Osher Lifelong Learning Institute, Winter 2025

Health Economics

Berkshire Community College
February 4, 2025

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Vassar College

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Available NEED Topics Include:

- US Economy
- Healthcare Economics
- Climate Change
- Economic Inequality
- Economic Mobility
- Trade and Globalization
- Minimum Wages
- Immigration Economics
- Housing Policy
- Federal Budgets
- Federal Debt
- Black-White Wealth Gap
- Autonomous Vehicles
- US Social Policy

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Course Outline

- **Contemporary Economic Policy**
  - Week 1 (1/21): Economic Update (Geoffrey Woglom, Amherst College)
  - Week 2 (1/28): Federal Debt and Deficits (Robert Rebelein, Vassar College)
  - **Week 3 (2/04): Health Economics (Robert Rebelein, Vassar College)**
  - Week 4 (2/11): Climate Change Economics (Sarah Jacobson, Williams College)
  - Week 5 (2/18): Tariffs and Their Effects (Alan Deardorff Umichigan)
  - Week 6 (2/25): The New Inequality (Geoffrey Woglom, Amherst College)

Submitting Questions

- **Please submit questions in the chat.**
  - I will try to handle them as they come up but may take them in a bunch as time permits.
- **We will do a verbal Q&A once the material has been presented.**
  - And the questions in the chat have been addressed.
- **OLLI allowing, we can stay beyond the end of class to have further discussion.**
- **Slides will be available from the NEED website tomorrow (https://needelegation.org/delivered_presentations.php)**

Healthcare is a very complex issue

Outline:

- U.S. Healthcare spending
- Assessing the current system
  - Access
  - Quality
- The economics of Healthcare
  - Includes reasons for rising expenditures
- Concentration in specific markets
  - Pharmaceuticals
  - Hospitals
  - Insurance
- Alternative Healthcare systems

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Before we start…

- Most of the data presented today comes from research done by the Kaiser Family Foundation. You can learn much more about healthcare at www.kff.org
- Expenditure = Price times Quantity

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Major Problems for the US

- **ACCESS** to healthcare is not always great
- **QUALITY** of healthcare is not always great
- Expenditure growth is unsustainable
- Increasing dependence on government payments
- Lack of competition in key markets

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Spending on Healthcare in the U.S.

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Health Economics is Big Business

- Healthcare is the biggest industry and the largest employer in the U.S.
- We spend **A LOT** on healthcare:
  - In 2023, U.S. national health expenditures were about **$4.9 trillion** ($14,570 per person) which is approximately **17.6% of GDP**
  - Expenditures grew 7.5% from 2022 to 2023
  - U.S. Healthcare would be the 3rd largest economy in the world

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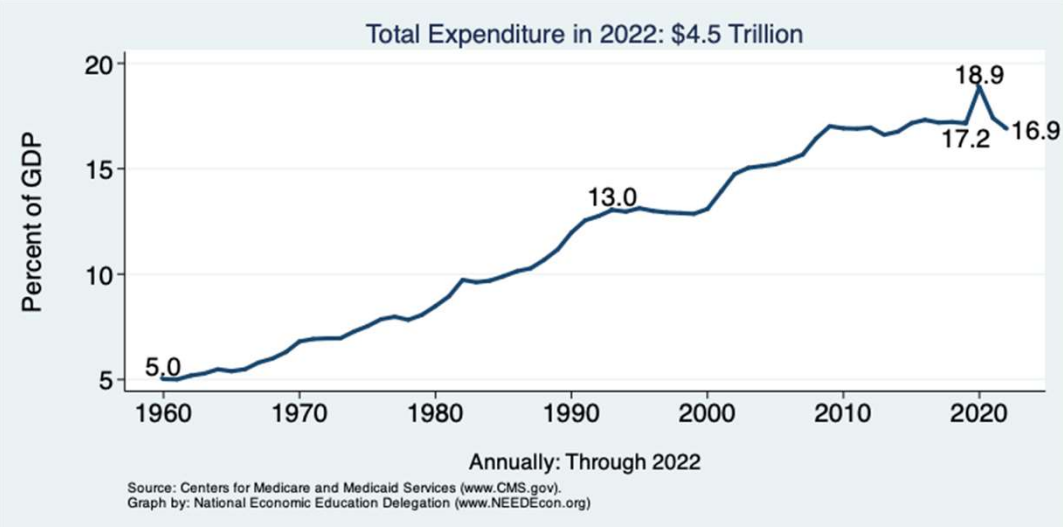
National Health Expenditure as Percent of GDP



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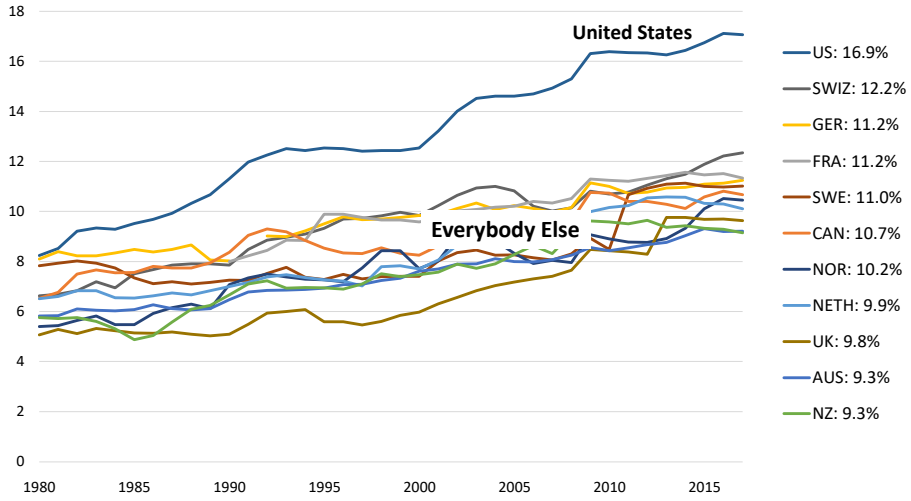
Health Care Spending as % of GDP, 1980–2018



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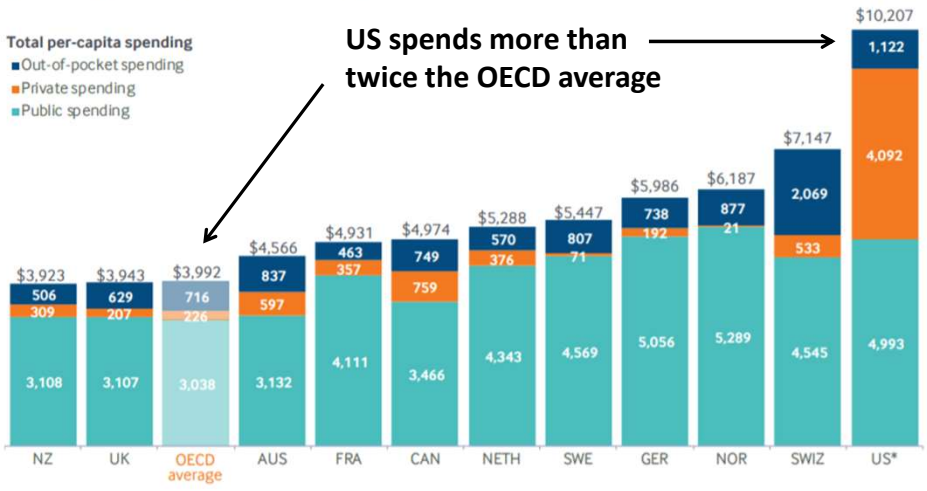
Source: Roosa Tikkanen and Melinda K. Abrams, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes* (Commonwealth Fund, Jan. 2020).

International Per Capita Healthcare Spending

Dollars (US$), adjusted for differences in cost of living



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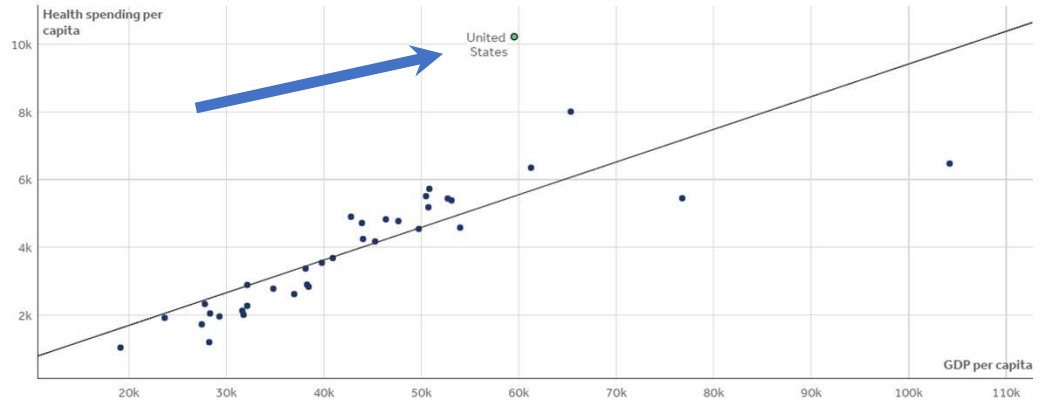
Source: Roosa Tikkanen and Melinda K. Abrams, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes* (Commonwealth Fund, Jan. 2020).

GDP per Capita and Health Spending per Capita, 2017



Notes: U.S. value obtained from National Health Expenditure data. Health consumption does not include investments in structures, equipment, or research.

Source: KFF analysis of OECD and National Health Expenditure (NHE) data • Get the data • PNG

Peterson-KFF Health System Tracker

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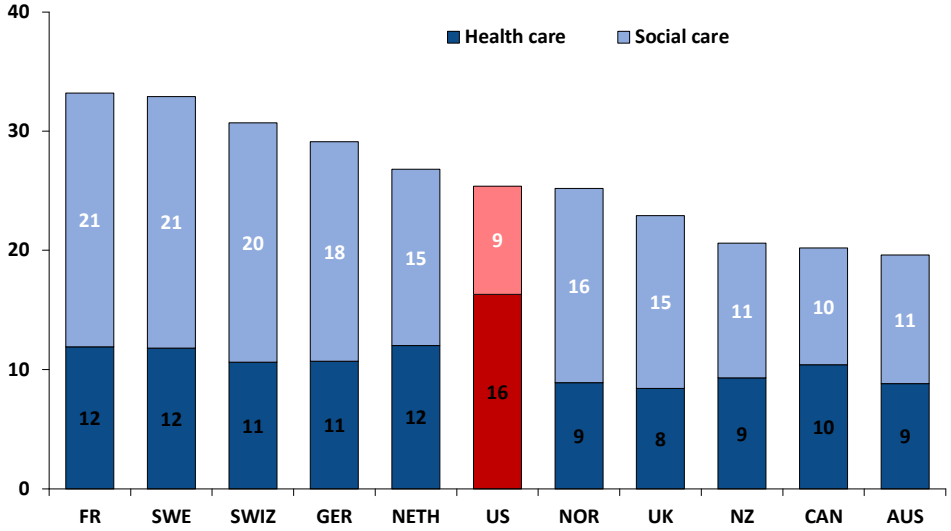
Health Care vs Social Care Spending



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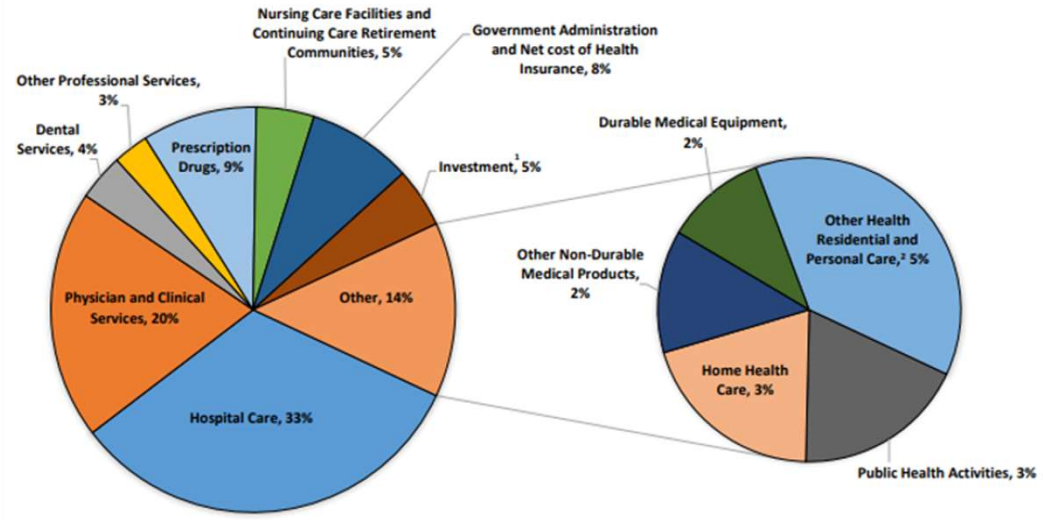
Source: E. H. Bradley and L. A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less*, Public Affairs, 2013.

Health Care vs Social Care Spending

- A 2013 study by Bradley and Taylor found that the U.S. spent the least on social services—such as retirement and disability benefits, employment programs, and supportive housing—among the countries studied in this report, at just 9 percent of GDP.
- From 2000 to 2011, for every dollar the US spent on health care, the country spent another $1.00 on social services, whereas across the OECD, for every dollar spent on health care, countries spend an additional $2.50 on social services

Selected Statistics

Where the money goes:



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Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

U.S. Health Care Expenditure Data

	Total ($bill)	Out-of-Pocket	Medicare	Medicaid	Private & other Health Ins.	Other Third-Party Payers	GDP ($bill)	Total Expends as a share of GDP	Medicare & Medicaid share of Federal Budget
1960	**$27**	**48%**	**0%**	**0%**	**27%**	**25%**	**$543**	**5%**	**0%**
1980	**$255**	**23%**	**15%**	**10%**	**31%**	**22%**	**$2,863**	**9%**	**8%**
2000	**$1,369**	**15%**	**16%**	**15%**	**36%**	**19%**	**$10,285**	**13%**	**19%**
2018	**$3,649**	**10%**	**21%**	**16%**	**37%**	**16%**	**$20,580**	**17.7%**	**27%**

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Average total health spending, by age and sex, 2021

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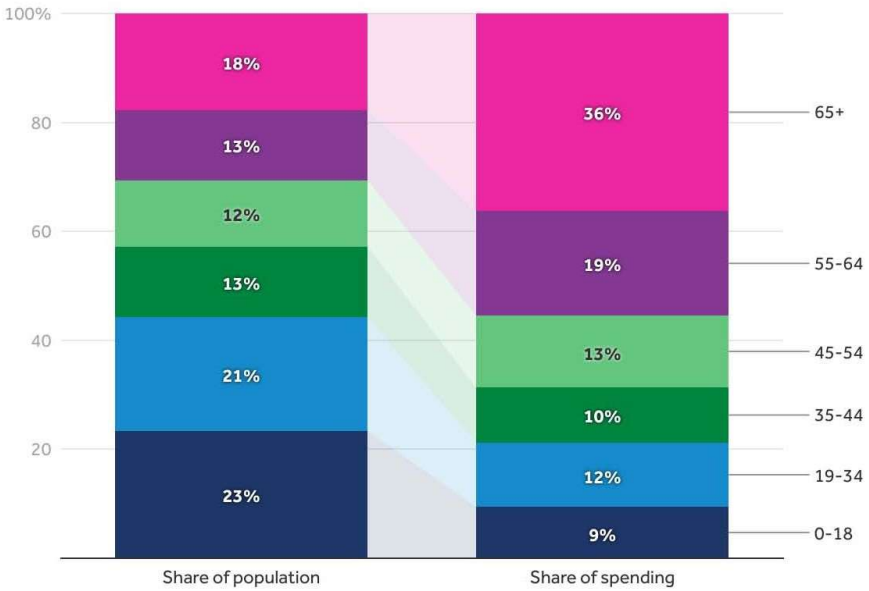
Share of total population and total health spending, by age group, 2021



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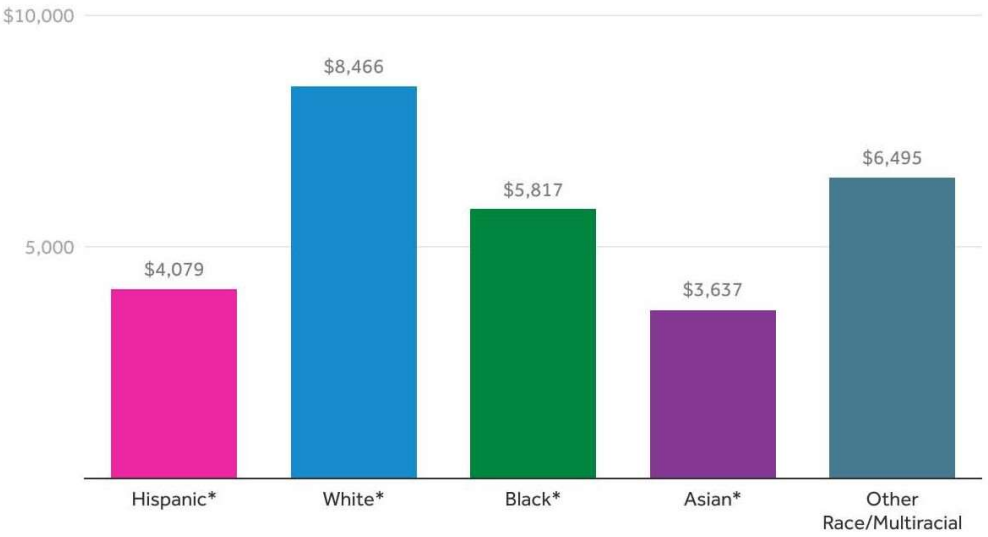
Average total health spending, by race/ethnicity, 2021



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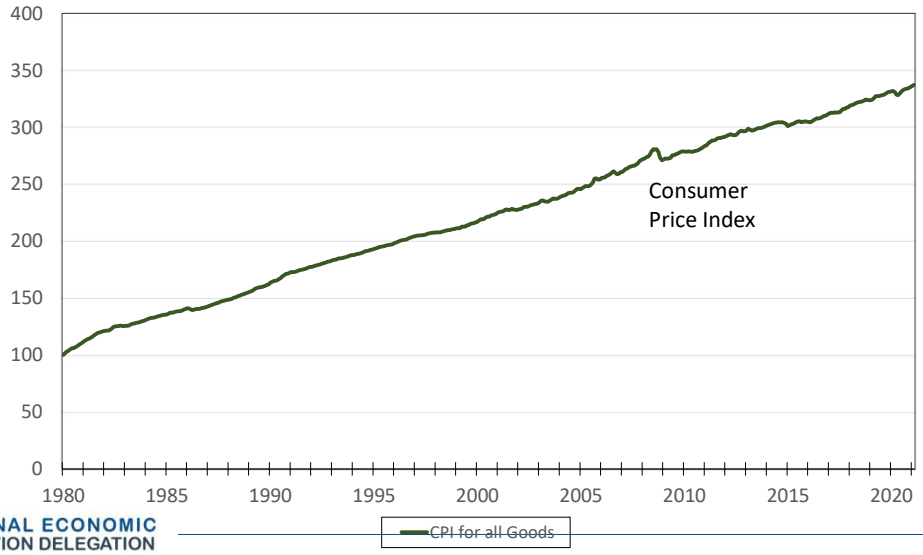
Inflation – CPI for all goods



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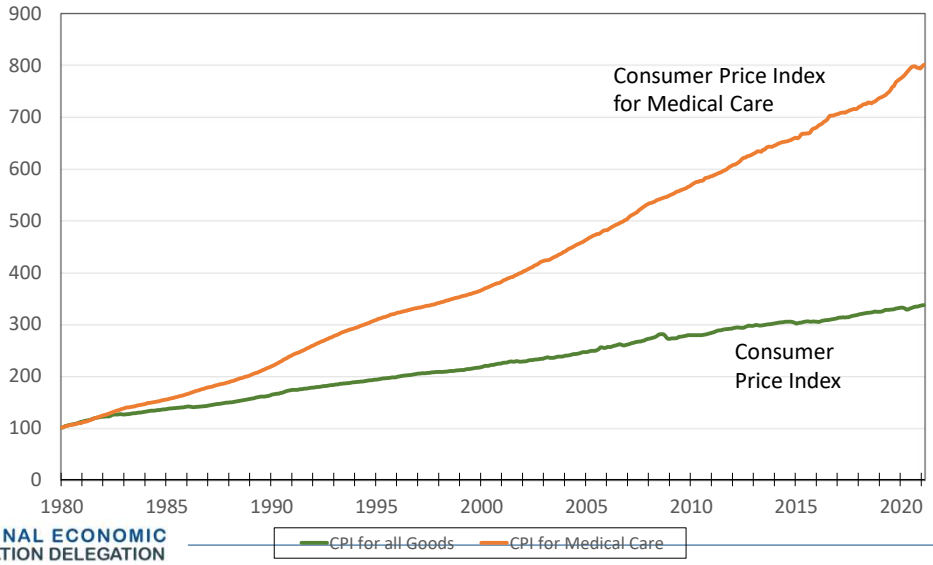
Inflation – CPI for Medical Care



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Assessing the U.S. Healthcare System:

Access to Healthcare Services

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Health Insurance Coverage, 2022 – 92.1%

Countries with Less Than Universal Coverage

Country	% of Persons
Slovakia	94.5
Chile	94.3
UNITED STATES	92.1
Poland	91.5
Mexico	90.2
Algeria	90.9
Jordan	55.0

Countries with Universal Coverage

Countries	% of Persons
Australia	100
Canada	100
Czech Republic	100
France	100
United Kingdom	100
Greece	100
Hungary	100
And 21 more	**99+**

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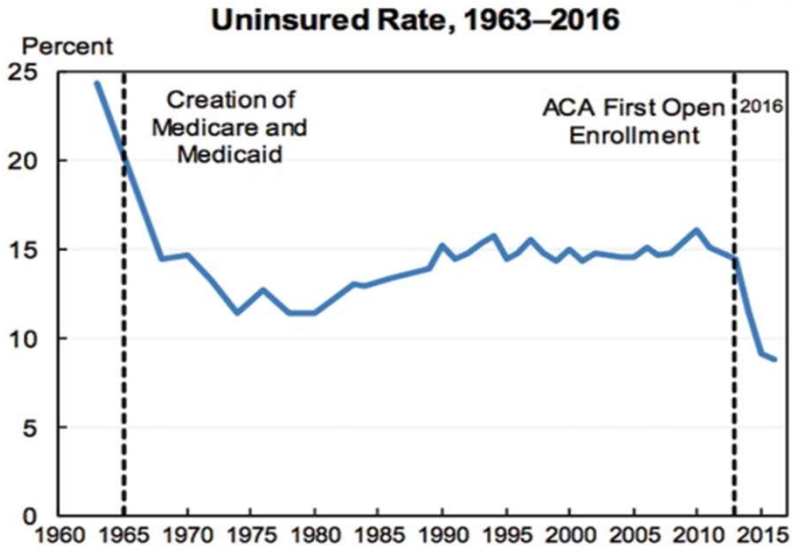
Source: Organization for Economic Cooperation and Development

Uninsured rate dropped dramatically after first ACA open enrollment in 2016



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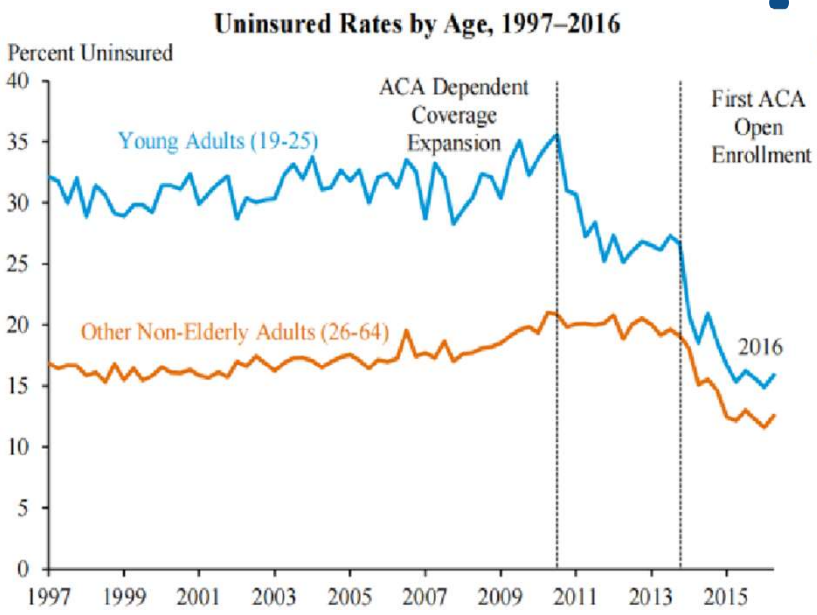
Uninsured Rate dropped dramatically with the ACA; Drop was more significant for young adults



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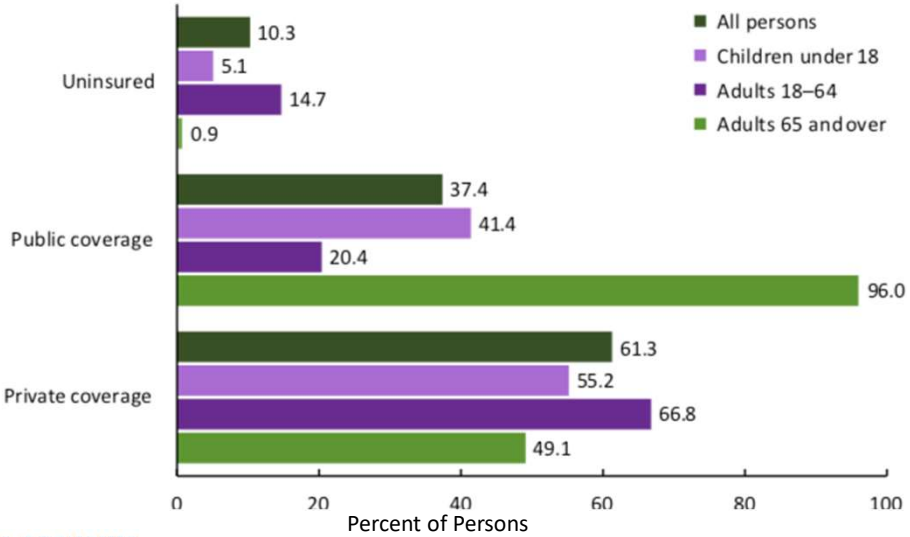
Health Insurance Coverage By Age, 2019



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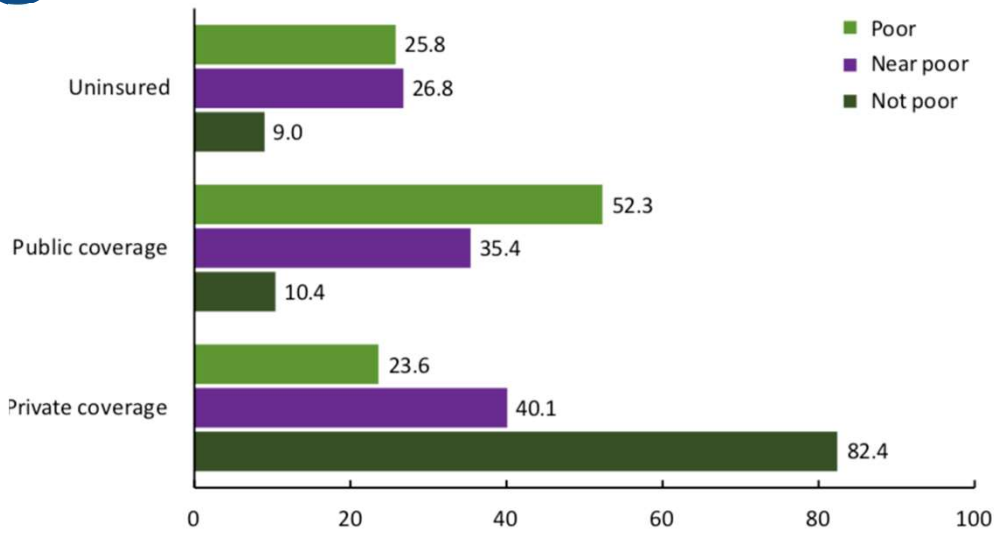
Source: National Center for Health Statistics

Health Insurance Coverage by Income, 2019



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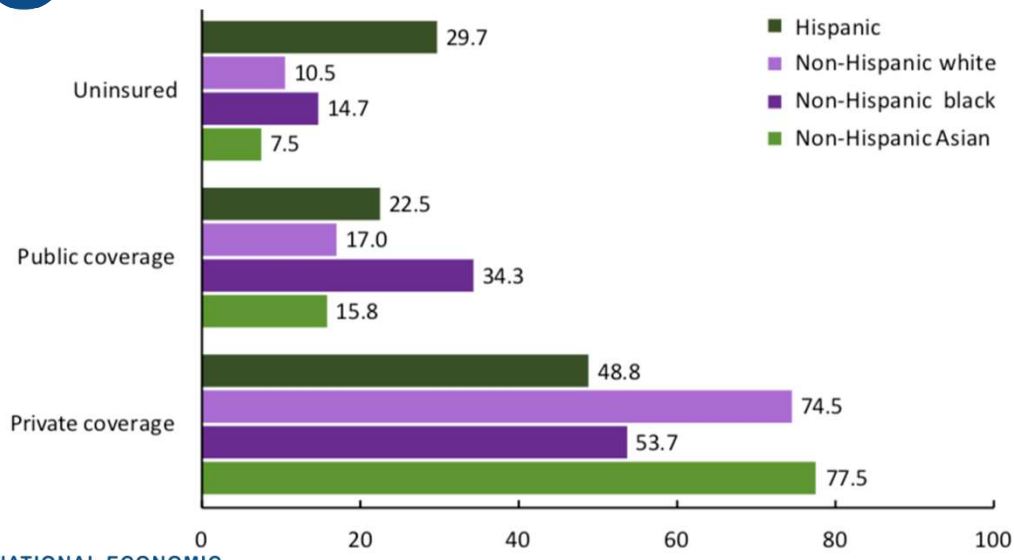
Source: National Center for Health Statistics

Health Insurance Coverage by Race, 2019



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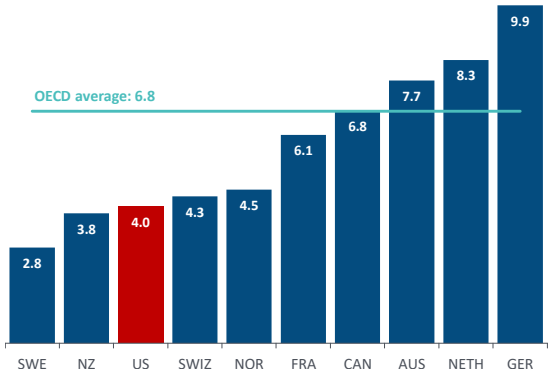
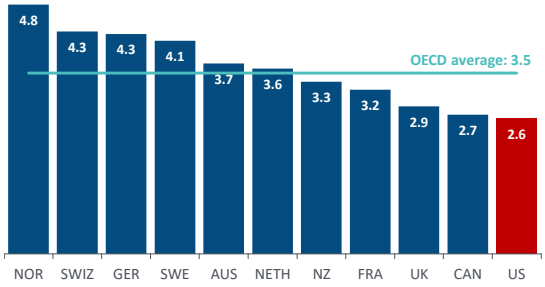
Source: National Center for Health Statistics

Physician Visits and Physician Supply

Average physician visits per capita, 2017



Practicing physicians per 1,000 population, 2018



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Source: Roosa Tikkanen and Melinda K. Abrams, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes* (Commonwealth Fund, Jan. 2020).

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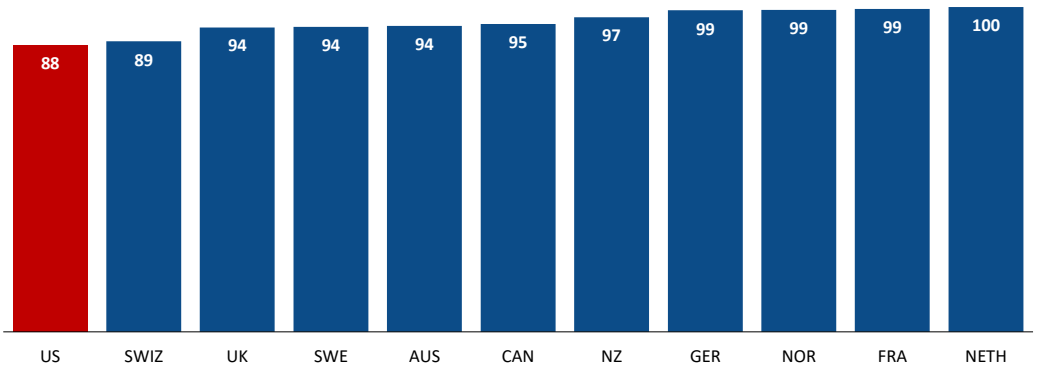
Percent of Women Ages 18–64 Who Reported Having A Regular Doctor/Regular Place of Care



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Source: Munira Z. Gunja et al., *What Is the Status of Women's Health and Health Care in the U.S. Compared to Ten Other Countries?* (Commonwealth Fund, Dec. 2018).

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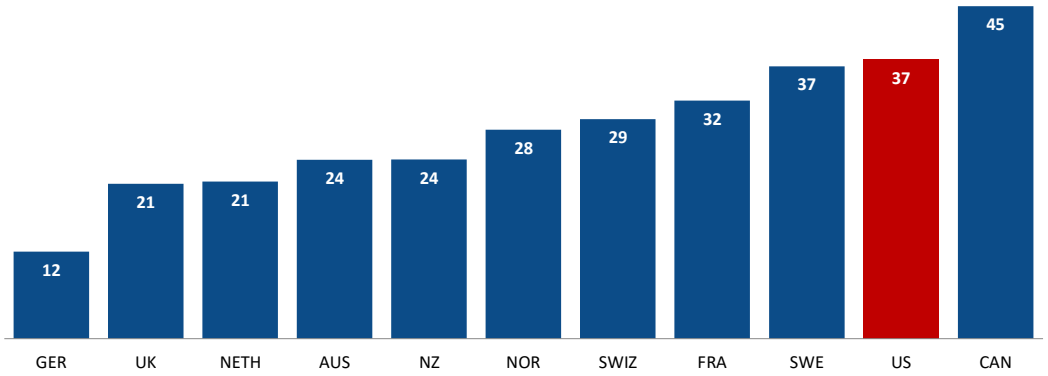
Percent of Women Ages 18–64 Who Reported Going to the Emergency Room in the Past Two Years



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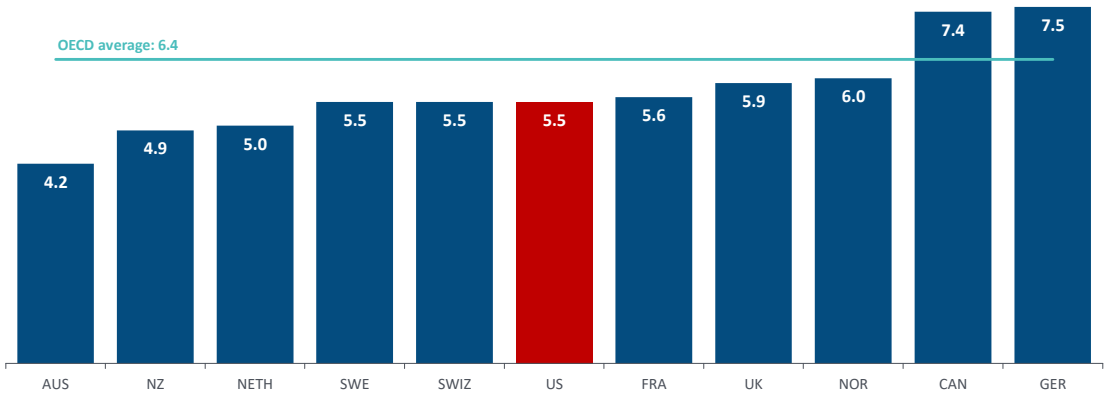
Source: Munira Z. Gunja et al., *What Is the Status of Women's Health and Health Care in the U.S. Compared to Ten Other Countries?* (Commonwealth Fund, Dec. 2018).

Hospital Acute Care Average Length of Stay

Average length of stay for acute care (days)



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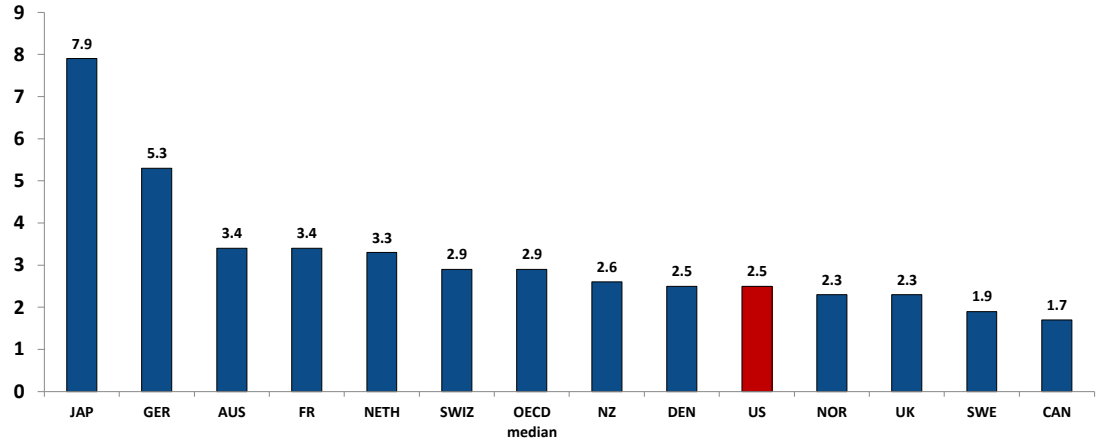
Acute Care Hospital Beds per 1,000 Population



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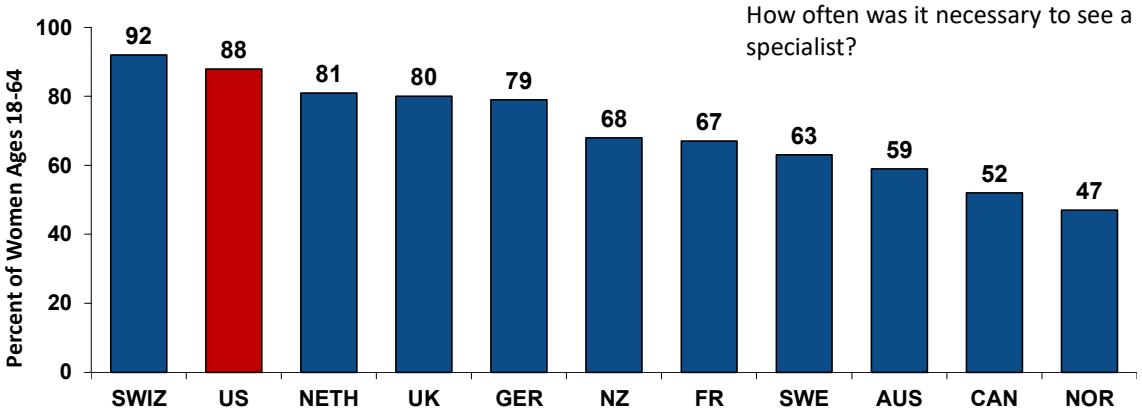
Source: OECD Health Data 2015.

Waited Less Than a Month to See A Specialist

But how much time did they spend with the specialist?

How often was it necessary to see a specialist?



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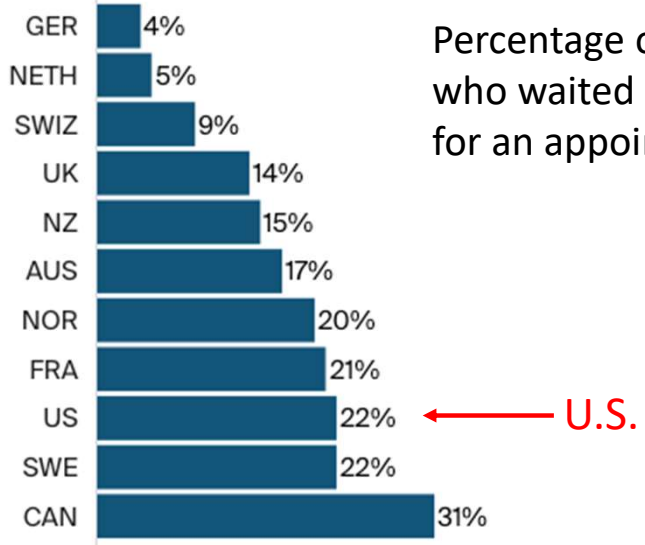
Source: 2011 Commonwealth Fund International Health Policy Survey of Sicker Adults in Eleven Countries.

More About Wait Times



Percentage of adults aged 65+ who waited more than 6 days for an appointment when sick.

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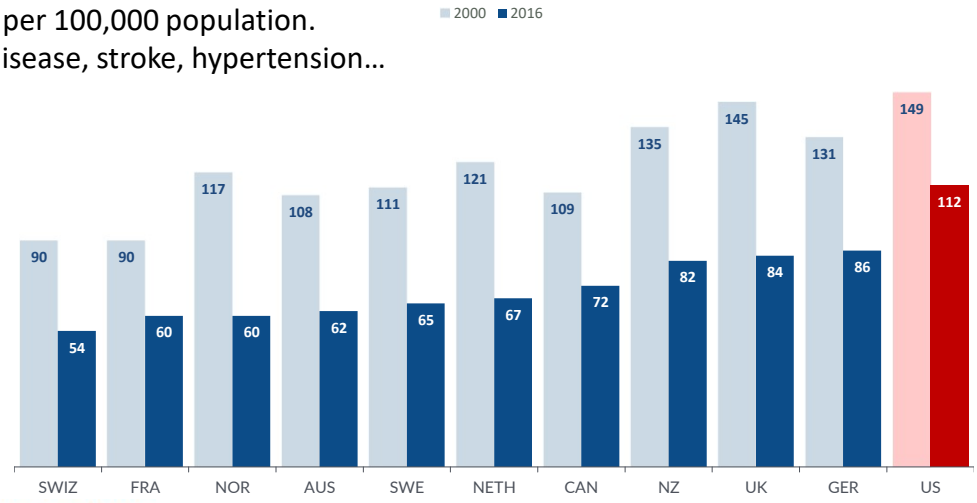
Source: Commonwealth Fund, Comparing Nations on Timeliness and Coordination of Health Care, 2021

Avoidable Deaths

Deaths per 100,000 population.
Heart disease, stroke, hypertension…



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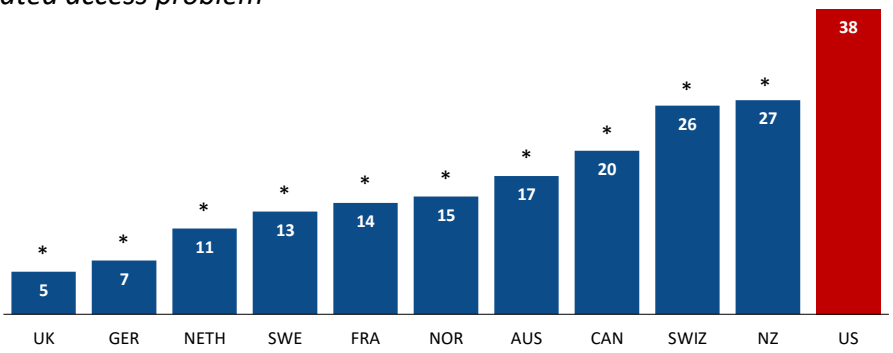
Source: Roosa Tikkanen and Melinda K. Abrams, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes* (Commonwealth Fund, Jan. 2020).

Skipped Care Because of Cost

Percent of women ages 18–64 with at least one cost-related access problem



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Source: Munira Z. Gunja et al., *What Is the Status of Women's Health and Health Care in the U.S. Compared to Ten Other Countries?* (Commonwealth Fund, Dec. 2018).

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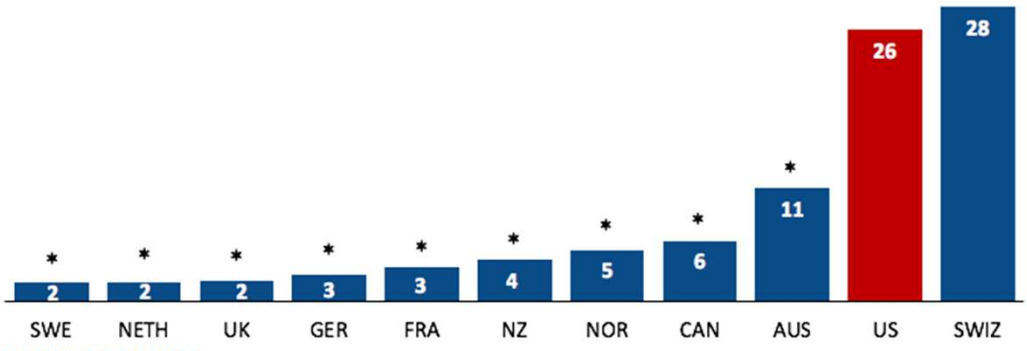
Out-of-Pocket Costs

Percent of women ages 18–64 with out-of-pocket costs of $2,000 or more.



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Source: Munira Z. Gunja et al., *What Is the Status of Women's Health and Health Care in the U.S. Compared to Ten Other Countries?* (Commonwealth Fund, Dec. 2018).

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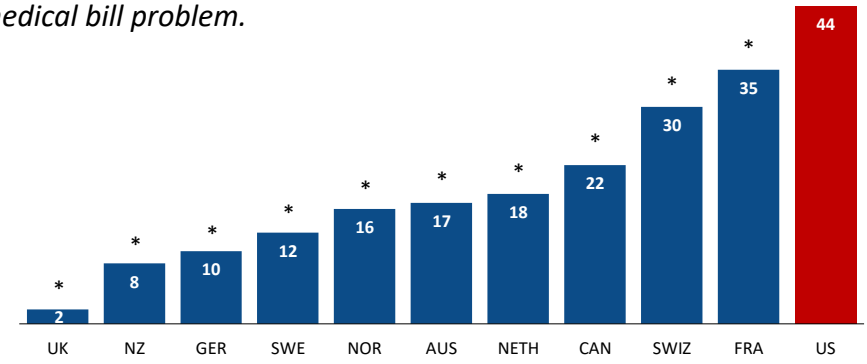
Medical Bill Problems

Percent of women ages 18–64 with at least one medical bill problem.



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Source: Munira Z. Gunja et al., *What Is the Status of Women's Health and Health Care in the U.S. Compared to Ten Other Countries?* (Commonwealth Fund, Dec. 2018).

Notes about Healthcare Access

- **Insurance coverage in the U.S. is not universal.**
  - Is universal in every other developed country.
- **Wait times are not necessarily lower in the U.S.**
- **Supply of medical personnel and equipment is lower than some other countries**
- **Emergency room use is higher in the U.S. than elsewhere.**
- **Specialized medicine more accessible in the U.S.**
- **Avoidable deaths are higher in U.S., perhaps indicating less access to care**

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Assessing the U.S. Healthcare System:
Quality of Healthcare Services

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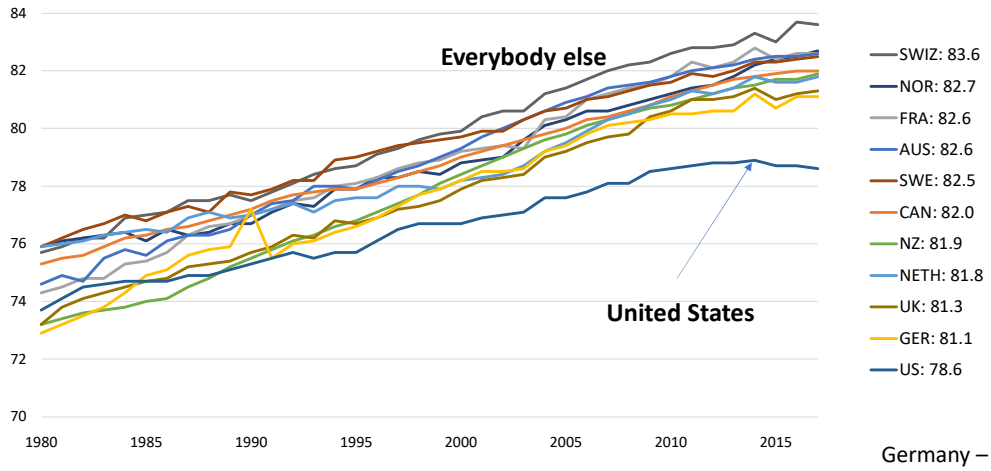
Life Expectancy: How Does the US Compare?



Germany – US = 2.5 years
Switzerland – US = 5 years

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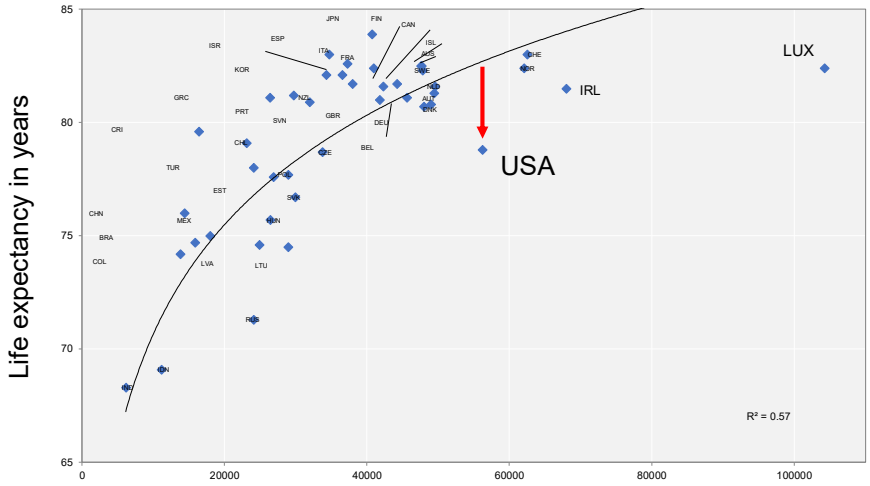
Source: Roosa Tikkanen and Melinda K. Abrams, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes* (Commonwealth Fund, Jan. 2020).

Life Expectancy & Per Capita GDP



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Life Expectancy at Birth by Race/Ethnicity, 2019

Race/Ethnicity	Life Expectancy (Years)
All Races	78.8
White	78.8
Black	74.8
Hispanic	81.9
Asian	85.6

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Source: KFF, Key Data on Health and Health Care by Race and Ethnicity

Income Also Matters – Reflecting Access?

Sex	Income Category	Life Expectancy (Years)	Difference High vs Low
Women	**Highest** Incomes (top 1%)	88.9	10.1 years
	Lowest Incomes (bottom 1%)	78.8	
Men	**Highest** Incomes (top 1%)	87.3	14.6 years
	Lowest Incomes (bottom 1%)	72.7	

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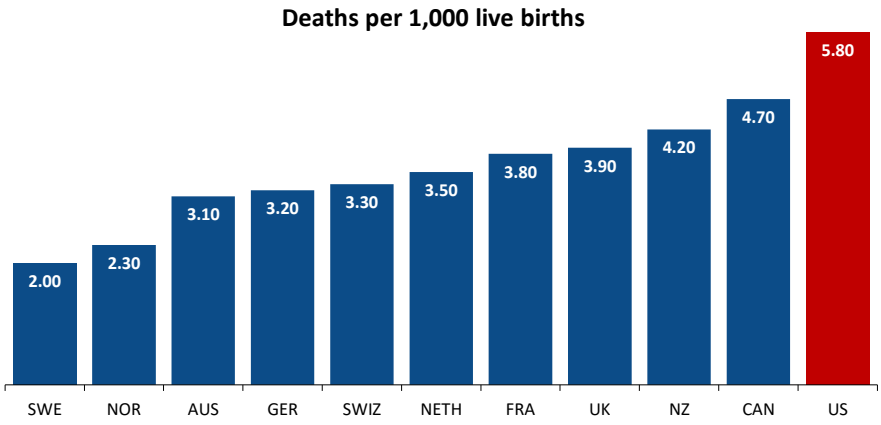
Source: https://healthinequality.org/documents/paper/healthineq_summary.pdf

Infant Mortality Comparison



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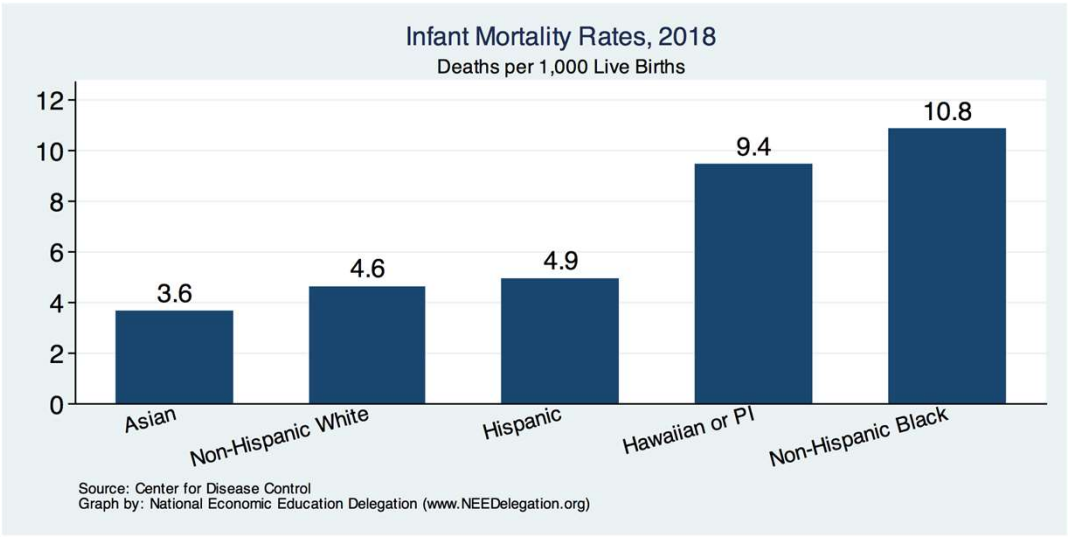
Source: NEED from OECD Data

Infant Mortality by Race/Ethnicity



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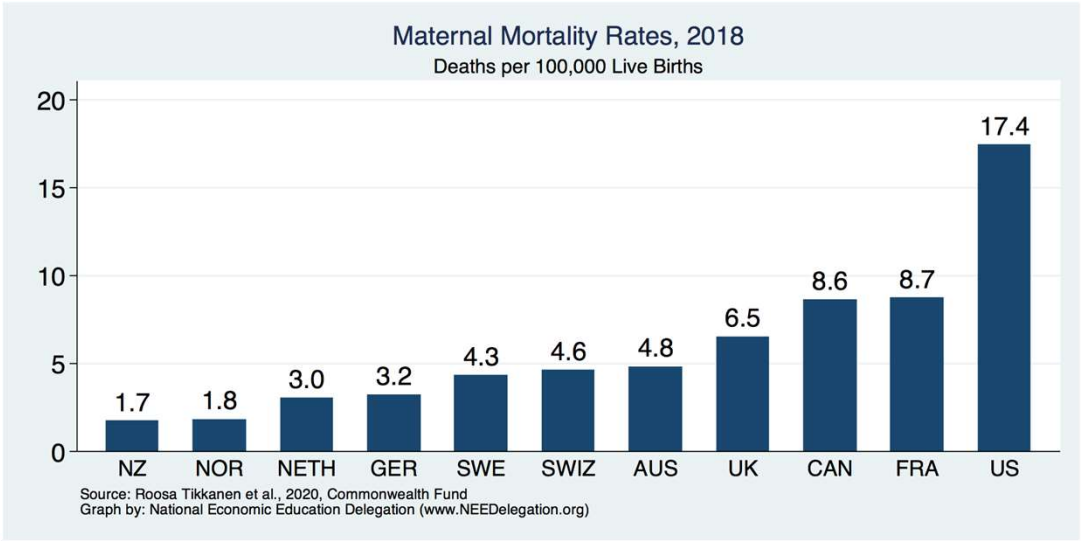
Maternal Mortality Rates



NATIONAL ECONOMIC EDUCATION DELEGATION

Source: Roosa Tikkanen et al., *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries* (Commonwealth Fund, Nov. 2020). https://doi.org/10.26099/411v-9255

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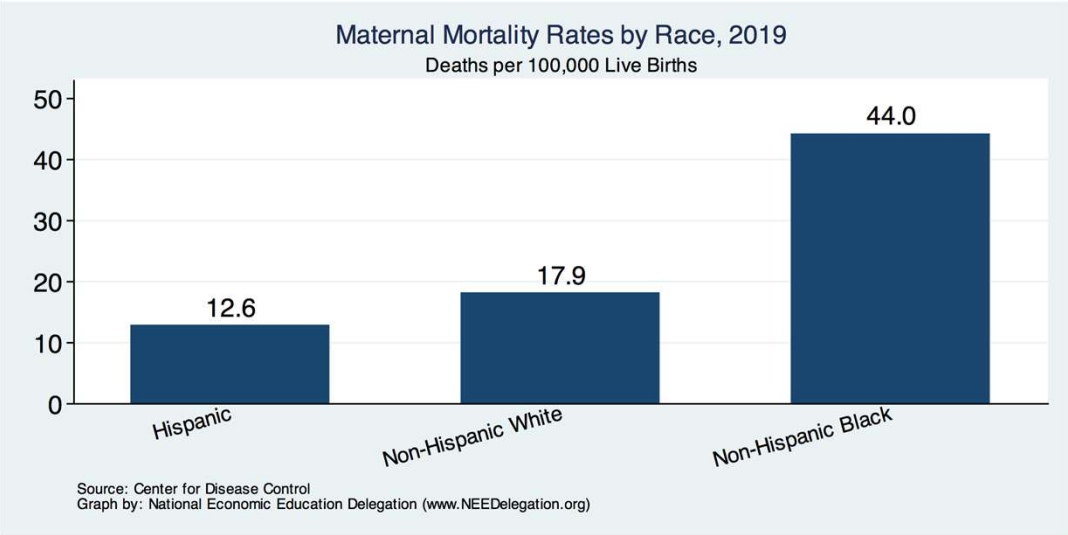
Maternal Mortality Rates by Race



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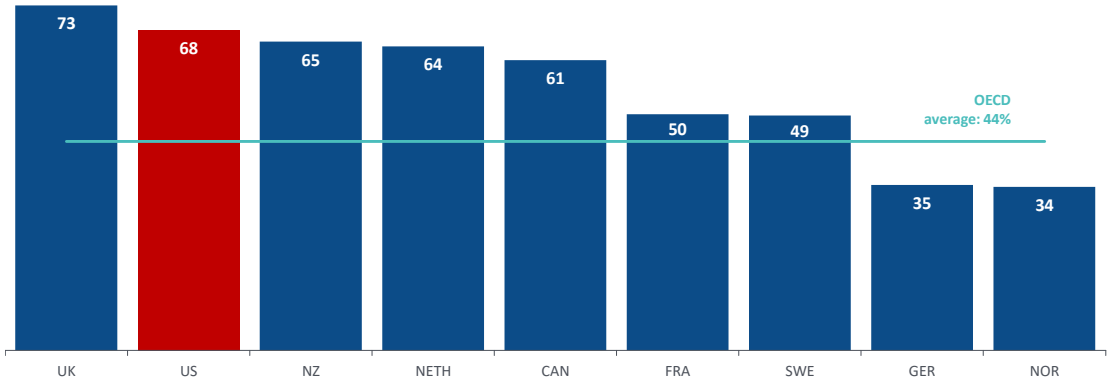
Flu Immunization

Percent of adults age 65 and older immunized (%).



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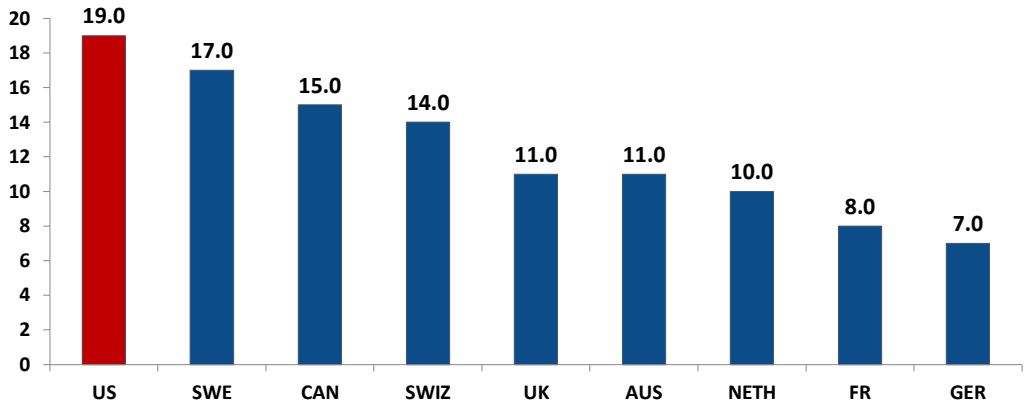
Source: Roosa Tikkanen and Melinda K. Abrams, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes* (Commonwealth Fund, Jan. 2020).

Percent of adults who have experienced medical, medication, or lab errors or delays



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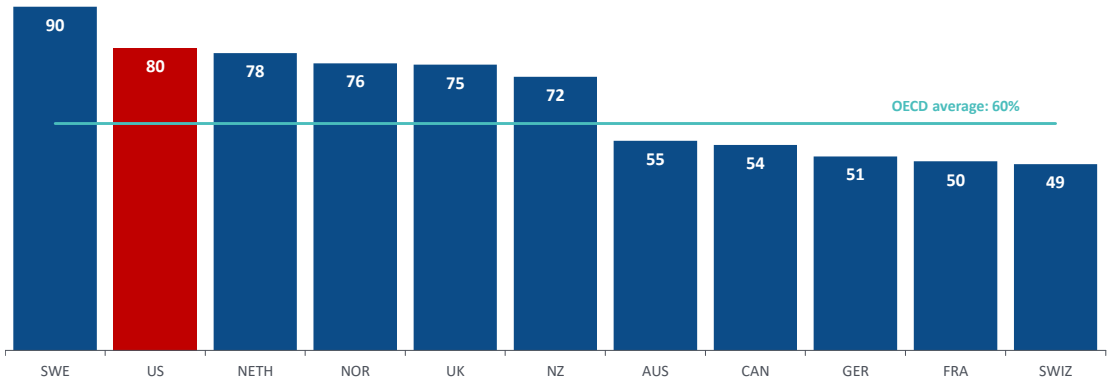
Source: 2016 Commonwealth Fund International Health Policy Survey.

Breast Cancer Screening

Percent of females ages 50–69 screened (%).



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Source: Roosa Tikkanen and Melinda K. Abrams, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes* (Commonwealth Fund, Jan. 2020).

Prevention and Screening

- The U.S. excels in **some** prevention measures (high ranking:
  - including **flu vaccinations** and **breast cancer screenings**.
- The U.S. has:
  - The highest average five-year survival rate for breast cancer,
  - but the Lowest for cervical cancer.

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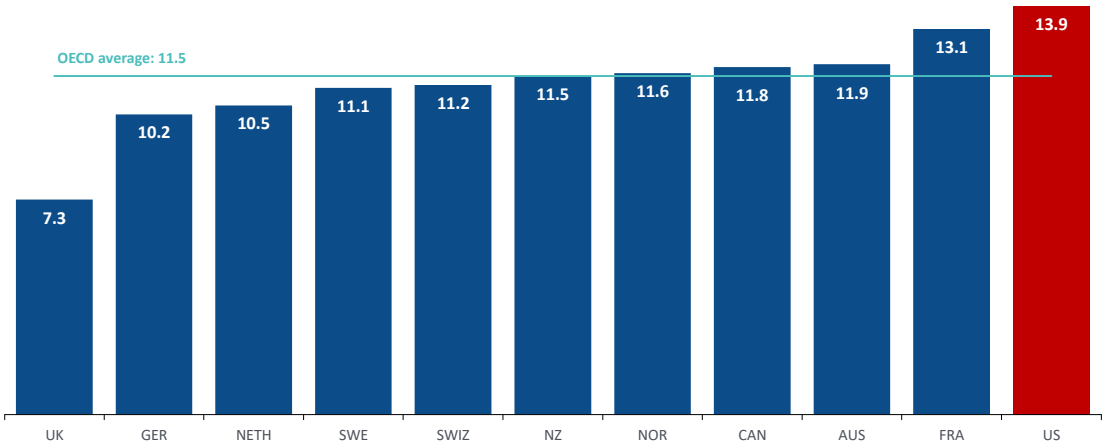
Suicides, 2016

Deaths per 100,000 population



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Source: Roosa Tikkanen and Melinda K. Abrams, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes* (Commonwealth Fund, Jan. 2020).

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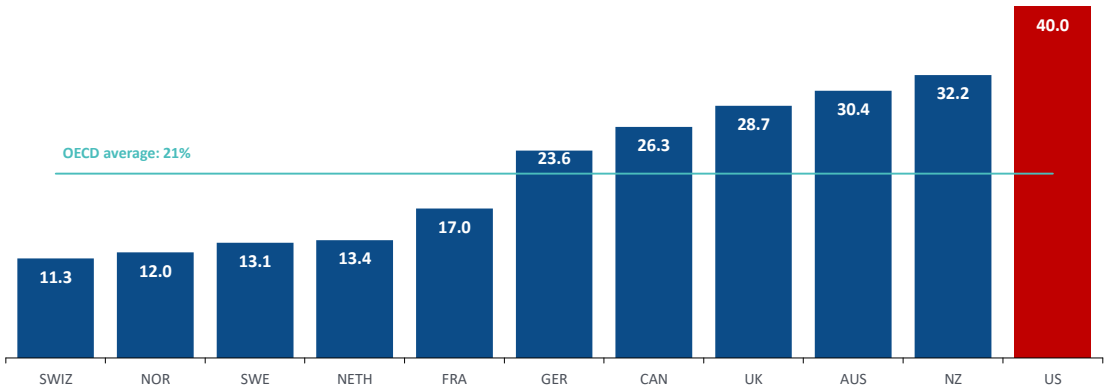
Obesity Rate, 2017

Percent (%)



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Source: Roosa Tikkanen and Melinda K. Abrams, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes* (Commonwealth Fund, Jan. 2020).

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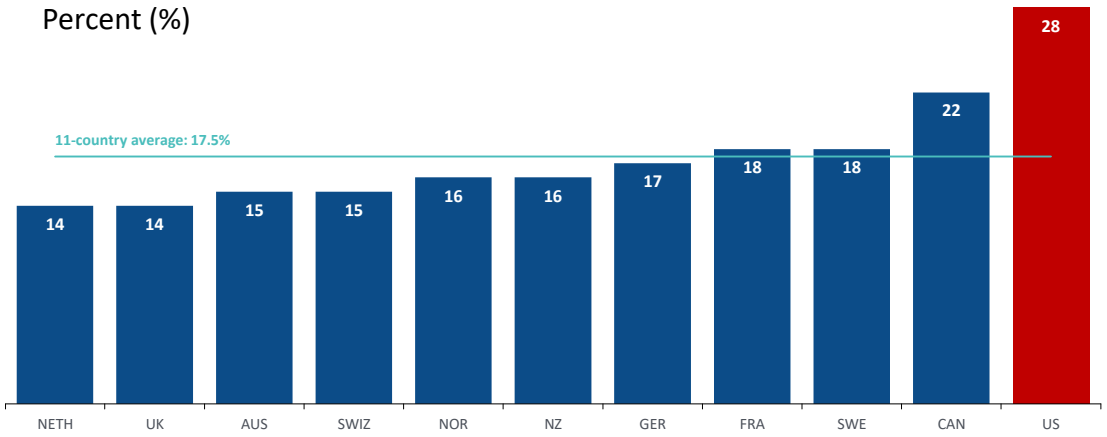
Adults with Multiple Chronic Conditions, 2016

Percent (%)



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Source: Roosa Tikkanen and Melinda K. Abrams, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes* (Commonwealth Fund, Jan. 2020).

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Notes About U.S. Healthcare Quality

- The U.S. has the **highest chronic disease burden**
  - and an obesity rate that is two times higher than the OECD average.
- The U.S. has **fewer physicians** and **fewer physician visits** than most peer countries
- The U.S. has the **highest rate of avoidable deaths**.
- Americans use more **expensive technologies** and **specialists**
  - MRIs, and specialized procedures, such as hip replacements, more often than our peers.
- The U.S. outperforms its peers in terms of many **preventive measures**

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Notes About U.S. Healthcare Quality

- The U.S. has the **highest chronic disease burden**
  - and an obesity rate that is two times higher than the OECD average.
- Americans had **fewer physician visits** than peers in most countries
  - which may be related to a low supply of physicians in the U.S.
- The U.S. has among the highest # of **hospitalizations from preventable causes**
  - and the highest rate of avoidable deaths.
- Americans use some **expensive technologies**
  - MRIs, and specialized procedures, such as hip replacements, more often than our peers.
- The U.S. outperforms its peers in terms of **preventive measures**
  - One of the highest rates of breast cancer screening among women ages 50 to 69.
  - Second-highest rate (after the U.K.) of flu vaccinations among people age 65 and older.

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Quality of Care Notes

- Metrics of quality in the U.S. don't compare well to other countries.
- The system has challenges: obesity, lifestyle, etc.
- The system has bright spots: immunization and screening rates

The Economics of Healthcare

An Economic View

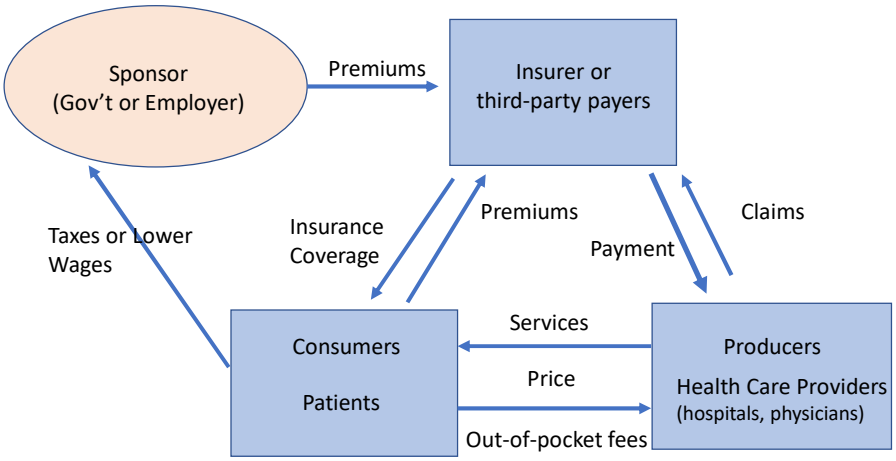
The Healthcare system consists of many markets:

- Medical services
- Physicians
- Nurses
- Other care providers
- Hospital facilities
- Pharmaceuticals
- Health Insurance
- Medical supplies (e.g., diagnostic and therapeutic equipment)
- Nursing homes
- Rehab facilities
- Other?

Medical Services Unlike Other Products

- For most products, the price reflects the good's value to buyers and the cost to sellers for producing the good; prices adjust to balance supply and demand.
  - These equilibrium prices guide economic decisions and help to allocate society's scarce resources.
- Third-party payment system separates buyers from the true cost of the products/services they are consuming
- Many healthcare products/services are heterogeneous across consumers
- Buyers are poorly informed and ask suppliers what they need

Health Care Markets are Different



How much does an office visit cost to produce?

- Any ideas? Includes cost of facility and supplies, wages for doctors and nurses and other staff, their utilities and insurance, etc.
- We pay a small co-pay
- As a result, we consume more than we would if we had to pay the full cost

Rising HC Expenditures: Demand factors

- Rising incomes
  - health care is a “normal” good
- Aging population
- Unhealthy lifestyles
- Over-indulgence in specialized care
  - 2 in 5 adults in the U.S. get general care from specialists

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Rising HC Expenditures: Demand factors (cont.)

- Role of providers:
  - Supplier induced demand (?)
  - Defensive medicine (?)
- **Third-party payer system separates consumers from the cost of services**

  ➔**Prices can’t properly signal surpluses or shortages, etc.**

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Rising HC Expenditures: Supply Factors

- Limited supply of physicians
- Changes in medical technology
  - improved quality of tests, procedures, drugs, etc.
- Slow productivity growth
- Complex payment systems
- High administrative costs & lack of price control
  - Health care payers and providers spend $496 billion per year on billing/insurance costs

Two Comments

1. The United States has the only profit-motivated healthcare system in the world.
2. We have a health RESTORATION system, not a health **CARE** system.

Another Difference: "Right" or Moral Imperative

- **Health care as a product is often viewed as a "right" or moral imperative.**
  - This view argues for greater government interaction in the market, primarily to promote access.
    - ➔Subsidies for insurance and care.
    - ➔Market regulations to reduce inequities.
- **Unfettered free markets are unlikely to achieve social goals with respect to health care.**

How Much Did Your Flu Shot Cost?

- **Who knows? It's generally offered for free.**
- **Providers of the shot do pay for it.**
  - Some reported prices:
    - Sacrament, CA $85
    - Long Beach, CA $42
    - Washington, DC $15
- **Who really pays for the flu shot?**
  - YOU DO! Higher premiums.

Prices are negotiated with the Vaccine producer.

Differences are a reflection of More or less bargaining power.

Source: https://kffhealthnews.org/news/the-startlingly-high-cost-of-the-free-flu-shot/

Consequences of Rising Expenditures

- Reduced access to care
  - Waiting for treatment increases costs
- Slower wage growth
- Personal bankruptcies
- Impact on government budgets

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Tradeoffs

Tradeoffs take place among access, quality, and cost:

- Increasing quality in health care may lead to higher health care costs.
  - This could mean a compromise in access (affordability).
- I.e., with increasing quality, access may suffer.
- By increasing access, quality and cost may suffer.
- By decreasing costs, quality may suffer.

In healthcare in the United States, there are potential opportunities to improve all three simultaneously.

E.g., it is possible that increasing quality can reduce costs.

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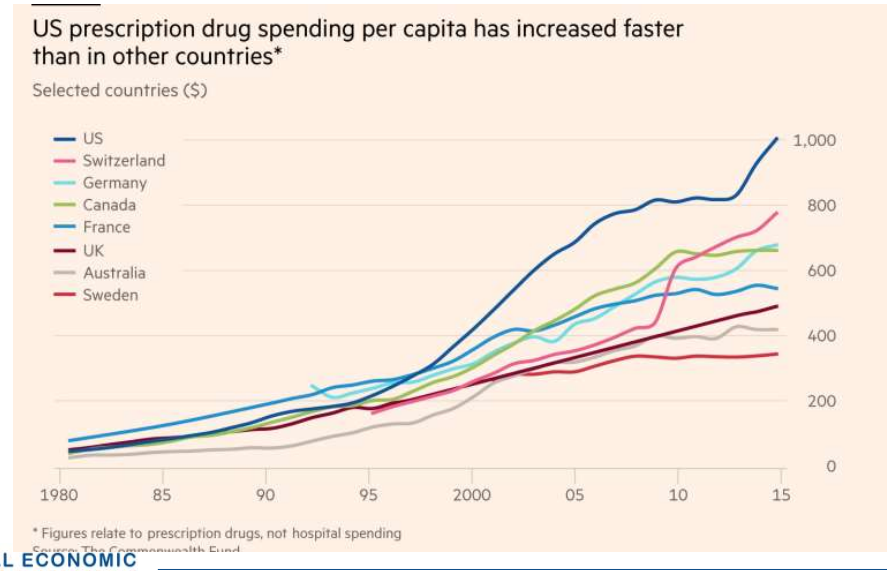
Concentration in specific markets:

1) Pharmaceuticals

Spending on Pharma: Trends Over Time



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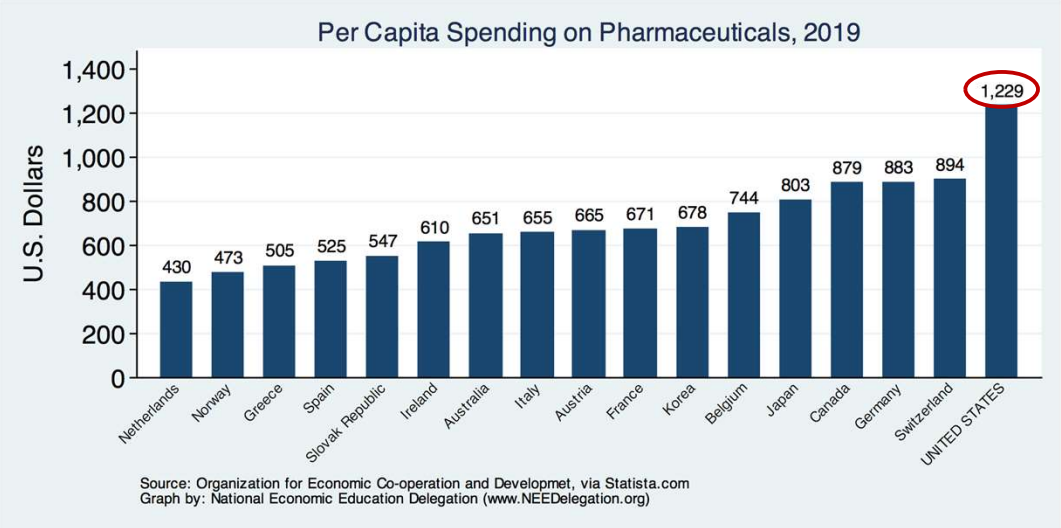
Spending on Pharmaceuticals



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International Drug Price Comparisons

Drug Prices for 30 Most Commonly Prescribed Brand-Name and Generic Drugs, 2006–07
US is set at 1.00

	AUS	CAN	FR	GER	NETH	NZ	SWITZ	UK	US
Brand-name drugs	0.40	0.64	0.32	0.43	0.39	0.33	0.51	0.46	1.00
Generic drugs	2.57	1.78	2.85	3.99	1.96	0.90	3.11	1.75	1.00

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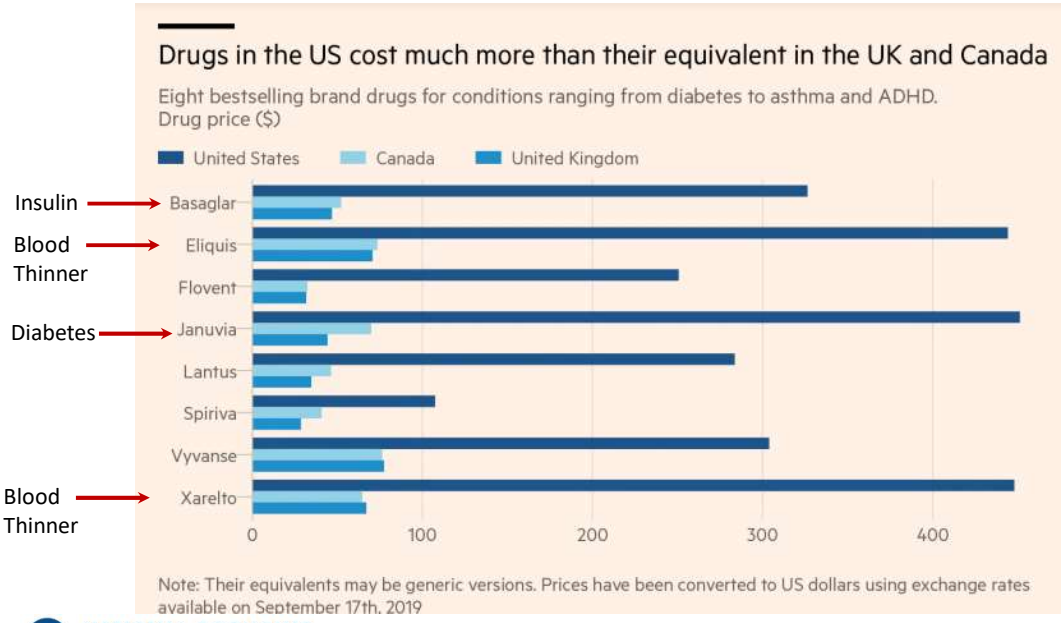
Source: IMS Health; analysis by Gerard Anderson, Johns Hopkins University.



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Reasons for higher drug prices

- **By law**, Medicare (Part D) **cannot** negotiate drug prices like other insurance programs do.
  - Beginning 01/01/2026, Medicare will be allowed to negotiate prices for 10 drugs (Part of the Inflation Reduction Act of 2022)
- In 2017, Medicare spent nearly $8 billion on insulin.
  - The researchers said that if Medicare were allowed to **negotiate** drug prices like the U.S. Department of Veterans Affairs (VA) can, Medicare could **save about $4.4 billion *just* on insulin**.
- Growing concentration of pharmaceutical companies.

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How Much is Negotiation Worth?

- The CBO estimates that drug pricing negotiation would reduce federal spending by $456 billion and increase revenues by $45 billion over 10 years. This would include:
  - direct savings for Medicare Part D **($448B)**
  - lower spending for the Affordable Care Act's subsidies for commercial health plans
  - lower spending for the Federal Employees Health Benefits Program
  - more government tax revenue because employers using savings from reduced premiums to fund wage increases for their workers.

Source: Congressional Budget Office, https://www.cbo.gov/system/files/2019-12/hr3_complete.pdf

Concentration in Pharmaceutical Companies

- The number of mergers and acquisitions involving one of the top 25 firms more than doubled:
  - 29 in 2006 to 61 in 2015
- Between 1995 and 2015, 60 drug companies merged into 10.

According to the GAO:

- **Between 2006 and 2015:**
  - Pharma and Biotech revenues increased from $534 billion to $775 billion (2015 $)
  - 67% of drug companies saw an increase in profit margins.
  - Top 25: profit margins were between 15 and 20%.
    - Across non-drug companies, profit margins are 4-9%.
- **Mergers**
  - # held constant, but deal values increased.
  - Largest 10 companies had about 38% market share – higher in narrower markets.
- **Between 2008 and 2014:**
  - 179 to 263 drug approvals occurred annually
    - 13% of approvals were for novel drugs.
- **Research indicates that fewer competitors are associated with higher prices.**
  - Especially in the market for generics.
- **Mergers have a varied impact on innovation: R&D spending, patent approvals, and drug approvals.**
  - Certain merger retrospective studies have found a negative effect.

https://www.gao.gov/assets/gao-18-40-highlights.pdf

Concentration in specific markets:

2) Hospital Consolidations

Hospital Monopolization

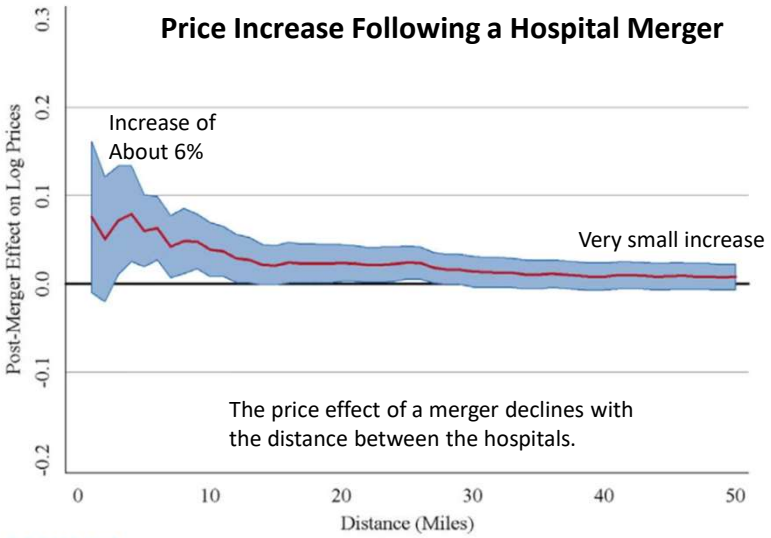
- Less competition in health systems, hospitals, medical groups, and health insurers has surged in recent years.
- Between July 2016 and January 2018:
  - Hospitals acquired 8,000 more medical practices.
  - 14,000 more physicians left independent practice to become hospital employees.
- Between 1999 and 2018, hospital profit margins soared!
  - From 100% in 1999 to 317% in 2018.
- Evidence suggests that with more government oversight and restraining mergers, health care costs would have been lower.

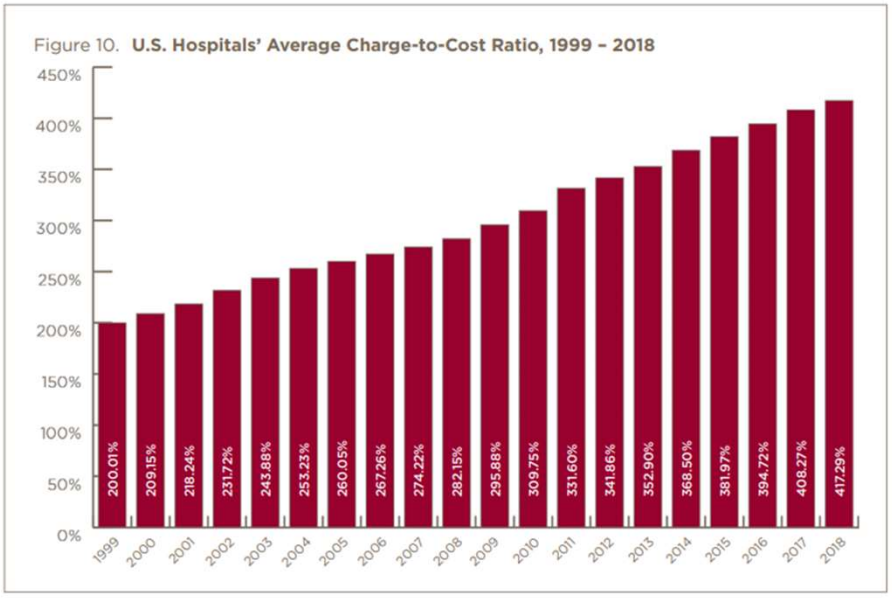
Potential Benefits of Consolidation

- **Consolidation could lead to potential benefits ("Triple Aim")**
  - Coordination of care
  - Investment in care coordination, quality.
  - Reduction of costly, unnecessary duplication.
  - Achievement of scale.
    - Costs
      - Risk contracts
      - Volume-outcome.
- **But, …**
  - Consolidation isn't integration.
  - Evidence doesn't support the claims.
    - Consolidation has not led to lower costs, better quality, or coordinated care.
    - If anything, just the opposite has happened.
    - We have 30 years of experience with consolidation to draw on.
      - Hospital mergers, integrated deliver systems, physician practice mergers, hospital acquisitions of physician practices…

Source: Martin Gaynor, NIHCM.org, Supersized: The Rise of Hospital Giants

Evidence on Consolidation





Hospital Monopolization Across the Nation

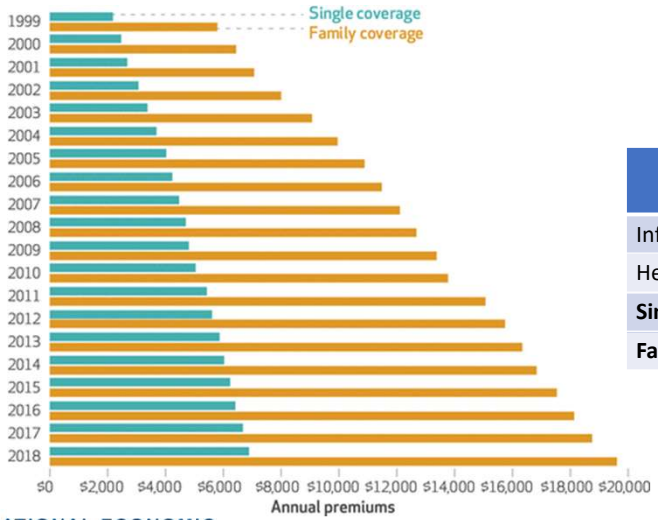
- Hospitals Charge Patients More Than Four Times the Cost of Care
- The most expensive hospitals cost of care range from 1,129% at the low end to 1,808% at the high end.
- Most of the top 100 most expensive hospitals are located in states in the south and west.
  - Florida had the highest number, with 40 hospitals.
  - Other top states included Texas with 14 hospitals, Alabama with eight, Nevada with seven, and California with six.

Concentration in specific markets:

3) Health Insurance

Average Annual Insurance Premiums, 1999-2018

Employer provided, Not Adjusted for Inflation



Single: ~$2,000 to ~$7,000
Family: ~$5,900 to ~$19,500

	Average Annual Rate of Change
Inflation	2.19
Health Care CPI	3.68
Single coverage	**6.51**
Family coverage	**6.52**

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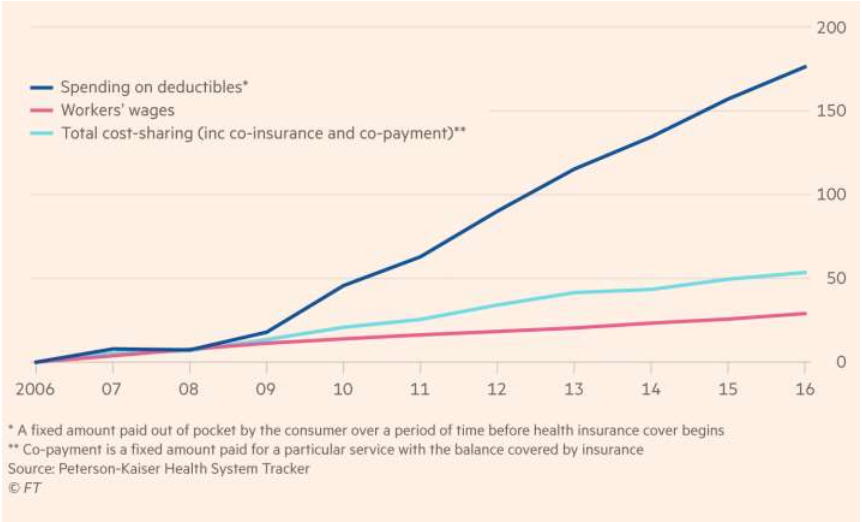
Source: The Commonwealth Fund

Spending on Deductibles



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Reason for Higher Health Insurance Rates

- Rising prices in the health sector
- Advances in medical technologies
- Increased demand for services
- Decreasing competition in health insurance markets

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Monopolization of Health Insurance Markets

- As of 2011, there were close to **100 insurers** in **Switzerland** competing for consumer health care dollars, **forcing firms to compete** by setting prices to just cover costs.
- In the United States, **markets are state specific;** consumers can choose only from plans available in the state in which they reside.
- In 2019, of the 50 states and the District of Columbia:
  - 21 had only 1 or 2 insurers (up from 11 in 2014)
  - 14 had 3 or 4, and
  - 16 states had 5 or more. (CA had 11)

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Source: KRR, Number of Issuers Participating in the Individual Health Insurance Marketplaces

Alternative Health Care Systems

Definition: Universal Coverage

- **Universal coverage –** refers to a healthcare system in which ***all*** individuals have the same insurance coverage.
- Generally, this coverage includes:
  - Access to all needed services and benefits.
  - Protects individuals from excessive financial hardships.
    - Medical indebtedness is the #1 cause of bankruptcies in the United States.

Definition: Single-Payer

- **Single-payer** - refers to financing a healthcare system by making one entity solely and exclusively responsible for paying for medical goods and services. (Not necessarily the government.)
- Only the financing component is nationalized.
  - The money for the payment can be either collected by:
    - Taxes collected by the government
    - Premiums collected by National or Public Health Insurance
- **Single-payer systems: 17 countries**
  - Norway, Japan, United Kingdom, Kuwait, Sweden, Bahrain, Brunei, Canada, United Arab Emirates, Denmark, Finland, Slovenia, Italy, Portugal, Cyprus, Spain, and Iceland.

Definition: Socialized Medicine

- **Socialized medicine** – this model takes the single-payer system one step further.
  - Government not only pays for health care but operates the hospitals and employs the medical staff.
- This is NOT, and has NEVER been, part of the debate in the United States.

Definition: Third-Party Payer

- A **third-party payer** is an entity that pays medical claims on behalf of the insured. Examples of third-party payers include government agencies, insurance companies, health maintenance organizations (HMOs), and employers.
  - Employer-sponsored health plans
  - Individual market health plans
  - National health insurance

Potential pros and cons of national insurance

- **Potential Pros**
  - Universal coverage
  - Government controls quality of care
  - No medical bills or co-pays (or debt!)
  - Consolidated medical records (lower administrative costs; fewer errors)
  - Higher wages/wage growth
- **Potential Cons**
  - Higher taxes
  - Long wait times for elective services
  - Government determines service eligibility
  - May reduce incentives for innovation

Key ACA components

- **Expand health insurance coverage (i.e., increase access)**
  - Individual mandate
  - Corporate mandate
  - Insurance Exchanges
  - Medicaid expansion
- **Electronic medical records**
- **Cost effectiveness studies**

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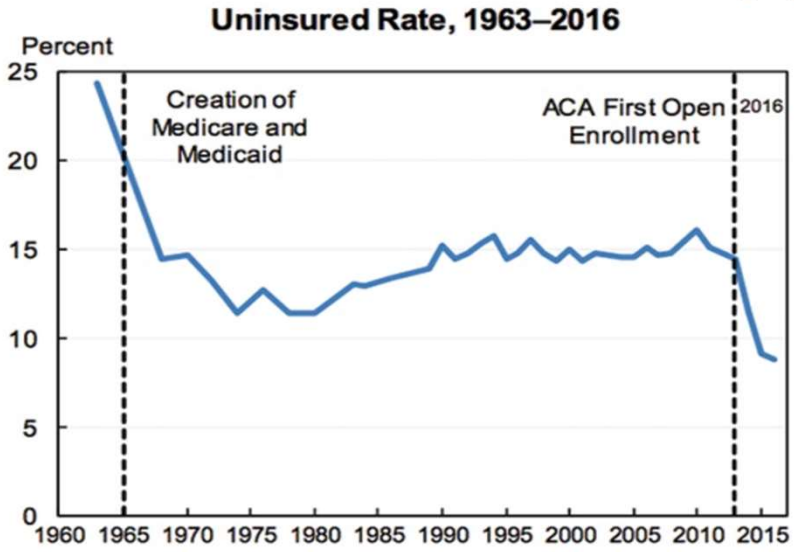
Uninsured rate dropped dramatically after first ACA open enrollment in 2016



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Summary

- US HealthCare system is **not performing well**.
  - Very expensive with low quality and access.
- One reason for rising expenditures is the **monopolization** of healthcare markets.
- **Universal health insurance** would increase access and perhaps also reduce costs.

Closing Thoughts…

- Is health care a right or a privilege?
- Must have someone decide how to ration healthcare services. Currently, health insurance companies do this
- Changing the focus from maximizing profits to maximizing health would help.

Thank you!

Any Questions?

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