

The second-year progress would implement the eligibility age to be reduced to 35. The third year would be a time gap for processing the remainder of applications and eliminating possible hiccups that could occur. The executive summary addresses the benefits of the fourth year by professing that every individual who is a resident of the United States will be entitled to benefits for comprehensive health care services and will get a Medicare for All card that they can use to receive the health care they need (Sanders, 2022).

Medicare Extra for All is another proposal created by the American College of Physicians (ACP); It has a vastly different plan layout than the Medicare for All Act of 2022. The first year of enactment would only offer a public option for bare counties, and the second year would then expand to make the public option to all other counties. Many Americans find it difficult to navigate the health insurance market especially when deciding whether to purchase and enroll in the original Medicare plans or to select coverage through Medicare Advantage plans. Medicare Advantage essentially offers coverage similar to Medicare plans but is sold as a whole instead of parts like Medicare. Original Medicare Part A covers inpatient hospital and skilled nursing services; doctor visits, outpatient services and some preventative care is covered by Part B. Medicare Advantage plans cover all the above (Part A and Part B), and most plans also cover prescription drugs (Part D).

The Center for American Progress (CAP) created their own version of a Medicare Extra plan. The Center for American Progress Action Fund is a nonpartisan policy institute and advocacy group committed to enhancing the well-being of all Americans through innovative

progressive concepts, effective leadership, and united efforts.

The Center for American Progress's Medicare Extra plan combines elements from Obamacare and Medicare-for-all to address different critiques. It offers universal coverage, uses Medicare pricing to control costs, and centers on public insurance. It aims to minimize middle-class tax increases and maintain employer-based private insurance for those satisfied with it. The plan includes means-tested premiums and cost sharing for all except the poorest. An analysis by Avalere estimates that Medicare Extra would provide universal coverage, adding 35 million people to the insured while reducing national health expenditures by over $300 billion yearly. The government's cost would range from $2.8 trillion to $4.5 trillion over ten years, but could potentially be financed through wealth taxes. However, the actual running costs would be higher, around $400-500 billion per year once fully implemented (Klein, 2019).

Adam Gaffney, a pulmonologist at the Cambridge Health Alliance, an instructor at Harvard Medical School, and president of Physicians for a National Health Program, an advocate for single-payer healthcare, expressed a nuanced perspective when questioned about Medicare Extra. He characterized it as a form of a public-option plan but emphasized its strength in achieving universal coverage, a claim other public-option proposals cannot make. During his interview from Vox he responded, “It’s a public-option plan,” he said, “but it’s the most robust of the public-option options. It would in fact achieve universal coverage. The other public options can’t claim that” (Klein, 2019).

Gaffney's primary criticisms centered on the continued reliance on premiums, copayments, and deductibles in Medicare Extra, as opposed to Senator Bernie Sanders's preferred plan, which integrates all financing through the tax code, thereby eliminating

deductibles and copayments altogether. Gaffney underscored the persistence of substantial out-of-pocket expenses, estimating them to be in the realm of thousands of dollars annually within the framework of Medicare Extra (Klein, 2019). By 2031, Avalere predicts nearly 200 million Americans would enroll in Medicare Extra, with an additional 121 million in employer-sponsored plans and 33 million retaining original Medicare. While Medicare Extra would dominate, it differs from the current private-dominant system.

Medicare Extra would operate by establishing an expanded public insurance program with comprehensive benefits, including vision, dental, and reproductive health coverage, building on the Medicare name. Premiums are income-based, with those below 150 percent of the poverty line paying nothing, while those at 500 percent or more have contributions capped at 9 percent of income. Cost sharing is also income-dependent, with a maximum cap of $5,000 even for high-income individuals. Newborns, the uninsured, and legal residents upon turning 65 are automatically enrolled in Medicare Extra. Medicaid and Obamacare would merge into this program, allowing those with various existing coverage options to opt in.

The plan reduces costs by extending Medicare's pricing power to the entire system, setting hospital prices at 110 percent of current Medicare rates and other services at prevailing Medicare rates. This approach is notable for including employer-sponsored coverage through all-payer rate setting, offering pricing savings akin to Medicare-for-all without excluding private insurance. Importantly, Medicare Extra doesn't eliminate private health insurance; it allows individuals to keep their employer-based, traditional Medicare, or VA insurance. Additionally, private options, "Medicare Choice" plans, are available within Medicare Extra, with reimbursements at 95 percent of the program's rates. Individuals throughout the system,

including those with employer-based plans and traditional Medicare, can choose to purchase Medicare Extra, making them eligible for regular subsidies and employer cash-outs, unlike the current structure of Obamacare. The underlying question posed by CAP's Medicare Extra plan is whether healthcare reform can combine the benefits and efficiencies of single payer without incurring the disruption, taxes, and political resistance that a complete system overhaul typically entails.

In summary, the Medicare Extra plan aims to strike a balance between reform and public sentiment, attempting to provide comprehensive healthcare while limiting the tax burden and the perception of government intrusion. One key argument is that Medicare Extra's preservation of a role for private insurance may prevent potential administrative savings from reducing premiums or expanding coverage. The debate on administrative costs in healthcare is ongoing, with differing opinions on whether private overhead is wasteful. Medicare Extra's design prompts questions about whether the role of private insurance is essential. It's believed that true single-payer systems could achieve more significant cost reductions, as increased private involvement may lead to lobbying for higher payments.

The politics of healthcare reform involve a struggle between interest groups benefiting from private insurance and public fear of reform. The public's lack of awareness regarding employer contributions to healthcare costs plays a significant role in this debate. The Medicare Extra plan aims to extend the benefits of reform without forcing people into it, preserving the choice for individuals. It complements other Democratic proposals for universal health coverage, presenting different trade-offs. In contrast, the Republican side focuses on legal challenges to the Affordable Care Act and policy options that could leave millions without coverage.

Politics

The essential purpose of politics is to promote human prosperity. The famous philosopher Aristotle defined human flourishing to require the basics of biological survival, along with good character and the 'finer things in life' which can simply be understood as 'happiness'. For over two millenniums it has been plainly understood that healthcare is a basic necessity, yet we must pay for it when honestly, we already have paid for it; we just don't all have it. Politics are supposed to solve the citizens' problems. The people should have the power; today our nation is corrupted by fraud and abuse in every sector due to greed because humans' lust for money and power. America is overdue for an investment in itself. We need national health insurance to improve America's well-being as a whole.

The National Health Insurance System is more widely accepted than ever before due to the effects from the Covid-19 pandemic. The nation's healthcare system was in the spotlight for over two years and remains there still today because of its lack of performance during Americas' most recent and ongoing health crisis. In hindsight, the majority of the population believe that the nation should have been adequately prepared to respond and act accordingly to a pandemic and we failed. A government can only truly be prepared to care for all their citizens' health by doing so equally; Power distribution by State allowed each Governor to mandate their own health policies which divided the nation. Panic was just as contagious as Covid-19 causing people to hoard supplies which drove the entire nation into a shortage of personal protection equipment, not to mention daily essentials. The publics' actions to the recent pandemic are valid proof medical resources need to be managed and controlled so all health professionals can at least protect themselves while they selflessly put the lives on the line to save ours.

An article published by American Health Public Association titled “Universal Health Coverage: A Political Struggle and Governance Challenge” describes how without support in domestic politics, a redistributive policy such as United Health Insurance is unlikely to happen. The authors, Scott L. Greer, PhD and Claudio A. Méndez, MPH, point out how the U.S. democratic politicians are more in favor of a universal health policy than most republicans. This is all due to democrats favoring socialism and republicans abide to their capitalist conservative methods. In the article it states, “The complexities of organization, political coalitions, and parties, a long-standing issue in comparative politics, therefore demand attention; the relationship between left-party success and UHC policies is not simple, and part of the reason is the interaction between politics and governance… Governance shapes the likelihood that UHC will be adopted and actually implemented for three reasons” (Greer & Méndez, 2015). The authors produce valid points that the division of political parties makes it near impossible for UHC to pass into law due to the conflicts of interest along with the difficulties of organization that accompany our country’s unique constitutional federal republic government. The authors continue to elaborate, “First, it is a prerequisite for some policies. Just as policies for UHC can cost too much for a given state, they can also demand a level of expertise, accountability, and good public administration that is not always available… Second, governance, particularly political institutions, can shape the likelihood of pro-UHC forces winning in politics. Veto points at which a policy can be blocked include bicameralism, referenda, strong supreme courts, and some forms of federalism… Third, governance affects the likelihood that programs will be entrenched by affording programs greater or lesser real effectiveness and greater or lesser political defenses” (Greer & Méndez, 2015). The authors advise that advocates should focus

their attention on ways they can create institutional safeguards for a right to health, "Policies create politics," after all.

Innovative Future of Healthcare

Technology influences nearly every aspect of our daily lives and our health is no exception. The innovative advances in technology are the driving force dominating the healthcare sector in the market today. American minds are molded to the belief that the latest technology, regardless of the price tag, is simply the best option available. Forbes magazine published an online article titled *How Technology is Transforming the Future of Healthcare* in which the author, Benard Marr, denotes their explanation in what they predict for the future of healthcare. The most relative excerpt from the article states, "Companies and healthcare organizations are using immersive technologies to provide medical training for doctors and other health practitioners. Fundamental VR — a virtual reality medical education platform accredited by the Royal College of Surgeons in England — has developed a VR solution that acts like a flight simulator for surgeons, so they can practice in a controlled environment before operating on real patients" (Marr, 2023). While modern VR technology is highly advanced than its initial created form; medical professionals began using VR in surgeries nearly three decades ago. Medical VR's long history began with applications of virtual reality and augmented reality (AR), which have been around since at least the early 1990s. VR-based surgical planning process using hardware developed by NASA and the majority of numerous early applications mostly were designed specifically to assist doctors visualize complex anatomy with the aim of facilitating surgical planning and training.

The generations of people today, and specifically those of tomorrow, rely on the functionality of advanced technology for our healthcare needs. Innovation will be the key factor

to successfully implementing a universal health care system due to the enormous amounts of information and data processes required to manage and organize a nationwide health exchange. Usability and desirability are two key qualities often possessed by successful innovations. America cannot afford to delay preparing for the implementation of a project on such a massive scale. The current M4A proposal estimates it will take four years minimum to just enroll and changeover to the new Medicare system. No great success comes without failures. There will be complications to be resolved, but the system has its footing; Americas healthcare sector will be reborn.

Technology is ready and available for remote care to be efficient and effective. The patient will take responsibility in assistance in the application and management of sensors used to monitor their body's vitals. Chronic conditions can be monitored from home by healthcare providers when the patient can maintain their health at home. This is more affordable for the patient by reducing the average length of stay in the hospital. Patients in rural areas will benefit greatly from more remote care and less trips to medical facilities that involve much time and money spent by the patients' expense. A patient will have greater access to care by the option to select medical console from any doctor in the world. Earlier this year author Jay Singh's book, *Future care: Sensors, Artificial Intelligence, and the reinvention of medicine*, was released providing an incredible insight into expectations and realities we should all be aware of from a physician's perspective and experience. The author thoroughly describes how healthcare from the con one e of your own home can be just if not better than at your local hospital or medical clinic. Artificial Intelligence can illustrate while the sensors current readings will guide the physician(s) to make more informed decisions due to this reinvention of patient treatment.

Expectations of patients have been reset by patients because of the pandemic and now healthcare professionals require technology to be more resourceful than ever before. Clinical and patient management systems need the latest software updates, impenetrable network security, and data access platforms easy to navigate and use by the professional and patient. Doctors and nurses will use clinician dashboards to monitor patients' health provided by the sensors used by the patient remotely at their home. The system will alert staff when abnormal readings are detected, or when customized target readings are reached specifically set to alert the physician.

Artificial Intelligence (AI) will be able to mirror the patient's body for the physician to have a 3-dimensional view of the current state of the patient. This will all be possible by the patient performing a self-scan of their body from their computer and transmitting the image instantly to the doctor for review.

The only way forward in patient care according to this author is for forthright transparency, enforced accountability, and restructured institutions. An overall of the entire medical system is needed to be financially feasible to make costs for patients more accurate and justified. No organization should be allowed to charge unrealistic amounts to patients for services. The author also addresses how outcomes in healthcare improve by using a patient-centric care model. Market trends prove the winds of change are happening already which is why the U.S. needs to act now. The opinion of expert physician(s) should be irrefutable proof to all that the overhaul desperately needed for the healthcare infrastructure needs to be implemented by the United States immediately. Bernie Sanders and fellow politicians alike have already outlined a the most feasible plan so far presented for the country.

The United States will struggle immensely to keep up with the with corporal giants trying to keep their financial footing intact. Mega corps do not want to lose a penny and will waste no time in making it their mission to discourage the American public and congress in supporting Universal Healthcare Insurance. These companies will go to no end to disillusion people into believing their lies, but surely the majority of the American public has enough sense and personal experience to not be fooled. Besides, once the bill has passed with no veto and a plan is set in motion, many who once renounced such a plan will now support it. Ultimately the biggest cost-saver of them from a renovated healthcare system will be the reformed way of how we practice medicine. Prevention and wellness in the future will be the top expenses in healthcare instead of treatment which lowers the cost of healthcare in its totality.

Finance

The biggest question carrying the most weight is how a nation with a trillion-dollar deficient could possibly create funding for such a project; especially when such a project would require an astronomical budget. A group of authors previously mentioned explored potential cost estimates for UHI in the United States. In the scholarly article titled “Universal Healthcare in the United States of America: A Healthy Debate”, authors give a simple explanation on why implement a new system will be challenging and costly. The authors state, “The cost of a universal healthcare system would depend on its structure… One proposal for universal healthcare recently pushed included options such as a 7.5% payroll tax plus a 4% income tax on all Americans, with higher-income citizens subjected to higher taxes… In terms of the national economic toll, cost estimations of this proposal range from USD 32 to 44 trillion across 10 years, while deficit estimations range from USD 1.1 to 2.1 trillion per year” (Zieff et al., 2021).

Senator Bernie Sanders campaign for the presidential election of 2020 centered on his healthcare proposal called ‘Medicare for All’. The plan the presidential candidate proposed that the federal government should provide healthcare to all Americans. Studies show that costs could be between $25 trillion and $32 trillion over 10 years. Sanders had suggestions for funding it, including redirecting $2 trillion of current government spending, along with raising taxes on income over $250,000 and reaching a 52% marginal tax rate on income over $10 million (Paula & Field, 2019).

Model Plans

Presenting a viable plan can garner support from opposing factions once we elucidate practical objectives and methodologies. To address the substantial budget required for implementing the new system, a tax increase would be implemented. This increase would be income-based, ensuring that individuals with lower income bear a smaller percentage of the burden compared to the affluent. Modest but crucial tax hikes on tobacco and alcohol would be introduced. Adjustments can be made as cost savings come into play. It's imperative for the American public not to succumb to panic but rather to trust that the government isn't attempting to exert control over every aspect of their lives. The reality is that the government lacks the necessary resources and capacity for such a comprehensive approach, given the pressing priorities it must address. While nobody welcomes tax hikes, they will be essential for at least a decade to finance the new healthcare system. The resulting benefits will outweigh the temporary burden, ultimately leading to a reduction in healthcare costs for the United States.

The American College of Physicians (ACP) believes national health insurance coverage will have to be compulsory for universal coverage to be achieved. In the schlolarly article titled

“Envisioning a better U.S. Health Care System for all: Coverage and cost of care” the authors further explain why the ACP believe a National Health Insurance plan would have to be mandated. They recommend the following guidelines for changing over to a new universal health insurance system. The authors assert, “The American College of Physicians recommends that the United States transition to a system that achieves universal coverage with essential benefits and lower administrative costs” (Crowley et al., 2020). Administrative costs account on average a quarter of healthcare spending; Once again the United States outspends its peer nations in the healthcare administration sector. “Coverage should not be dependent on a person's place of residence, employment, health status, or income” (Crowley et al., 2020). Ensuring that coverage is not contingent upon an individual's geographical location of residence, professional occupation, health condition, or financial earnings is paramount in establishing a fair and equitable healthcare system. It is imperative that access to essential services and support is not determined by where a person lives, their job, their state of health, or their economic standing. The article then elaborates on characteristics of access to care to state, “Coverage should ensure sufficient access to clinicians, hospitals, and other sources of care. Two options could achieve these objectives: a single-payer financing approach, or a publicly financed coverage option to be offered along with regulated private insurance” (Crowley et al., 2020).

The article "Envisioning a More Comprehensive U.S. Healthcare System: Addressing Coverage and Cost of Care" delves into the imperative for the United States to undertake comprehensive measures in addressing healthcare coverage and costs. This exploration is grounded in the empirical evidence and findings presented by the American College of Physicians (ACP). The Health and Public Policy Committee of the ACP meticulously crafted this article, drawing upon an array of resources derived from scrutinizing studies, reports, and

surveys on healthcare coverage. The ACP, through extensive research, has formulated proposals delineating potential avenues for healthcare reform in the United States, emphasizing the implementation of a national health insurance system. The article provides intricate insights into the historical and current payer systems in the United States (Crowley et al., 2020).

A central assertion made by the ACP posits that administrative costs and processing times act as formidable barriers, disproportionately diverting time away from patient care, particularly in comparison to peer countries. This predicament is a source of challenge and frustration for patients, clinicians, and other medical personnel. The article underscores the necessity for focused attention on underserved and disadvantaged communities, particularly in rural areas, addressing concerns such as physician shortages and negative health effects stemming from social determinants. It is highlighted that social determinants exert an 80% influence on an individual's overall well-being. The United States, as per the ACP's assessment, lags behind peer countries in healthcare outcomes, marked by elevated rates of chronic diseases and diminished life expectancy. Notably, family premiums for employee-sponsored insurance have surged twofold since 2009, outpacing inflation costs. The overarching goals targeted are universal coverage and access, with the understanding that mandating universal coverage is imperative for its realization.

However, critics raise concerns about potential drawbacks associated with universal coverage, including perceived limitations on freedom of choice, prolonged waiting times, and the imposition of price controls. The ACP's recommendations for achieving universal coverage encompass a single-payer financing approach or a publicly financed coverage option, supplemented by optional and regulated private insurance.

A single payer reform similar to Canada's healthcare insurance would have more cost savings than a 'public choice' model. Despite a challenging beginning, most Canadians have now embraced their single-payer healthcare system, ensuring coverage for everyone with all medical professionals and healthcare facilities operating within the network. Health costs, once comparable to U.S. levels in the 1960s, have since decreased by about 40%, with administrative savings accounting for half of the reduction. While certain aspects of healthcare funding have been tightly managed in Canada, physicians continue to maintain substantial incomes, with Canadian internists' average take-home pay being around CAD$300,000. Moreover, Canada's health outcomes consistently outperform those of the United States across various conditions, such as cystic fibrosis, end-stage renal disease, and type 1 diabetes, showcasing the quality of care (Woolhandler & Himmelstein, 2020).

Canada's positive healthcare experience is a crucial element supporting the ACP's endorsement of a single-payer system. Implementing a single-payer reform with insurance overhead reduced to 2% (similar to Canada and traditional Medicare) could lead to annual savings exceeding $200 billion. Additionally, the existing multipayer system imposes unnecessary complexity and expenses on healthcare providers. For instance, the Cleveland Clinic has to navigate a staggering 210,000,000 different prices. Shifting to a single-source payment approach could simplify reimbursement processes, such as replacing per-patient hospital payments with global budgets and establishing standardized billing and documentation requirements. These changes would allow hospitals and doctors to save billions in billing-related costs, reallocating those funds to expand care and ensure affordable universal coverage. Achieving universal coverage would present higher costs under the "public choice" model co-endorsed by the ACP alongside single payer. Multipayer systems involving for-profit insurers

have not yielded significant administrative savings, as for-profit insurers tend to have high overhead costs universally. The presence of multiple payers would impede efforts to streamline providers' billing-related work, further underscoring the benefits of a single-payer system (Woolhandler & Himmelstein, 2020).

The text *The Price We Pay: What Broke American Health Care--and How to Fix It* provides insights from the perspective of a healthcare provider, offering a nuanced examination of the flaws within the American healthcare landscape. The author's objective is to comprehend healthcare dynamics and scrutinize it through the lens of its core clinical mission, which is to serve patients. As a surgeon, the author transitioned from wielding a scalpel to conducting extensive research, seeking to perceive patient challenges not merely from an operating room standpoint but from the broader perspective of the healthcare system.

The author contends that the present-day healthcare system, characterized by a business model steeped in price gouging and inappropriate care, poses a threat to the longstanding legacy of public trust in medicine. The imperative, as proposed by the author, is for healthcare providers to realign their practices with the noble mission of medicine. The escalating costs of health insurance are attributed to the intricate financial maneuvers within the realm of medicine, involving middlemen, kickbacks, and concealed expenses. While profits burgeon, the toll on individuals within the existing system is severe, manifesting in over-testing, over-diagnosing, and over-treatment becoming commonplace in certain medical domains.

The burgeoning healthcare costs are increasingly exerting a stifling impact on businesses in the United States. In response, the author advocates for a novel policy on price transparency for hospitals. This proposed regulation would mandate hospitals to disclose actual cash prices for

commonly sought-after services, integrate a price estimator on their websites, and unveil the confidential discounts extended to each insurance company (Makary, 2021).

The author Marty Makary distinguishes the difference between genuine concern and marketing maneuvers that healthcare providers will strategize to deliver cures or maximize profits (Makary, 2021). A notable example given in the text tells when the surgeon created and mailed a survey to professional peers from all over the country. Colleagues from John Hopkins and himself conducted this survey in which two thirds responded of whom equate to 2,100 respondents. They believe 21% of everything done in medicine is unnecessary. Health screening is described by Makary to be a double-edged sword; It is a powerful tool for detecting disease and preventing unforeseen possibility of tragedies, but it also can be used as a business model to recruit patients and prescribe unnecessary treatments just to turn a nice dime.

Decorum and benevolence ought not to be employed as mere stratagems but rather as intrinsic values we mutually extend to one another. Foundational healthcare represents an inalienable human entitlement and should be accorded commensurate significance. Regional county health departments administer vital vaccinations and medical assessments for the local populace, concurrently meticulously tracking and disseminating epidemiological data. Prospective mothers and adolescents stand to benefit from comprehensive family planning services, encompassing essential health screens and contraception options. The strategic positioning of the Department of Community Based Services (DCBS) offices alongside health departments renders them opportune hubs for facilitating applications and providing guidance for the realization of a National Health Insurance program.

The Role of Private Entities

The future of private insurance companies is questionable once a national healthcare insurance mandate has its roots firmly in place. The Health Affairs online journal published an article titled “Medicare for All: An Analysis of Key Policy Issues” that examines different possible key policy designs that could be used in the Medicare-for-All plan. The authors elaborate, “Within a national health insurance system, there are three possible types of private insurance: duplicative, complementary, and supplementary. Duplicative (or substitutive) insurance covers the same benefits as the public plan. Complementary insurance covers cost-sharing requirements in the public plan, as Medigap plans do in traditional Medicare. Supplementary insurance covers services not included in the public plan.

Duplicative insurance could increase competition in the health care system, but the presence of multiple insurers would erode the administrative savings of a single-payer system and could induce further inequities in care if providers exited the public system or gave priority to privately insured patients. A major disadvantage of complementary insurance is administrative inefficiency (on average, Medigap insurers spend less than 79 percent of premiums on medical claims). If Medicare for All had low-cost sharing, complementary insurance would likely be unnecessary. The role of supplementary insurance would depend on the comprehensiveness of the public plan. If Medicare for All covered fully comprehensive benefits, supplementary insurance might be limited to “luxury” items such as experimental treatments, brand-name drugs when generics are available, and higher-end hospital amenities” (Johnson et al., 2020).

Peer Countries National Healthcare

Peer nations outperform the U.S. in health outcomes drastically because the citizens have better access to quality care and preventive services (Telesford et al., 2023). Dr. Carroll is the

chief health officer of Indiana University and writes often on health policy. He believes National Health Insurance is necessary and a system should be implemented right away. The author explains, “Universal coverage matters. What doesn’t is how you provide that coverage, whether it’s a fully socialized National Health Service, modified single-payer schemes, regulated nonprofit insurance or private health savings accounts” (Carroll, 2023). All of the countries the author studied have some sort of apparatus that provides everyone coverage in an easily explained and uniform way. This methodology allows them to focus on more important aspects of health care, such as quality and overall better patient outcomes.

Despite the staggering toll of the recent pandemic, with over one million Americans losing their lives, it's evident that healthcare reform isn't a top priority in the current United States political landscape. This oversight is regrettable, as it fails to acknowledge the fundamental flaws in the American healthcare system. Notably, the U.S. stands out among developed nations due to its lack of universal healthcare coverage, extravagant healthcare spending that surpasses global averages, and outcomes that are mediocre at best.

When healthcare reform discussions do arise, they typically revolve around two choices: maintaining the existing system, which is largely private, or transitioning to a single-payer system similar to Canada's. This dichotomy is always strikingly peculiar, as authentic single-payer systems like Canada's are relatively rare worldwide, and Canada's performance often mirrors the U.S.'s in various international rankings. Additionally, no other nation seems to have a healthcare system as intricate and convoluted as the United States. A more fruitful debate would involve exploring alternatives from around the world. However, many resist such suggestions, believing that the American healthcare system is an intrinsic part of the nation's DNA, with roots

in the Constitution or the Founding Fathers. Others argue that healthcare systems from other countries couldn't function in the U.S. due to its sheer size. Everyone can contend that these justifications are unsound. Our employer-based insurance system exists largely due to World War II wage freezes and I.R.S. tax policies, rather than being a product of the Founding Fathers' intent. Furthermore, much of healthcare regulation occurs at the state level, making our nation's size less of an obstacle to reform than some might think. Change is indeed possible if we are willing to pursue it.

The author travelled to five other countries and studied their healthcare systems: Britain, France, Singapore, New Zealand, and Australia. Australia and New Zealand are the only countries from this selection that use a single-payer system. They are both unique from each other and different from Canada system. They allow for private insurance for most healthcare unlike Canada; this addition can prioritize the patient’s appointment and maximize benefits. Australia has high out-of-pocket cost in most notably in the form of co-pays and deductibles. Public health, social policy, and living standards are the product of responsibility of Australia. The public health agency in New Zealand that was just established a year prior applies a specific interest in emphasizing social health determinants such as housing, income, and education all the while addressing racism in the delivery of healthcare in targeted areas.

Britain has no out-of-pocket expenses for nearly all healthcare. Relatively few people purchase private insurance, but it is optional to purchase private insurance just like in other countries, that allows the patient to pay for care that may become available quicker and equipped with more amenities.

The single payer model best describes the system used by France; this because nearly everyone acquires insurance from one of a few collective funds. These collective funds are determined by employment or life situations. Most people in France expect to pay out-of-pocket costs upfront for outpatient care then later reimbursed by the insurance payer. Singapore health system relies on the personal spending of the individual with insurance only available for catastrophic coverage or for access to a private system that no one hardly utilizes. The author elaborates why the U.S. falls behind in the healthcare sector of its peers. Carroll comments, “But the United States can’t decide on a universal coverage scheme, and not only does it leave too many people uninsured and underinsured; it also distracts us from doing anything else. We have all types of coverage schemes, from Veterans Affairs to Medicare, the Obamacare exchanges and employer-based health insurance, and when put together, they don’t work well. They are all too complicated and too inefficient, and they fail to achieve the goal of universal coverage. Our complexity, and the administrative inefficiency that comes with it, is holding us back” (Carroll, 2023).

“Competition for more patient volume leads to higher prices, and while we don’t explicitly ration care, we do so indirectly by requiring deductibles and co-pays, forcing many to avoid care because of cost” (Carroll, 2023). The author explains precisely why the healthcare system in America fails to other nations. The author continues to elaborate, “I’m convinced that the ability to get good, if not great, care in facilities that aren’t competing with one another is the main way that other countries obtain great outcomes for much less money. It also allows for more regulation and control to keep a lid on prices” (Carroll, 2023).

The takeaway from this article is that America can and should be inspired from peer countries; It is not the differences between the countries health systems that America should focus on but the likenesses, which more than likely account for why they achieve better health outcomes than the United States.

The Swedish healthcare system is decentralized and funded primarily through taxes. It's organized into 21 regions and 290 municipalities. The Ministry of Health and Social Affairs oversees healthcare policy noted by the World Health Organization. Sweden maintains high healthcare expenditure and universal coverage, promoting good health outcomes. Reforms have focused on improving service availability, enhancing patient choice, strengthening primary care, and streamlining specialist care. These reforms aim to reduce waiting times, ensure care continuity, and enhance overall system efficiency. Efforts to increase healthcare system efficiency continue, with changes in payment models and digitalization. Future developments may involve a more prominent national government role (WHO,2023).

Partisans

Advocating for National Health Insurance is challenging though support from allies provide sustainability to help reinforce efforts and broaden impact. The main supporters of a National Health Insurance mandate, such as expansion of Medicare and Medicaid for everyone, include American College Association of Physicians (ACAP), Physicians for a National Health Program (PNHP), representatives and members of the Democratic Party, and Senator Bernie Sanders. Strong alliances create a broad base of activity but building alliances across organizations requires much needed time and effort. Relationships and activities between these organizations keep the momentum fire burning and keep progression moving forward even in the face of resistance.

The Peterson Center on Healthcare and KFF are partnering to monitor how well the U.S. healthcare system is performing in terms of quality and cost. The Peterson-KFF Health System Tracker provides clear, up-to-date information on trends, drivers and issues that impact the performance of the system. It also illustrates how the U.S. is performing relative to other countries and how different parts of the system are performing relative to one another.
It is their goal that their tracker will put a spotlight on performance and spark discussion about how the health system can be improved. Healthcare providers, employers, payers, consumer advocates or policy makers, can access data analyses that provide insight as to what is driving the performance of one of the most vital sectors in the U.S. economy.

The website describes the mission of their work as it explains, “Our work places a heavy emphasis on data and evidence, addressing key questions through collections of charts, which provide data with additional context and synthesis of the latest research and developments. We also provide regular insight briefs for a more in-depth look at topical questions” (Peterson-KFF, 2023). The Peterson Center on Healthcare is a non-profit organization dedicated to making higher-quality, more affordable healthcare a reality for all Americans. The organization is innovative focused and driven to transform U.S. healthcare sector into an efficient system by finding innovative solutions that improve quality and lower costs and accelerating their adoption on a national scale. The Center, established by the Peter G. Peterson Foundation, collaborates with stakeholders across the healthcare system and engages in grant-making, partnerships and research (Peterson-KFF, 2023).

The Kaiser Family Foundation (KFF) stands as a non-profit organization that uniquely combines elements of policy research, polling, and journalistic endeavors into a cohesive entity.

Functioning independently, they serve as an authoritative source for health policy research, polling, and journalism. This distinctive amalgamation of capabilities empowers the organization to harness its expertise and resources in fulfilling a vital role within the realm of health policy.

KFF is actively engaged in the execution of specialized public health information campaigns, guided by a steadfast belief in the transformative potential of facts and data to serve as a counterbalance to the pervasive influence of financial interests and misinformation that frequently cloud the landscape of health policy. In a domain often marred by misinformation, KFF endeavors to provide credible information, thereby acting as an advocate and amplifier for the voices of those who often find themselves marginalized. Their program is dedicated to exploring the intricate facets of health financing and policy, extending into the realm of public programs. Their expertise extends to the complex landscape of health insurance, spanning various programs, plans, and technical intricacies. At the core of their mission lie concerns of inequality, economic security, and the determinants of social health, which collectively shape our society and, at times, create divisions.

Notably, KFF has initiated a novel project focused on the pervasive influence of disinformation in distorting policy debates, thereby further deepening polarization within the nation. An illustrative example is found in the realm of COVID vaccines, where their commitment extends beyond the mere generation of quality information to actively countering disinformation, recognizing that it is an imperative facet of their mission.The American Medical Association (AMA) firmly advocates for the improvement of the Affordable Care Act (ACA) while discouraging the pursuit of Medicare-for-All. In an insightful article titled "Why Enhancing the ACA is the Preferable Approach Over Pursuing Medicare-for-All," the AMA

underscores the substantial progress that the ACA has achieved, leading to millions of Americans gaining vital health coverage. This accomplishment aligns with one of the AMA's longstanding policy objectives, which is to expand access to and the availability of affordable, high-quality health insurance.

Rather than forsaking the ACA and jeopardizing the stability of coverage for those individuals who generally express satisfaction with their insurance, the AMA maintains that the present moment calls for dedicated investment in not only rectifying the law but also enhancing its provisions (AMA, 2023). This perspective underscores the AMA's commitment to building upon the foundation of the ACA to ensure that it better serves the healthcare needs of the American population.

An organization previously mentioned, PNHP (Physicians for a National Health Program) is an organization of health care professionals that support a single-payer national health insurance (NHI) program in which the government finances health care but leaves the delivery of health care to private entities. The previously mentioned groups may not all agree on whether to expand Medicare for all citizens, or to remodel and build upon the existing ACA, but their common denominator is all these organizations support national healthcare insurance.

Presidential Candidacy for 2024 – Health Policy

The 2024 presidential race has initiated with over a dozen Republican contenders aspiring to challenge President Joe Biden's pursuit of a second term. In an online article by Larry Levitt for the JAMA Health Forum titled "Health Care Issues in the Early Stages of the Presidential 2024 Election," the absence of explicit mentions or proposals regarding National Health Insurance among the candidates is highlighted. Current discussions predominantly revolve

around the legal challenges faced by former President Donald Trump, overshadowing policy matters. Notably, healthcare issues, often less emphasized in Republican primaries compared to Democratic contests, are gaining significance due to the diverse healthcare records and stances of former President Trump and various current/former governors within the Republican lineup, contrasting with President Biden's positions (Levitt, 2023).

The complexity of elections makes it challenging to discern which candidate genuinely comprehends, advocates for, and promotes the well-being of America's healthcare. Larry Levitt explores additional facets of healthcare that could potentially take center stage during the presidential debates. As the campaign unfolds, Levitt suggests that additional healthcare issues may emerge as divisive points among the candidates. For instance, the Trump campaign's critique of Governor DeSantis for his approach to COVID-19 measures, despite initial support, reflects the evolving stances on vaccination and pandemic management. Biden, having navigated the nation through the majority of the COVID-19 era, will confront the task of defending his record in the upcoming election (Levitt, 2023).

During Trump's tenure, attempts to repeal and replace the Affordable Care Act (ACA) were unsuccessful, a move that would have impacted Medicaid expansion, federal funding, the uninsured population, and preexisting condition protections. Notably, DeSantis, as a former US House Representative, supported a similar plan that faced impediments in the Senate, with Senator Tim Scott also endorsing this repeal and replace efforts.

While presidential elections typically don't hinge on specific issues, Levitt contends that the 2024 election might deviate from the trend since 2008, where health insurance reform, the ACA, or the desire to abolish the program may not take center stage. Nevertheless, a spectrum of

healthcare issues, including abortion rights, federally funded Medicare and state-funded Medicaid, pharmaceutical costs, epidemic preparedness, trust in science, and medical care aligned with gender identity, will serve as noteworthy considerations for voters. These healthcare matters can serve as meaningful indicators of the candidates' overarching political ideologies, even if they aren't extensively discussed during the campaign.

Conclusion

The provision of high-quality and economically accessible healthcare represents the bedrock upon which individuals are empowered to lead lives characterized by productivity and fulfillment. Concurrently, it stands as a cornerstone in the construction of robust national economies. The concept of national health coverage, in essence, pivots upon the guarantee of unfettered access to essential medical services, unfettered by the specter of financial destitution. It is imperative that the United States embark upon a journey of self-investment, leveraging its domestic resources to foster greater self-sufficiency, particularly within the intricate labyrinth of the healthcare sector.

The quintessence of societal disparities in American life is perhaps most vividly unveiled by the intricate tapestry that constitutes the nation's healthcare system. A multifaceted amalgamation of privately managed insurance mechanisms, publicly administered healthcare programs, and the intricate web of political influences intermingle, inadvertently driving healthcare costs to unmanageable heights. This deleterious escalation engenders significant impediments to the accessibility of life-saving medical interventions for sizable swaths of the population, thereby exacerbating the profound schisms that persist within American society. The

CBO originally estimated that Obamacare would cost $940 billion over ten years. That cost has now been increased to $1.683 trillion (Perry, 2023).

Lack of emphasis on prevention healthcare has devasting effects on the nation. The American Public Health Association (APHA) reminds us by clarifying, “Today, seven in 10 deaths in the U.S. are related to chronic diseases such as obesity, diabetes, high blood pressure, heart disease, and cancer, which are largely preventable. Additionally, 90% of our health care dollars are spent treating such diseases. However, only three cents of each health care dollar spent in the U.S. go toward prevention” (APHA, 2023).

The mitigation of the prevalent deficit in healthcare personnel, particularly physicians and nurses, can be aptly addressed through the implementation of a strategic initiative involving the provision of financial assistance for aspiring medical students, who, in due course, may assume the mantle of healthcare administrators in anticipation of a future where the national healthcare insurance system envisages a reduction in the demand for administrative personnel. Numerous healthcare administrators, at present, hold academic qualifications at the level of a bachelor's or associate degree, replete with foundational curriculum prerequisites that encompass subjects of utmost medical import, including Anatomy & Physiology, Biology, and Medical Terminology, among others. In consequence, individuals harboring aspirations of advancing their educational attainment would likely find themselves focusing their intellectual pursuits primarily on nursing coursework and clinical training. It is of paramount significance to retain and foster the presence of healthcare professionals within the healthcare industry, for the inexorable expansion of healthcare demand on the horizon necessitates the perpetuation of a skilled workforce to cater to the burgeoning healthcare needs of our society.

The Healthcare Administration requires a too far great percentage of a patient's healthcare charges. These administration costs can be drastically reduced once the United States government is the primary payer. Private insurance companies will have no choice but to simply their administration overhead due to loss of profits which will prove evidently it was always abused for the sake of maximum profit at the expense of the patient known as the insurance enrollee. Private practicing physician offices are becoming a rarity in the United States due to the extreme overhead costs most notably malpractice insurance and salaries along with the steep price tag of innovative medical technology. Patient practice software and platforms, electronic health records, and health information training can seriously drain the budget of a small-scale clinic leaving little to no profit at all; in the worst scenarios clinicians are forced to shut their doors permanently or form a partnership with a conglomerate healthcare company.

This nation needs National Health Insurance so every citizen has access to quality healthcare. With every American utilizes preventive care many future chronic conditions in patients could be prevented ultimately saving the country billions. The United States must act quickly as inflation rises by the day; there will never be a day when the cost of implementing a national healthcare system will be affordable, yet in the end the savings will be evident.

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