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Abstract

Health care is universally among the most regulated sectors. In most nations, heavy regulation of the supply of health care goods and services care is coupled with marked centralization of the payment for medical care. The United States has a far less centralized but still highly regulated system characterized by its unique private components. More than 200 million Americans, including most seniors on Medicare, use private insurance. In response to a large uninsured population and increasing health costs, the Affordable Care Act (ACA) of 2010 expanded federal authority over all health care via extensive regulations, mandates, and taxes. Although more people enrolled in government insurance, the new regulatory environment generated substantial increases in private insurance premiums, fewer insurance options, narrower acceptance of insurance by doctors and hospitals, and a record pace of provider consolidation.

America's government programs, Medicare for seniors and Medicaid for the poor, are unsustainable without reforms. Most hospitals, nursing facilities, and in-home providers already lose money per Medicare patient served. Federal expenditures for health care and Social Security are projected to consume all federal revenues by 2049, eliminating the capacity for national defense, interest on the debt, or any other program. Health care costs are increasing, and the projected demand for medical care by an aging population and lifestyle-related disease threatens the sustainability of the entire system.

These fiscal concerns have prompted new calls for singlepayer health care in the United States, emblematic of the broader discussion about the relative merits of socialism versus free-market capitalism. The intuitive attractiveness of singlepayer health care is mainly driven by a simple concept: the government explicitly "guarantees" medical care that would cost less overall. However, single-payer systems universally hold down expenditures by limiting availability of doctors, treatments, medications, and technology. Moreover, countries with decades of single-payer experience are now forced to pay for private health care to solve their failures. The illusion of broadening access in single-payer health care disguises a vastly restrictive regulatory power, with costs that are enormous and far reaching.

This paper will review the costs and historical evidence on performance of single-payer health systems, the extreme version of hyper-regulation. The record on access and quality of such systems will be contrasted with the United States system. In light of the need for reforming health care, this paper also will note an alternative approach that offers simplification via strategic deregulation to enhance market competition.

Introduction

The overall goal of US health care reform is to broaden access for all Americans to high-quality medical care at lower cost. In response to a large uninsured population and increasing health care costs, the Affordable Care Act (ACA, or "Obamacare") aimed first and foremost to increase the percentage of Americans with health insurance. It did so by broadening government insurance eligibility, adding extensive regulations and subsidies to health care delivery and payment, and imposing dozens of new taxes. The ACA was projected to spend approximately \$2 trillion over the first decade on its two central components: expanding government insurance and subsidizing heavily regulated private insurance.

Through its extensive regulations on private insurance, including coverage mandates, payout requirements, copayment limits, premium subsidies, and restrictions on medical savings accounts, the ACA counterproductively encouraged more widespread adoption of bloated insurance and furthered the construct that insurance should minimize out-of-pocket payment for all medical care. Patients in such plans do not perceive themselves as paying for these services, and neither do physicians and other providers. Because patients have little incentive to consider value, prices as well as quality indicators, such as doctor qualifications or hospital experience, remain invisible, and providers do not need to compete. The natural results are overuse of health care services and unrestrained costs.

In response to the failures of the ACA, superimposed on decades of misguided incentives in the system and the considerable health care challenges facing the country, US voters at the time of this writing are being presented with two fundamentally different visions of health care reform: (1) a single-payer, government-centralized system, including Medicare for All, the extreme model of government regulation and authority over health care and insurance, which is intended to broaden health care availability to everyone while eliminating patient concern for price; or (2) a competitive, consumer-driven system based on removing regulations that shield patients from considering price, increasing competition among providers, and empowering patients with control of the money. This model is intended to incentivize patients to consider price and value, in order to reduce the costs of medical care while enhancing its value, thereby providing broader availability of high-quality care.

Outside a discussion of the role of private versus public health insurance are two realities. First, America's main government insurance programs, Medicare and Medicaid, are already unsustainable without reforms. The 2019 Medicare Trustees report projects that the Hospitalization Insurance Trust Fund will face depletion in 2026.¹ Most hospitals, nursing facilities, and in-home providers lose money per Medicare patient.² Dire

warnings about the closure of hospitals and care provider practices are already projected by the Centers for Medicare and Medicaid due to the continued payment for services by government insurance below the cost of delivery of those services. Regardless of trust fund depletion, Medicare and Medicaid must compete with other spending in the federal budget. America's national health expenditures now total more than \$3.8 trillion per year, or 17.8 percent of gross domestic product (GDP), and they are projected to reach 19.4 percent of GDP by 2027. In 1965, at the start of Medicare, workers paying taxes for the program numbered 4.6 per beneficiary; that number will decline to 2.3 in 2030 with the aging of the baby boomer generation. Unless the current system is reformed, federal expenditures for health care and social security are projected to consume all federal revenues by 2049, eliminating the capacity for national defense, interest on the national debt, or any other domestic program.³

Second, beyond the growing burden from lifestyle-induced diseases,⁴ including obesity⁵ and smoking, that will require medical care at an unprecedented level, America's aging population means more heart disease, cancer, stroke, and dementia—diseases that depend most on specialists, complex technology, and innovative drugs for diagnosis and treatment. The current trajectory of the system is fiscally unsustainable, and millions are already excluded from the excellence of America's medical care.⁶

The Impact of Affordable Care Act Regulations

As a direct result of the ACA's new regulations on insurance pricing and its new mandates on coverage, millions of Americans lost their existing private health plans. The Congressional Budget Office (CBO) projected that about 10 million Americans will be forced off their chosen employerbased health insurance by 2021—a tenfold increase in the number that was initially projected back in 2011.⁷ Meanwhile, private insurance premiums have greatly increased under ACA regulations on insurance, most notably those rules approximating modified community rating for premiums and approaching guaranteed issue of coverage. In its first four years, ACA private insurance premiums for individuals doubled and for families increased by 140 percent; this occurred even though insurance deductibles (the amount that must be paid before services are covered by the plan) increased by over 30 percent for individuals and by over 97 percent for families (fig. 1).⁸ As time passed, insurance options and prices on ACA



Figure 1. Impact of ACA regulations on private insurance premiums and deductibles, first four years. *Source:* eHealth, January 2017 data.

exchanges continued to worsen, according to the Department of Health and Human Services (HHS).⁹ Many exchange enrollees continued to face large year-on-year premium increases in 2018, according to Kaiser Family Foundation analysis,¹⁰ even in the face of markedly higher deductibles. The shift into government insurance itself also increases private insurance premiums. Because government reimbursement for health care is below cost, costs are shifted back to the privately insured, pushing up premiums. In some calculations, the underpayment by government insurance adds \$1,800 per year to every family of four with private insurance.¹¹ Nationally, the gap between private insurance payment and government underpayment has become the widest in twenty years, doubling since the initiation of Obamacare.¹² Choices of private insurance and covered providers under them are dwindling as well, disproving the theory that the law would increase insurance choices and competition. According to a December 2014 study, the exchanges were offering 21 percent fewer plans than did the pre-Obamacare individual market, a decrease to 310 plans nationally in 2015 from 395 plans in the individual market in 2013, the last year before the implementation of Obamacare.¹³ For 2018, only one exchange insurer offered coverage in approximately one-half of US counties. As the CBO stated, "Insurance premiums are lower in markets with more insurers, because insurers have stronger incentives to keep premiums low."14 This rise will affect not only the individual paying the premiums but also taxpayers, because taxpayers subsidize those increasing premiums under Obamacare. Note that the federal government (i.e., federal taxpayers) subsidizes most private premiums-directly or indirectly—at a cost of roughly \$300 billion in fiscal year 2016.

For middle-income Americans dependent on subsidized private insurance through government exchanges, the ACA eliminated access to many of the best specialists and best hospitals. Soon after ACA regulations were fully implemented, McKinsey reported that 68 percent of those policies covered only narrow or very narrow provider networks, double that of the previous year.¹⁵ The majority of America's best hospitals in the National Comprehensive Cancer Network were not covered in most of their states' exchange plans. And since late 2014, under Obamacare insurance plans, we have been experiencing a severe shortage of the specialists essential to diagnose and treat stroke, one of the most disabling and lethal diseases in the United States (in some cities, the number of specialists is actually down to zero). Almost 75 percent of ACA private plans became "highly restrictive,"¹⁶ with far fewer hospitals, primary care doctors, and specialists¹⁷ accepting that insurance.

The ACA regulatory environment has encouraged a record pace¹⁸ of consolidation across the health care sector, including mergers of doctor practices and hospitals. The last period of hospital mergers increased medical care prices substantially, at times by over 20 percent,¹⁹ according to a Robert Wood Johnson Foundation report. Robinson and Miller reported that when hospitals owned doctor groups, per patient expenditures were 10 to 20 percent higher, or an extra \$1,200-\$1,700 per patient per year.²⁰ Capps, Dranove, and Ody found that physician prices increased on average by 14 percent for medical groups acquired by hospitals; specialist prices increased by 34 percent after joining a health system.²¹ In the wake of the ACA, overall health care expenditures continue to increase—for individuals, for employers, and for taxpayer-funded government programs.

Single-Payer Health Care: The Data on Performance

Single-payer health care is a term that encompasses a variety of health systems in which government insurance, funded by taxes, is the principal payer for all medical care services for its citizens, thereby controlling access to medical care. This arrangement may or may not be associated with legal, alternative private insurance options. Single-payer health care is often misunderstood as a simple system, because one central administrative authority replaces an otherwise more fragmented system. However, its overriding position as the single payer dominates or wholly restricts the delivery of health care goods and services, eliminating market alternatives and ultimately controlling the access and quality of virtually all medical care.

Demographic and fiscal concerns in the wake of the ACA have prompted new calls for single-payer health care. The notion that single-payer health care represents a compelling goal for reform of the US health system is mainly driven by the intuitive attractiveness of a simple concept: the government explicitly "guarantees" medical care. Indeed, many nations claim to "guarantee" health care; many further insist that such health care is provided "free of charge." For instance, England's National Health Service (NHS) Constitution explicitly states, "You have the right to receive NHS services free of charge." Yet the National Health Service taxes citizens about £125 billion per year, roughly equivalent to US\$160 billion per year. Canada's "free" health care costs the average family about C\$13,311 per year for government health insurance; families among the top 10 percent of income earners in Canada pay C\$39,486.²² Note that beyond direct expenditures for health care, Canada's "free" health care also costs billions of dollars to the overall economy and to individuals in forgone wages. For instance, Stokes and Somerville found that the total lost economic output from waiting longer than medically recommended for treatment for total joint replacement surgery, cataract surgery, coronary artery bypass graft surgery, and magnetic resonance imaging (MRI) scans in 2007 was an estimated \$14.8 billion.²³

Funding the costs of single-payer health care by involuntary taxation is often cited as the main objection to its implementation, and there is no question that a nationalized single-payer system would require massive new taxes on workers. The California State Senate's 2017 analysis by the Appropriations Committee estimated that the single-payer health care proposed for California alone, SB 562, the Healthy California Act, would cost about \$400 billion per year, more than double the state's entire annual budget. Senator Bernie Sanders's bill to establish single-payer health insurance in the United States, the Medicare for All Act, sometimes called M4A, has been estimated to cost over \$32 trillion in its first decade.²⁴ Doubling all currently projected federal individual and corporate income tax collections would be insufficient to finance the *added*

federal costs of the plan. On the other hand, overall direct health care expenditures in nationalized single-payer systems are lower than in the United States. Single-payer systems universally hold down health care expenditures by limiting availability of doctors, treatments, medications, and technology through their power over patients and doctors as the only direct payer.

An evaluation of single-payer health care must examine its well-documented half-century record in providing timely, quality medical care. Single-payer systems in countries with decades of experience have proved to be inferior to the United States system in important objective measures of both access to care and quality. The truth is that single-payer systems, including those Canada and in the United Kingdom, Sweden, and numerous other European and Nordic countries, impose extremely long wait times for doctor appointments, diagnostic procedures, drugs, and surgery, specifically as a means to contain expenditures. And that failure to deliver timely medical care has serious costs, including pain, suffering, and death; worse medical outcomes; permanent disability; lack of patient choice about health care; and tremendous societal costs. Moreover, those countries with decades of single-payer experience are now reducing their broadest regulatory constraints by overtly using taxpayer money to shift the patient to *private* health care to solve their failures, in many cases even outside their own borders.

Delays and Waiting Lists for Medical Care. In those countries with the longest experience of single-payer health care, published government data demonstrates massive waiting lists

statistics for the government of Canada, "waiting time has been identified as a key measure of access" and is "the major barrier among those who experienced difficulties obtaining care."27 In Canada's single-payer system, the 2017 median wait from general practitioner (GP) appointment to specialist appointment was 10.2 weeks; when added to the median wait of 10.9 weeks from specialist to first treatment, the median wait after seeing a doctor to start treatment was 21 weeks, or about five months.²⁸ An average wait for a Canadian cardiology patient was 6.4 weeks for the cardiologist appointment after seeing the GP and another 5.3 weeks to start treatment, which means 11.7 weeks from GP appointment to first treatment. The average Canadian woman waits 13.2 weeks after seeing the GP to see the gynecologist and another 9.3 weeks for first treatment, or 22.5 weeks total from GP visit to treatment. For simply an appointment with the qualified specialist after already waiting and seeing the GP, Canadians wait another 13.4 weeks (three months) for an ophthalmologist; they wait another 22.1 weeks (five months) to see a neurosurgeon; and they endure their bone and joint pain for 17.9 weeks (four months) while waiting to see an orthopedist for further evaluation before another 23.8 weeks for treatment (fig. 2). Barua and Jacques estimated that the purely monetary costs of waiting in Canada exceeded C\$6.3 billion during 2018, or about C\$5,860 per person, without considering medical costs, such as increased risk of mortality or adverse events that result directly from long delays for treatment.²⁹ Indeed, the Supreme Court of Canada, in the 2005 Chaoulli v. Quebec decision, famously stated, "Access to a waiting list is not access to health care."

and delays that are virtually never found in the United States. In England alone, according to UK government statistics, a record-setting 4.4 million patients are on NHS waiting lists as of late 2019; 95,252 have been waiting more than six months for treatment; and more than 3,400 patients have waited more than one full year as of July 2018—all after already receiving initial diagnosis and referral.²⁵ As recently as 2013, NHS England felt it necessary to proclaim "zero tolerance" of waits for treatment of more than 52 weeks-a full yearafter diagnosis.26

According to Statistics Canada, the national organization in charge of producing official



Figure 2. Canadians face long wait times between seeing their GP and receiving treatment from a specialist. *Source:* Adapted from B. Barua and M. Moir, *Waiting Your Turn: Wait Times for Health Care in Canada, 2019 Report*, Fraser Institute.

Despite the clear importance of the availability of medical care when it is needed, prolonged wait times for care are commonly found in health systems with government-controlled nationalized health insurance—not just as a consequence of limitations and imbalances in supply and demand but specifically as a means of restricting access.³⁰ In fact, "waiting lists are the most commonly used means of limiting demand" in these health systems.³¹ In many countries that otherwise rely on free-market economics, the health care sector stands out as being subjected to far more regulation and centralization akin to programs under socialism.

Long waits are a defining characteristic of hyper-regulated single-payer systems as a means of cost containment, but they stand in stark contrast to US health care. Aside from organ transplants, "waiting lists are not a feature in the United States," as stated by the OECD and verified by numerous studies.³² For instance, Ayanian and Quinn note that "in contrast to England, most United States patients face little or no wait for elective cardiac care."33 Low-risk patients in the United States "sometimes have to wait all day or even be rescheduled for another day," according to the Agency for Healthcare Research and Quality's "Technology Assessment: Cardiac Catheterization in Freestanding Clinics"-that is, a wait of even one day was considered notable. Ironically, US media reporting of wait times was widespread and cited as a wake-up call for whole-system reform when 2009 data showed that time to appointment for Americans averaged 20.5 days for five common specialties (note that in 2017, after the implementation of the ACA, wait times had increased by 30 percent compared with 2014).³⁴ That reporting failed to note

cataracts, a disease causing severe disability that prevents independent living and is associated with numerous other secondary medical problems. We will then consider access to prescription drugs, medical technology, and critical care. Specific examples of health care outcomes from some of the most significant illnesses are also discussed.

Cancer. Delay in initiation of treatment for cancer, the world's number one or two leading cause of death, is associated with worse survival.³⁵ In the United Kingdom's single-payer NHS, more than 22 percent of cancer patients referred for "urgent treatment" currently wait more than *two months* for their first treatment after receiving the diagnosis in England (NHS wait time statistics in Q4 2019)—a number that has been increasing despite government efforts and that exceeds even its own arbitrarily set "standard," which declared that it would be acceptable for 15 percent of cancer patients to wait two full months for first treatment (fig. 3).

In the United Kingdom, 9.6 percent of breast cancer patients received first treatment within the two-month period after specialist diagnosis, but 30 percent of colorectal cancer patients, 28.2 percent of lung cancer patients, and 29.2 percent of urological cancer patients waited more than two months after "urgent referral" to start therapy. Similarly, 21 percent of brain surgery patients in England wait more than four months after diagnosis to be treated. In Canada's single-payer system, the most recent data revealed a median wait for neurosurgery, after patients have already seen the doctor, of 32.9 weeks—about eight months.

that those US waits were for healthy checkups in almost all cases, by definition the lowest medical priority. Even for lowpriority checkups and purely elective, routine appointments, US wait times are far shorter than for seriously ill patients in countries with single-payer health care.

Although an exhaustive study of access to every medical or surgical treatment is impossible to perform and beyond the scope of this paper, it is enlightening to look at access to care for a two common diseases: cancer, representing a life-threatening disease, where timely diagnosis and treatment are critical to outcome; and



Figure 3. NHS statistics on patient waits for treatment after GP "urgent referral for cancer," past decade through Q2 2019–20.

One study of 3.67 million US patients with breast, prostate, lung, colorectal, renal, and pancreas cancer from 2004 to 2013 showed a median wait of twenty-seven days.³⁶ All cancer treatment began in less than two months, except for prostate cancer, generally a more indolent tumor (up to eighty-seven days). Note that timely access to treatment of cancer reveals significantly longer waits (24 percent to 91 percent longer) from initial diagnosis to treatment in the US single-payer Veterans Affairs system than in other hospital settings.³⁷

Cataract surgery. Cataract, a degenerated, opacified lens in the eye, is the world's leading cause of blindness, affecting more than 24.4 million Americans age forty and older. By age seventy-five, approximately half of all Americans have cataracts, according to National Eye Institute statistics. Surgical removal of the lens is the only treatment, without which patients often have severely limited vision even approaching blindness. Intraocular lens replacement has been universally established as the treatment of choice. The visual impairments in elderly patients can be severe enough to prevent independence, and the time waiting for cataract surgery can represent a large proportion of their remaining lives. Brown calculated quality-of-life impact from the SHARE data of ten European nations that given a 3.3-month average wait for surgery and an additional twelve months from a patient noting disabling vision loss means 15.3 months between disability and treatment.³⁸ She calculated that this wait for cataract surgery had the equivalent negative impact as having limb amputation or significant coronary artery disease.

In a study of ten European nations, the average patient waited more than three months for cataract surgery, and 31.6 percent of patients overall waited longer than three months.³⁹ This does not include the wait of up to one full year to see the ophthalmologist. More recent OECD data shows the following waits (fig. 4) for cataract surgery after referral by a specialist:⁴⁰

Country	Waiting Time (days)
Austria	30.0
Denmark	63.0
Finland	103.0
Israel	132.0
Netherlands	58.8
New Zealand	75.0
Norway	129.0
Spain	105.0
Sweden	57.0
Portugal	133.3
United Kingdom	78.3

Figure 4. Waiting times for cataract surgery, after appointment with specialist physician, in selected OECD nations.

For their vision-restoring surgery, most recent data shows that Canadians with cataracts waited a median time of 20.2 weeks. In contrast, there is almost no waiting for cataract surgery in the United States beyond patient-chosen deferral. In fact, thousands of people from other countries commonly seek their cataract surgery in the United States every year.

Prescription drugs. The regulations of single-payer systems prevent patient access to the newest drugs for cancer and serious diseases, sometimes for years, unlike US regulations. Even though pharmaceuticals are perhaps the most heavily regulated technology in the nation, requiring staggering costs and time until approval for use, the United States has been by far the most frequent location for launching new drugs of virtually all types. The United States is the most frequent originator of new cancer drugs—by a factor of at least four—surpassing any country studied in the previous decade, including Germany, Japan, Switzerland, France, Canada, Italy, and the United Kingdom, according to Annals of Oncology.⁴¹ Two-thirds of the "novel drugs" approved in 2015 (twentynine of forty-five, or 64 percent) were approved in the United States before any other country.⁴² Women in single-payer Canada and in the United Kingdom even had far fewer choices of hormonal contraceptive drugs (62 percent and 54 percent, respectively) than American women, who had access to twenty-six contraceptive drugs over a fifteen-year period, as reported in the Canadian medical literature in 2016.43

Cancer drugs, generally making up the largest proportion of all new drugs, deserve special consideration, because time is of the essence for treating these life-threatening diseases. The OECD showed that survival is strongly associated with the system's availability of new cancer drugs, and specifically more so than the provision of drugs free of charge.⁴⁴ Of all newly approved cancer drugs from 2009 to 2014, single-payer systems of the United Kingdom, Australia, France, and Canada had approved only 30–60 percent of those approved in the United States by June 30, 2014.45 Of the world's fifty-four new cancer drugs launched from 2013 to 2017 and available within two years, fifty-one (94 percent) were available within two years in the United States (fig. 5).⁴⁶ For Brits with cancer, only thirty-eight of fifty-four (70 percent) were available; for Canada's cancer patients, only twenty-nine of fifty-four (53 percent) were available; cancer patients in France had access to only twenty-three of fifty-four (43 percent); and Australian cancer patients had access to fifteen of fifty-four (28 percent).

And yet, in 2017, single-payer NHS England introduced a new regulation, the "budget impact test,"⁴⁷ to cap drug prices specifically based on system expenditures rather than medical efficacy. This regulation will further restrict drug access, even though cancer patients could be forced to wait years for life-saving drugs, some already available in the United States. As just one important projection under that single-payer NHS



Figure 5. Availability of the world's new cancer drugs, by country, within two years after 2013–17 launch (as of December 2018). Exact number of drugs available in each country of the world's total of 54 total is noted; green shaded column in chart indicates percentage of the 54 total. *Source*: IQVIA Institute, *Global Oncology Trends 2019: Therapeutics, Clinical Development and Health System Implications*, 2019; data from Statista, https://www.statista.com/statistics/696020/availability-of-new-oncology-drugs-by-country.

rule, a dementia drug for Alzheimer's disease would be required to cost only £29.60 per year, less than US\$4 per month,⁴⁸ or it would be unavailable to patients (as calculated by the Alzheimer's Society), ironically restricted due to overall cost to the system specifically because so many patients need it.

Medical imaging technology. Sophisticated imaging technology, including magnetic resonance imaging (MRI) and computed

tomography (CT) scanning, has revolutionized diagnosis and treatment. Today, imaging is central to the diagnosis and treatment of most the world's most serious disorders, including cancer,⁴⁹ stroke,⁵⁰ and heart disease, and it has long been proven cost-effective.⁵¹ Moreover, numerous studies have proved that the availability of CT and MRI scanners is highly correlated with better outcomes in diseases with the most mortality and morbidity.⁵² Access to state-of-the-art imaging is a foundation of twenty-firstcentury medical care.

All governments impose heavy regulatory burdens on manufacturers of medical devices, including diagnostic imaging technology, for proof of safety and efficacy prior to and during use in the clinical setting. Separately, notwithstanding the importance of diagnostic scanners in medical care, highly centralized health systems more broadly regulate the purchase and utilization of these expensive scanners, specifically to limit the outlays for their use. Single-payer, centralized health systems, particularly those of Canada and the United Kingdom, are notorious for their low numbers of CT and MRI scanners (figs. 6, 7).⁵³ Overall, the United States employs far lighter regulatory restrictions on the availability and utilization of advanced technology devices such as CT and MRI scanners. However, regulatory certificate-of-need (CON) requirements⁵⁴ in thirty-four states, Puerto Rico, and the District of Columbia still limit approvals of competitive medical technology. The original intent of CON laws was to support indigent care by limiting overinvestment in unnecessary equipment and facilities. CON regulations fail to increase the level of indigent care but do restrict the

supply of regulated medical services in those states: fewer beds per person and fewer MRI and CT scanners per person.⁵⁵ Availability of imaging is specifically reduced in nonhospital settings, driving patients to seek MRI, CT, and PET (positron emission tomography) scanning either out of state or in hospitals, likely increasing costs.⁵⁶



Figure 6. CT scanners by country, most recent data available. Source: OECD.



Figure 7. MRI scanners by country, most recent data available. Source: OECD.

ICU and critical care. Concerns about the lack of capacity of medical systems and hospitals to deal with intensive-care unit (ICU) and critical care needs became a top issue in 2020, as the world grappled with the COVID-19 pandemic. No country can realistically have instant availability of unlimited emergency medical care, whether doctors, drugs, or technology. Preparedness

can without question be improved, though, and all systems will now focus on preventing future shortcomings. In the context of this manuscript, the evidence in peer-reviewed medical journals is clear on two facts: (1) the United States is the most well-equipped system in the world for these patients, and (2) the United States has the best outcomes from severe respiratory disease requiring ICU treatment.

Medical care for the sickest patients requires ICU access, technology, medications, and highly skilled, specialist physicians. Despite some variations in terminology, the availability of ICU beds in the United States dwarfs the availability in single-payer systems. According to a Columbia University study, the United States has 20–31 beds per 100,000 people, more than all other countries

cited data from the National Center for Biotechnology Information, and the journals Intensive Care Medicine and Critical Care Medicine noted that the United States had 34.7 critical care beds per 100,000, leading Germany (29.2), Italy (12.5), France (11.6), South Korea (10.6), Spain (9.7), Japan (7.3), the United Kingdom (6.6), China (3.6), and India (2.3).⁵⁸ Adjusting these numbers as a proportion of each nation's specific elderly population,⁵⁹ data shows that the United States exceeds every other country in available critical-care beds per 100,000 of its sixty-five-plus population (fig. 8), those most at risk for needing an ICU: United States (239.31), Germany (136.13), South Korea (83.73), France (64.62), Italy (58.82), Spain (52.98), India (38.33), the United Kingdom (38.24), China

(32.73), and Japan (29.13). Ironically, as we hear critics of the US system now bemoaning an alleged shortage of ICU beds, some critics recently pushed for more regulation to constrain the increasing number of ICU beds through certificate-of-need laws.⁶⁰ However, the United States has shifted even further toward more ICU beds as a percentage of total hospital beds.⁶¹



Figure 8. Available critical care beds, per 100,000 and per 100,000 aged 65 years and older, by country. *Sources:* N. McCarthy, "The Countries with the Most Critical Care Beds per Capita," *Forbes*, March 12, 2020; World Bank staff estimates based on age/sex distributions of United Nations Population Division's *World Population Prospects: 2019 Revision*.

in that study, including Canada's 13.5, Denmark's 6.7–8.9, Australia's 8.0–8.9, Sweden's 5.8–8.7, Japan's 7.9, the United Kingdom's 3.5–7.4, and New Zealand's 4.8–5.5.⁵⁷ Statista

Outcomes in severely ill patients cared for in ICUs are also reported as superior in the United States. The journal *Lancet Infectious Diseases* reported a study of more than 25,000 ICU patients with sepsis, a severe illness due to infection typically requiring ICU care, in which the odds of hospital death were between 51 percent and 65 percent higher in Europe than in the United States.⁶² Although their reported "adjusted" odds for death were only 5 percent to 19 percent higher in Europe than in the United States, those researchers asked "is the higher mortality rate in Europe than in USA due to a lower number of ICU beds available in Europe." Other analyses have shown that there is a strong correlation between ICU beds and hospital death in ICU patients,⁶³ including in patients specifically with sepsis and severe respiratory illnesses, many of whom need mechanical ventilators for assisted breathing.

Numerous studies have consistently demonstrated mortality rates from severe sepsis in Western Europe and Japan to be significantly higher than in the United States.⁶⁴ In one global study of 1,794 patients in sixty-two countries with severe sepsis in which 1,545 (86 percent) were admitted to the ICU, the overall hospital mortality was 28.4 percent. Among regions with more than 100 patients, North America (98 percent were US patients) had the lowest hospital death rate (24.2 percent).⁶⁵ Acute respiratory distress syndrome (ARDS), another life-threatening condition that depends on mechanical ventilators as the mainstay of patient management, of survival in ICUs and in hospitals were significantly higher in the "high-income rest-of-world countries" than in high-income European countries. 68

Outcomes from serious disease. Long waits in single-payer systems for diagnosis, treatment, drugs, and technology have major consequences for patients, as documented throughout the peer-reviewed medical journals. In single-payer systems, patients are often waiting months, even after their doctors recommended urgent treatment for the most life-threatening illnesses. The ultimate consequence of single-payer care's hyper-regulation and restricted access is worse health outcomes compared with the US system for nearly all of the most serious diseases-the illnesses that cause the most deaths, as well as the most important chronic diseases that lead to the most disability, including cancer,⁶⁹ heart disease,⁷⁰ stroke,⁷¹ high blood pressure,⁷² and diabetes⁷³ (figs. 9–11). As one indicator of outcomes, Barua, Esmail, and Jackson calculate that among women in Canada alone over a sixteen-year period, more than 44,000 additional patients died due to Canada's wait times for medically necessary nonemergency treatment.74 Although potentially stressed beyond any foreseeable need, the US system is uniquely prepared to care for patients with life-threatening diseases.

comprises 10 percent of all ICU admissions. ARDS has a high global mortality rate of 35 percent to 46 percent.⁶⁶ Although it is difficult to find international comparison data, the American fatality rate was at the lowest end of that range, 34.8 percent, in one 2011 study of 435 ARDS patients.⁶⁷ A 2017 study in *Lancet Respiratory* Medicine compared ARDS outcomes in "high-income European countries" (over 90 percent of cases from the United Kingdom [1,441], France [1,312], Spain [1,030], Italy [752], the Netherlands [412], Sweden [330], Ireland [277], Germany [275], and Portugal [247]) with ARDS outcomes in "high-income rest-of-world countries" (over 90 percent of cases from the United States [1,421], Australia [695], Japan [643], and Canada [380]). The odds



Figure 9. Comparison of five-year survival rate, United States versus Western Europe, 2000–2002, from seven common cancers. The United States has superior survival from all common cancers compared with Western European nations. *Source*: A. Verdecchia et al., "Recent Cancer Survival in Europe: A 2000–02 Period Analysis of EUROCARE-4 Data," *Lancet Oncology* 8, no. 9 (September 2007): 784–96.



Figure 10. Comparison of five-year survival rates for men and women, United States versus western European nations. Note the statistically significant increased survival for American men and women compared with the average Western European and especially the United Kingdom. *Source:* Verdecchia et al., "Reent Cancer Survival in Europe."



Figure 11 continued on the next page.

It should be noted that the superior disease outcomes in the United States are generally reported as group data for all affected patients. It is also true that some disease outcomes, as well as broader measures not necessarily reflective of only health care, including life expectancy and infant mortality, are worse for certain populations, including some minorities and lower socioeconomic groups in the United States.⁷⁵ This is not unique to the United States.⁷⁶ Throughout the developed world, and regardless of health care system, infant mortality rates, as one example, are far worse for minority and lower socioeconomic populations. For instance, racial-ethnic minorities consistently demonstrate significantly higher infant mortality rates, roughly double those of the majority population, in the government-run systems of Canada⁷⁷ and the United Kingdom⁷⁸ (fig. 12). While these differences by race are among the most perplexing dilemmas and most serious problems in society, they are likely multifactorial and identifiable even when the effects of other risk factors (maternal age, marital status, parity, and education) are taken into account.

As opposed to the new enthusiasm of some for a move toward single-payer care in the United States, those countries with decades of single-payer experience are now reducing their broadest regulatory constraints by overtly paying for private health care to solve their failures. In 2016, the UK government spent more than half of its total budgetary increase from taxpayers on private and other non-NHS providers.⁷⁹ Even though England's NHS is projected to hit a £30 billion funding shortfall in 2020-21, one of the very few areas where funding is increasing is to non-NHS providers. Sweden, often heralded as the paradigm of a successful welfare state, increased municipal government spending on private care contracts by 50 percent in the past decade as a deregulatory move to repair its single-payer system. Primary care clinics and nursing facilities are now run by the private sector or receive substantial public funding. Major deregulation in pharmacies⁸⁰ to permit private sector



Figure 11. High blood pressure: access to treatment by percentage of diagnosed patients receiving treatment, by country, ages thirty-five to sixty-four years (top); and successful control by percentage of treated patients by country, ages thirty-five to sixty-four years (bottom). The United States has more effective medical care for high blood pressure compared with other developed countries, including those held as models for single-payer care. *Sources*: K. E. Thorpe, D. H. Howard, and K. Galactionova, "Differences in Disease Prevalence as a Source of the U.S.-European Health Care Spending Gap," *Health Affairs* 26 (2007): w678–w686; E. M. Crimmins, K. Garcia, and J. K. Kim, "Are International Differences in Mortality at Older Ages: Dimensions and Sources, eds. E. M. Crimmins, S. H. Preston, and B. Cohen, Panel on Understanding Divergent Trends in Longevity in High-Income Countries. Committee on Population, Division of Behavioral and Social Sciences and Education, National Research Council. (Washington, DC: National Academies Press, 2010); K. Wolf-Maier et al. "Hypertension Treatment and Control in Five European Countries, Canada, and the United States," *Hypertension* 43, no. 1 (January 2004): 10–17.



Figure 13. Underpayment to hospitals for delivered care, Medicare and Medicaid, 2004–17. Note the significant jump in the deficit to hospitals from payment *below cost* of services by government insurance in 2012, after ACA regulations came into effect. *Source:* Analysis of American Hospital Association Annual Survey data, 2018, community hospitals.

competition has also been introduced into Sweden's previous government monopoly on prescription and nonprescription drugs. In a striking regulation pullback, Denmark's patients using taxpayer-funded singlepayer health care can choose a private hospital—even outside the country—if the waiting time for the treatment exceeds one month.⁸¹ The governments of Finland, Ireland, Italy, the United Kingdom, the Netherlands, Norway, Spain, and Sweden, all with single-payer care, also now spend taxpayer money on private care, sometimes even outside their own countries, to solve their failures to deliver adequate care.

Medicare for All: Creating an American Single-Payer System

Single-payer systems hold down health care costs by limiting availability of doctors, treatments, medications, and technology. Our own government's Medicare and Medicaid programs employ similar methods to hold down costs. Data on payments to health care providers shows a significant underpayment from both Medicare and Medicaid for health care (fig. 13).⁸² That underpayment—payment for services *below the cost* of administering those services—has increased significantly since the implementation of the ACA.

Underpayment for medical care has consequences beyond shifting costs to those with private insurance. Beyond the limited access to doctors due to belowcost payments by Medicaid, the medical literature demonstrates that disease outcomes under government insurance are worse than those for medically similar patients under private coverage (fig. 14); race and income were not associated with worse outcomes in several of these studies (Medicaid patients are typically using purely government insurance with its restrictive coverage for medical care, without supplemental private insurance).⁸³



Figure 12A–D. Infant mortality rates of (A) United States, (B) United Kingdom, (C) Quebec, and (D) Canada by race and ethnicity of mother. Note significantly higher infant mortality rates of minority populations in these countries, with or without single-payer health care. *Canada calculations defined infants as "live birth" for all births 500g or larger birth weight. *Sources:* US Centers for Disease Control and Prevention, *User Guide to the 2016 Period Linked Birth/Infant Death Public Use File*, 80, ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/DVS/periodlinked/LinkPE16Guide. pdf; Office for National Statistics (UK), "Large Differences in Infant Mortality by Ethnic Group" June 24, 2008; Office for National Statistics (UK), "Pregnancy and Ethnic Factors Influencing Births and Infant Mortality: 2013," October 14, 2015, https://www.ons.gov.uk/peoplepopulationandcommunity/ healthandsocialcare/causesofdeath/bulletins/pregnancyandethnicfactorsinfluencingbirthsandinfantmortality/2015-10-14; Z.-C. Luo et al., "Birth Outcomes and Infant Mortality among First Nations, Inuit, and non-Indigenous Women by Northern versus Southern Residence, Quebec, *Journal of Epidemiology and Community Health* 66, no. 4 (September 2012): 328–33; Public Health Agency of Canada, *Key Health Inequalities in Canada: A National Portrait*, 2018, 81, https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/science-research/key-health-inequalities-canada-national-portrait-executive-summary/key_health_inequalities_ful_report-eng.pdf.

Medical Disorder	Comparison of Patient Outcomes with Medicaid versus Private Insurance
Major surgery	Need longer hospital care (42% longer), incur more hospital costs (26% more), and are almost two times more likely to die in the hospital than those with private insurance; 13% more likely to die, stay in the hospital 50% longer; and cost of care 20% more than those with <i>no</i> insurance (LaPar et al., <i>Annals of Surgery</i> 2010; 893,658 major surgeries)
Cancer of the mouth and throat	50% more likely to die than patients with private health insurance (Kwok et al, <i>Cancer</i> 2010; 1,231 patients)
Colon cancer	57% more likely to die postoperatively than patients with private insurance, a death rate not significantly different from that of the uninsured (Kelz et al., <i>Cancer</i> 2004; 13,415 adults)
Heart procedures	More likely to die from strokes and heart attacks than patients with private insurance and suffered the same outcome as those who lacked insurance altogether; more than twice the risk of death, heart attack, or other serious cardiac event within one year of cardiac surgery compared with privately insured patients (Gaglia et al., <i>American Journal of Cardiology</i> 2011; 13,573 patients)
Lung transplants	Die sooner than patients with private insurance undergoing lung transplants for end-stage pulmonary diseases; 8.1% less likely to survive ten years after surgery than privately insured and uninsured patients (Allen et al., <i>Journal of Heart and Lung Transplantation</i> 2011; 11,385 patients)

Figure 14. Comparison of medical outcomes by source of insurance. Even after standardizing for medical differences among patients, Medicaid patients fare worse than those under private insurance, sometimes even worse than those with no insurance at all.

Owing to Medicare's below-cost payment for care, access to care is already at risk, and this would undoubtedly worsen if expanded to Medicare for All. The Office of the Actuary of the Centers for Medicare and Medicaid Services (CMS) in 2019 warned of serious limitations in availability of care for Medicare beneficiaries. CMS calculated that most hospitals, skilled nursing facilities, and in-home health care providers already lose money per Medicare patient. It warned that "we expect access to Medicare-participating physicians to become a significant issue in the long term under current law" even without moving toward Medicare for All.⁸⁴

A shift to the extreme regulatory milieu of Medicare for All or any similar single-payer system would almost immediately jeopardize access to timely medical care, as documented in the proposals themselves. By eliminating private insurance, Medicare for All imposes large and immediate reductions in payments to doctors and hospitals now treating patients under private insurance, including cuts of more than 40 percent for hospitals and 30 percent for physicians that would grow more severe over time. As Blahous states, we cannot know with certainty the extent to which these cuts would disrupt the supply and timeliness of health care services.⁸⁵ It is also noteworthy that more than 70 percent of US seniors rely on private insurance to supplement or replace traditional Medicare, whether Medicare Advantage, Medi-Gap, and employer-sponsored coverage, and that millions more use private drug coverage.⁸⁶ Abolishing private insurance, whether overtly by law or by the slower pathway of introducing a "public option," will radically alter the timely access and high-quality health care that today's Medicare beneficiaries enjoy.

Strategic Deregulation in Health Care: Evidence before and during the Trump Administration

The impact on the price that consumers are paying directly for medical care is illustrated in two cases: (1) medical procedures not covered by insurance, and (2) insurance coverage with higher deductibles. Such simpler models of health care purchasing ultimately generate downward pressure on prices from doctors competing for patients. For instance, prices rapidly decreased when patients paid out-of-pocket for LASIK corrective vision surgery and MRI or CT screening. Additional evidence from studies of consumers' use of MRIs and outpatient surgery shows that introducing price transparency and defined-contribution benefits further encourages patients to compare price.⁸⁷

Consumer spending on health care is significantly lower for those using high-deductible coverage,⁸⁸ without any consequent increases in emergency room visits or hospitalizations and without the hypothesized harmful impact on low-income families or the chronically ill.⁸⁹ Health spending reductions averaged 15 percent annually, and the savings increased with the level of the deductible and when paired with health savings accounts (HSAs). More than one-third of the savings by enrollees resulted from lower costs per health care utilization, that is, value-based decision-making by consumers.⁹⁰ While especially relevant to patients using high-deductible plans with HSAs, these reforms pressure prices downward for all health care consumers.

The focus of the first years of the Trump administration in health care reform has been centered on strategic deregulation to increase competition and reduce prices, intended to improve access to high-quality health care for patients, regardless of source of payment. Although legislative "repeal and replace" efforts aimed at reversing in entirety the regulatory burdens and taxes of the ACA have stalled, several directives and agency-level initiatives have begun. Most can be considered deregulatory in nature, with specific objectives of improving price transparency; reducing barriers to competition among insurers, providers, and sellers; empowering consumers with access to tools and information to assess value; expanding choices; and decentralizing power from the federal government to the states.

Since 2017, specific deregulatory moves focused on health insurance demonstrate the impact of deregulation and included the following: (1) eliminating the individual mandate by setting the regressive tax penalty to zero; (2) permitting lower-cost, reduced-mandate group insurance offerings by broadening availability of Association Health Plans; and (3) reversing a regulatory limitation on lower-cost Short-Term Limited-Duration Plans. By expanding lower-cost-coverage choices for consumers and increasing competition among insurers, these deregulatory actions are estimated to save Americans \$450 billion over the decade.⁹¹

Insurance deregulation has also been implemented under Medicare. Nationwide, a record 3,148 private insurance plans now participate in Medicare Advantage (MA), a private coverage alternative to traditional government Medicare insurance selected by about one-third of seniors. After reversing a regulatory cap on MA plans, the average Medicare beneficiary can now choose from twenty-eight plans offered by seven firms in 2020. Nationally, the increase is 15 percent over 2019 and provides the largest number of plans in the history of the program. The continual increase in choices of coverage under MA from nineteen in 2016 to twenty-eight in 2020 reversed the trend of reduced choices under the Obama administration, when thirty-three plans offered in 2010 declined to eighteen in 2015.92 These private plans provide extra benefits not covered by traditional Medicare. HHS Secretary Alex Azar announced that average premiums for MA plans will drop by 23 percent compared with 2018-down to the lowest monthly premiums since 2007—likely a result of competition among insurers. This reduction in premiums reversed the increases seen from 2012 through 2015 under the Obama administration's regulatory policies.

The current presidential administration has also focused on improving price transparency to reduce the cost of health care. President Trump signed an executive order to require providers paid by Medicare to post prices for a range of procedures. He also introduced a legal requirement barring pharmacy gag clauses under Medicare Part D plans, 93 clauses that had prohibited pharmacists from volunteering that a medication may be less expensive than an insurance co-pay if purchased for cash—as was the case more than 20 percent of the time.⁹⁴ Data also reveals that prices vary tremendously between drugstores for the same exact drug. According to a December 2017 study, the national average price for a onemonth supply of five common generics ranged by a *factor of twenty* among different retailers for a given drug.⁹⁵ Even in a single city, the thirty-day supply price showed a tenfold to seventeenfold variation per drug. For the nearly forty million seniors taking five or more medications daily, the savings from price comparison shopping could be hundreds of dollars per month if patients were sufficiently informed and incentivized to consider prices.

Meanwhile, the Centers for Medicare and Medicaid Services (CMS) recently finalized its mandate requiring pharmaceutical manufacturers to disclose the list price of prescription drugs in direct-to-consumer television advertisements. The Trump administration also announced a proposal to do away with complex behind-the-scenes arrangements that generate rebates⁹⁶ of \$179 billion to pharmacy benefit managers (PBMs), replacing rebates with discounts to beneficiaries (patients) at the point of sale. PBMs are middlemen that control "formularies," the lists of drugs covered by a plan. Rebates from drug companies to PBMs are payments for influence-either to position a drug on the formulary as "exclusive" or to give it preferred status over competitors. PBMs act counter to patient interests while aggravating the lack of price transparency. These complex behind-the-scenes rebates reward inflated list prices, on which patient premiums are often based. This prevents patients from taking account of price. A growing number of tools are now becoming available to compare prices. CMS finalized a rule in 2018 requiring Medicare Part D drug plans to provide electronic tools to doctors that would at least allow discussion with patients regarding out-of-pocket costs for prescription drugs at the time a prescription is written.

High drug prices represent an especially difficult issue in health care. Drugs are probably the most significant reason for the past half century's unprecedented gains against the deadliest, most debilitating diseases. Yet there is a longstanding conundrum: the same policies that are associated with the lower prices seen in other countries—price regulation and weaker patent rights—are also associated with delayed launches and reduced access to drugs.⁹⁷ Any regulatory policy must be introduced without suffocating the innovation crucial to new drug development, given the unique need for massive capital investment at extraordinary risk for years until eventual market entry. For example, the Hatch-Waxman Act of 1984 represents an example of successfully combining government regulation with deregulation to generate the desired compromise-continued innovation in safe drug development, alongside increased price competition by generics. While it extended the length of a patent to partially offset the time spent on FDA-required clinical trials, the act simplified and expedited the development and approval processes for generics.98 Facilitating market entry to enhance competition among drugmakers has been an effective tool to dramatically lower prices (fig. 15).99

Inflation-Adjusted CPI for Prescription Drugs, 2009–19 Pre-Inauguration Post-Inauguration Pre-Inauguration Trend -Prescription Drug CPI / All Items CPI (ratio) 2.4 May-19 2.3 2.2 helow rend 2.1 2.0 1.9 1.8 1.7 Jul-10 Jul-16 Jul-17 Jul-18 Jul-09 Jul-11 Jul-12 Jul-13 Jul-14 Jul-15

Figure 16. The inflation-adjusted prescription drug price index has decreased significantly in 2017–19. The CPI covers retail transactions, which are about three-fourths of all prescription drug sales. Inflation adjustments are calculated using the ratio of the CPI of prescription drugs relative to the CPI-U (Urban) for all items. The pre-inauguration expansion trend in annual growth rates is estimated over a sample period from July 2009 through December 2016, with 2017–18 projected levels then reconstructed from projected growth rates. *Sources:* Bureau of Labor Statistics; Council of Economic Advisers, *Reforming Biopharmaceutical Pricing at Home and Abroad*, February 2018.

The FDA under the Trump administration has also made progress in facilitating drug approvals by streamlining and simplifying approval processes: the year 2017 saw sixty-eight new drugs and biologics approved and a 60 percent increase in generic drug approvals over the previous year.



Figure 15. The average generic drug price historically responds to market competition. Prices fall and stabilize to about 6 percent of its initial price two years following its launch, as the number of competing generics enter the market. *Source:* E. R. Berndt and M. L. Aitken, "Brand Loyalty, Generic Entry and Price Competition in Pharmaceuticals in the Quarter Century after the 1984 Waxman-Hatch Legislation," *International Journal of the Economics of Business* 18, no. 2 (2011): 177–201. *Source of data:* IMS Health, National Sales Perspective, National Prescription Audit: December 2009.

Over the years 2017 and 2018, average new prescription drug approvals as well as generic drug approvals increased by approximately 71.6 percent relative to 2008–sixteen under the previous administration. Similarly, average annual generic drug approvals increased by 69.3 percent in 2017 and 2018

relative to 2008–16. *The impact?* The average annual prescription drug inflation (CPI-Rx) was only 2.5 percent, compared with 3.5 percent in 2008–16. That rate was also significantly lower relative to the overall inflation index (CPI) during 2017–18 versus during 2008–16 (0.2 percent compared with 1.8 percent). And for the first time in decades, the average price of prescription drugs has declined (fig. 16).¹⁰⁰

Conclusion

In most nations, heavy regulation of the supply of health care goods and services care is coupled with marked centralization of payment for medical care. The United States has a far less centralized but still highly regulated system in which health expenditures are roughly equal from public and private insurance. The system is characterized by its unique private components: more than 200 million Americans, including most seniors on Medicare, use private insurance. The US system is the world's most effective by literature-based, objective measures of access, quality, and innovation, but US health care demands reform. Health care costs are high and increasing, and the projected demand for medical care by an aging population and the future burden of lifestyle-related disease threaten the sustainability of the system.

Although the regulatory expansion under the Affordable Care Act reduced the uninsured population, it generated increased private insurance premiums, a withdrawal of insurers from the market, and sector-wide consolidation that is historically associated with higher prices and reduced choices of medical care. In its wake, American voters are now presented with two fundamentally different visions for reform that have a diametrically opposed reliance on regulation and centralization: (1) the Democrats' single-payer proposals, including Medicare-for-All, based on the most extreme level of government regulation and authority over health care and health insurance; or (2) the Trump administration's consumerdriven system that relies on strategic deregulation to increase market-based competition among providers and empowering patients with control of the money. Both pathways are intended to contain overall expenditures on health care and broaden access.

Intuitively, a single-payer model of health care represents a simplification, but the reality is that such centralized systems impose overwhelming restrictions on both demand and supply. Government-centralized single-payer systems actively hold down health care expenditures mainly by sweeping restrictions on the utilization and payment for medical procedures, drugs, and technology under the single authority of the central government. The overall costs of this false simplification are enormous, creating societal costs that extend beyond calculated tax payments that are required to support such a system.

The alternative approach involves rule elimination and decentralization, that is, strategic deregulation, to induce competition for value-seeking patients. Reducing the price of health care by competition, instead of more regulation, generates lower insurance premiums, reduces outlays from government programs, and broadens access to quality care. Broadly available options for cheaper, high-deductible coverage less burdened by regulations; markedly expanded health savings accounts; and tax reforms to unleash consumer power are keys to achieving price sensitivity for health care. Reforms to increase the supply of medical care by breaking down longstanding anticonsumer barriers to competition, such as archaic certificates-of-need for technology, unnecessary state-based licensure of physicians, and overly regulated pathways to drug development, while facilitating transparency of price and quality among doctors and hospitals, would generate further competition and reduce the price of health care. Preliminary results from such deregulatory actions demonstrate promising results and offer an evidence-based context for the broader discussion of the role and reach of government regulation in socialism compared with free-market systems.

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