Practicality Over Partisanship: The Prospect of Universal Healthcare in the United States

by

Simon Brundage

A THESIS

submitted to

Oregon State University

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degree of

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Honors Scholar

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Abstract approved:_____

Raymond Tricker

My study of universal healthcare was motivated by the juxtaposition of social welfare and self-interest in the United States. Unlike most other industrialized countries—whom have adopted either a multi-payer or single-payer system of universal healthcare—the United States is situated uniquely, from both a philosophical and political standpoint. Among others, it was Adam Smith who emphasized the importance of rational self-interest in a capitalist economy. It is fascinating to consider universal healthcare in the United States because of our fixation with self-interest at the expense of the common good, and in which cases it is appropriate. Consequently, the United States has created a social safety net to accommodate for certain human rights, but not all. This thesis examines the intersection of the American politics and universal healthcare. Adam Smith's ideology played a crucial role in shaping our system of governance, and it was my goal to better explain why providing an adequate standard of medical care, as a right,

to every American is not the current practice, and why it is impractical this is the case. After review of existing literature, I also concluded a multi-payer universal healthcare system is the most practical path forward for the United States.

Key Words: Universal, healthcare, partisanship, capitalism, practicality

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I. Introduction

> "The disposition to admire, and almost to worship, the rich and the powerful, and to despise, or, at least, to neglect persons of poor and mean condition is the great and most universal cause of the corruption of our moral sentiments."

—Scottish political economist Adam Smith, *The Theory of Moral Sentiments*

The dichotomy of altruism and self-interest pervades many elements of civilized society, but none more so than the sphere of governance. While it is inarguable that civilization is hinged on altruism, self-interest has also earned acclaim as a root of economic success. In principle, this makes sense: self-interest inspires innovation and the creation of goods and services, and altruism encourages an investment in social services to create opportunity for those less fortunate. This balance of economic activity and social welfare enables civilization to thrive—or, at least, in principle it does.

In his time, Adam Smith emphasized the importance of rational self-interest and competition in creating economic growth. His work on these ideas in *An Inquiry into the Nature and Causes of the Wealth of Nations* laid the foundation for classical economics—and, by extension, modern “laissez faire” capitalism. Smith believed that self-interest is at the core of upward mobility for the larger population. He based this philosophy on two primary axioms:

1. Human beings are rational, and thus will seek to financially benefit themselves;
2. Because human beings are rational, a mutually agreed upon exchange of goods or services will leave both parties in better economic or social standing.

In the context of laissez faire capitalism, this philosophy suggests that a free market encourages all individuals to fulfill their self-interest, and that any exchange non-coercively initiated will be of benefit to both the producer and the consumer of a good or service. In today's uncertain times, trust and mutual benefit are more suppositions than expectations. That said, it is not out of the question to accept Smith's premise and reject his conclusion.

Perhaps the most infamous tenet of Smithian literature is that of the "invisible hand of the government," where Smith expressed the importance of allowing natural market forces—and not the government—to remedy societal ills. In *The Wealth of Nations,* Smith asserted that "every… [government] regulation introduces some degree of real disorder into the constitution of the state," which he claimed would "be difficult afterwards to cure without occasioning another disorder." This idea that regulations create disorder is counterintuitive. However, it comes from a faith in self-interest and the free market to right all wrongs—a presumption that market forces are emissaries of morality.

Of course, it is quite clear that it is not always market forces that decide whether an individual succeeds or fails in society. Often, there are other factors at play—factors which complicate the "rational" element of Smith's "rational self-interest." In practice, self-interest can function without any degree of rationality. Observing the current trend of income and wealth inequality in the United States, there has been no progress made in addressing inequalities between black and white households in the last 70 years, and "that close to half of all American households have less wealth today in real terms than the median household had in 1970" (Kuhn 2018). If market forces were, indeed, emissaries of morality, one would expect systemic inequities to lessen with respect to time. The worsening of racial and economic inequities points to a lack of mutually beneficial market exchanges.

It is for this reason that Smith's statement from *The Theory of Moral Sentiments* is ironic. Smith's emphasis on self-interest in *The Wealth of Nations* appears to contradict the central theme of *The Theory of Moral Sentiments*. Is it possible to share advocacy for self-interest, and awareness of "persons of poor and mean condition"? Neoclassical economist Alfred Marshall posed a similar question, believing Smith's definition of the economy weighed wealth and humanity unequally (Marshall 1879). After all, how could Smith

espouse human sympathy in *The Theory of Moral Sentiments*, yet focus on the merits of self-interest in *The Wealth of Nations*?

In many ways, Smith's apparent contradictions highlight the struggle between capitalism and socialism. Socialists argue there is a conflict of interests between social welfare and the quest for capital. Staunch capitalists argue welfare-based programs and regulations incentivize workers to be unproductive. To some, the philosophies are, at their core, incompatible.

Today, this conflict is reflected by the two-party system. While democrats believe in market and social interventions within the framework of a capitalist system, many republicans maintain these interventions, like Smith said, "[introduce] some degree of disorder into the constitution of the state." Naturally, neither republicans or democrats subscribe entirely to capitalist or socialist principles. However, there is certainly a distinction between the two parties, and it has led to philosophical disagreements on how to address systemic inequities in the United States.

This is where one should disagree with Adam Smith. It is not just a "disposition to admire… the rich and the powerful" that corrupts our moral sentiments; it is a disposition to partisanship over practicality that results in the "neglect [of] persons of poor and mean condition." The economy of the United States is preferential to those with wealth—this is indisputable. That said, the

status quo is maintained by a refusal to compromise and legislate in a nonpartisan manner. Our two-party system has become polarized, making even empirical data partisan. In a system where inequities are being intensified by a lack of prudent oversight and effective policymaking, this is dangerous.

There is no better example of this disposition to partisanship than the issue of healthcare in the United States. Article 25 of the Universal Declaration of Human Rights affirms that:

"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." (Human Rights 1948).

This notion that there be an adequate standard of living for every person, including "medical care" as a right, at least, in part, establishes universal healthcare as a human rights minimum for developed nations (Maruthappu 2012). This does not necessarily suggest that universal healthcare is a practical, and not partisan, pursuit. However, when the United States spends a larger share of its resources on healthcare than other developed nations—with less than favorable health outcomes, as well—there exists a utilitarian and deontological argument against the status quo. It is an argument rooted against the privatization of healthcare in the

United States. If maximum benefit is not being provided to the maximum number of Americans, is one's methodology utilitarian, or just dramatically inefficient?

Today, the United States spends nearly twice as much, per capita, on healthcare as Canada and Germany (OECD 2018). In terms of healthcare spending as a share of national GDP, rates are accelerating in most developed countries, with the average healthcare expenditure increase being around 3.4%. Among working adults in the United States, the uninsured rate for health coverage is approximately 15.5%, with many more underinsured. This combination of increased healthcare costs and a lack of affordable health insurance creates an unsustainable situation for the average American.

It is important to note that steps have been taken to address this situation. 19% of the United States' population are covered by Medicaid and the Children's Health Insurance Program (CHIP). These programs were instituted to provide a social safety net for those in poverty or who are unemployed. That said, due to an inexorable growth in services—and, consequently, dollars spent—even state governments have struggled to afford their share of program expenditures. Most of the cost share is still federally subsidized by medical assistance match rates (FMAPS), but this share has been dropping since 2010 (Valentine 2017).

This ultimately means that these programs have an expiration date. If states are struggling, in present day, to properly finance healthcare, it will only become

more difficult with curtailed federal subsidies. Medicaid was conceptualized to be a component of the welfare system; it was not meant to be a substitute for universal healthcare. Medicaid's inefficiencies are a symptom of a much larger issue, and highlight the need for a more sustainable solution to the rising costs of healthcare in the United States. Based on current trends, Smith's natural market forces are not going to do the trick.

Importantly, Adam Smith's philosophy is not inherently wrong. His published works focused on topics such as the free market and division of labor—rather, *The Wealth of Nations* was not a treatise assessing the importance of market-based healthcare reform. While he would likely have had qualms with government intervention in healthcare, Adam Smith could not have predicted the state of 21st century American political economy.

Despite this, Smith's statement regarding the "neglect [of] persons of poor and mean condition" carries with it an obligation to address the needs of those less fortunate. Unlike trade, healthcare is not defined by commodities; it is defined by necessities and inalienable human rights. It is past time that we absolved ourselves of this fixation with all-or-nothing laissez faire capitalism. Capitalism and universal healthcare are not mutually exclusive ideas—both are empirically proven to raise the standard of living in developed countries across the world. The

assertion that universal healthcare would make a country “socialist” is partisan propaganda.

The purpose of this paper is to address the basic reality that Adam Smith’s philosophy does not apply, in its entirety, to healthcare. As affirmed by the Universal Declaration of Human Rights, healthcare is a fundamental human right, and failure to provide every citizen with adequate healthcare is a human rights violation. This reality will be explored by answering the following questions—with each of these inquiries representing a separate section of this paper:

1. What are the issues with the current United States Healthcare system? How does it work?
2. What are the geopolitical, social, and socioeconomic trends that have influenced the polarization of universal healthcare?
3. What is the ethical framework of universal healthcare, and why does this framework define universal healthcare as the most moral methodology for distributing healthcare?
4. Why is universal healthcare the most practical system from an economical standpoint? How does public health insurance compare to a private healthcare market in terms of providing optimal service quality and cost efficiency?

5. What are the considerations for implementing universal healthcare in the United States?

Ideally, after a comprehensive assessment of these five questions, one can better understand the importance of universal healthcare, as well as envision what it might look like in the United States of America.

II. What are the issues with the current United States Healthcare system? How does it work?

One cannot discuss the merits of universal healthcare without first examining why the lack thereof creates an unsustainable situation. In this case, there are many issues regarding the current U.S. healthcare system, ranging from issues of uncoordinated care mechanisms, finance, and political setbacks.

The United States spends more on healthcare services, per capita, than any other nation in the world, with average spending amounting to over twice as much per person than other countries in the Organization for Economic Cooperation Development (OECD). While there is no specific reason for this fundamental inefficiency, a primary contributor lies in the United States' method of finance. Healthcare expenses in the United States are subsidized by a complex mixture of public payers—such as federal, state, and local government—and private insurance and individual payments. In many cases, federal and state governments are reliant upon employers to provide health insurance to their employees, as well as their respective dependents. Public payer options, such as Medicare and Medicaid, are reserved for those in poverty, unemployed, and the elderly.

The challenge in this diversity of payment strategies is in basic inconsistencies with benefits covered, medical care providers, and methods of accessibility. While an important facet of the mixed public and private payer

approach is that no person is absolutely without healthcare options, inconsistencies in coverage options cause many individuals to receive fewer and less coordinated services, as well as having more out-of-pocket costs. Some state and local health programs use charity as a revenue stream to address these inconsistencies and provide healthcare services to otherwise uninsured individuals.

Finance is not the only issue influencing the rising costs of healthcare in the United States. Indeed, because of limited federal involvement in healthcare delivery—as opposed to policymaking—healthcare services are often organized at the local level, with an overall loosely structured delivery system. Moreover, the overwhelming majority of hospitals are owned by private non-profit institutions, with most physicians being able to establish their practice wherever they choose. The federal and state government provides several primary care options to populations that do not currently have fee-for-service (FFS) systems, but typically it is incumbent upon municipalities to offer limited primary care services to those who are otherwise uninsured.

This mixture of loosely organized healthcare delivery mechanisms and inconsistent coverage options has resulted in a deeply flawed healthcare system for the United States. Coupled with the culture of partisanship with regard to healthcare in the U.S., there is not much room for wholesale reform, either. Notably, most reform has been focused in the private sector. Strategies for

controlling the cost of healthcare are generally focused on employee cost sharing, incentives to increase the number of primary care physicians available, and market-based solutions to increase competition among insurance providers. As mentioned before, health insurance coverage is largely an employer-based process—thus, even with the inception of the Patient Protection and Affordable Care Act (ACA), the United States healthcare system is an aspiring multi-payer system, at best.

Universal healthcare systems in other countries within the OECD have been conducive to not only better health outcomes, but also impactful cost-savings and an overall reduction of administrative waste. The lack of coordinated care mechanisms in the U.S. healthcare system leaves much to be desired in terms of efficiency, and there is no clear path forward to reform all areas of its fragmented multi-payer strategy. The levels of partisanship and disdain for socialized programs have become commonplace in the United States, which innately complicates local, state, and federal initiatives to establish a universal healthcare system. Certain states across the country have proposed variations of state-wide initiatives—however, in terms of developing a comprehensive federal initiative, domestic universal healthcare initiatives have fallen tantalizingly short.

Since the inception of Medicaid and Medicare in 1965 under President Lyndon B. Johnson, the only major healthcare legislation to be introduced in the

United States—and subsequently passed—is the Patient Protection and Affordable Care Act (Obama 2016). This Act innovated the former model of healthcare delivery in the United States, with the end goal of reducing the level of uncompensated care in the United States (eHealth 2018). Uncompensated care is reduced by increasing the number of healthcare revenue streams, which was done through the enforcement of an individual mandate—an essential provision that was repealed in December 2017 by the Trump administration via a comprehensive tax reform bill.

While the underlying premise of the ACA—or colloquially known as Obamacare—is similar to the goals of universal healthcare, its operation and implementation is quite different. A prime example of this difference is the contrast between the Australian (and Canadian) and American healthcare system. Although Australia and Canada's single-payer healthcare systems are unconventional, as most universal healthcare systems adopt a multi-payer approach, the differences between single-payer healthcare and Obamacare highlight the inefficiencies of a non-universal healthcare model, and how these inefficiencies play into the narrative of American politicians.

A single-payer healthcare system can be best described as a "Medicare-for-All" equivalent in the United States. This implies that the cost of healthcare is financed entirely by the public sector for public insurance and public hospital

options. Perhaps unintuitively, this does not mean that private sector healthcare is non-existent; it merely means that Medicare only covers "75% of a general practitioner, 85% of specialist, and 100% of public in-hospital costs" (Obamacare Facts 2017). The advantage to this methodology is that the level of uncompensated care in countries with universal healthcare is—for all intents and purposes—zero. Medicare in Australia is funded largely by a 2% levy on those above a certain income level. The portion of the cost not covered by this levy is compensated for by the government from a general fund.

In America, the revenue streams that fund our healthcare system are different. While the Affordable Care Act (ACA) implemented substantial reform—dropping the overall level of uncompensated care—out-of-pocket costs are still a large factor in individual healthcare options. American citizens pay payroll taxes into Medicare and Medicaid; however, these insurance mechanisms do not offer coverage to every American at every age. The nature of universal healthcare is that no citizens are excluded from coverage. Because payroll taxes and other healthcare-related taxes do not fully remove all uncompensated care, and out-of-pocket costs can make healthcare prohibitively expensive, the ACA fails to meet the requirements of universal healthcare.

As if this were not enough, the repeal of the individual mandate under the Trump Administration has accentuated the issue of uncompensated healthcare in

the United States. Since the purchase of health insurance became compulsory under the individual mandate, even healthy Americans were required to purchase insurance. This requirement increased the volume of revenue for healthcare compensation. The repeal of the ACA individual mandate marks a step-back from the pursuit of universal healthcare in the United States—and with the current levels of political partisanship in the United States Congress, it is impeccably difficult to find real, bipartisan solutions.

III. What are the geopolitical, social, and socioeconomic trends that have influenced the polarization of universal healthcare?

There are reasons that the United States ended up at this point; rather, healthcare, in and of itself, was not always a partisan issue, and universal healthcare did not always incite detest. There are clear geopolitical, social, and socioeconomic trends which have led the United States to this point, and created an intensely polarized debate surrounding universal healthcare.

Some scholarly conjectures assert that Americans, in general, have a more negative view of the government than other countries, and consequently are less willing to subscribe to a perceived "government-run" program (Vladeck 2003). Individuals opposed to universal health care may also discredit it due to the fact that healthcare resources in the United States generally compare favorably to the rest of the world, with urban areas carrying incredibly advanced and effective medical technology.

However, there are many areas in the United States—particularly rural—that are the exact opposite. This is not only due to the fact that rural areas carry a higher rate of poverty than urban areas; it can also be attributed to hospital proximity and the practicality of purchasing health insurance. If one has no intention of regularly visiting the doctor, or is overall a healthy person that does not require it, they are much less likely to purchase health insurance. This is the vital essence of why the

individual mandate exacerbated issues in rural areas, forcing rural residents to purchase insurance that they were unlikely to utilize. At that point, it merely became an added expense.

In *Universal Health Insurance in the United States: Reflections on the Past, the Present, and the Future*, Bruce Vladeck also argues that the absence of a defined working class has contributed to the polarization of healthcare (Vladeck 2003). Indeed, while the United States' wealth disparities are not unique (as most industrialized countries carry basic inequities in income and wealth), there is no cohesive, well-established party for working class citizens. Perhaps more to the point, there is no "Labor Party" in the United States, which makes it difficult to coalesce around the issue of universal healthcare. The 15.5% of Americans who are uninsured have not coalesced to reform the United States healthcare system, and consequently, the political pressure does not exist.

That said, one issue rises above the rest as the mortal enemy of a United States universal healthcare push: our country's deeply rooted sense of partisanship and rugged individualism (Vladeck 2003). The United States is largely driven by decisions made at the local and state level. Naturally, the federal government has a significant role in driving national policy—however, by and large, decisions are more frequently and effectively made at smaller scales. For many Americans, sustained government intervention in policy is, in essence, tantamount to socialism,

and socialism is only viewed favorably by 35% of the American population (Gallup 2016). In contrast, capitalism enjoys the support of 60% of the population.

These numbers, however, are ultimately irrelevant to the implementation of universal healthcare, as a country does not need to adopt centralized socialism to support a universal single-payer or multi-payer healthcare system. Not unlike Medicare, Medicaid, and social security, universal healthcare is simply a government-supported program within the framework of a capitalist system. Relevantly, Medicaid is supported by 74% of the American public, with around 52% believing that it functions appropriately for impoverished families (Kaiser Health 2018). The function of Medicaid as a social insurance program does little to hinder public opinion, which suggests that public opinion is more concerned with the nomenclature and connotations of "socialized medicine" than its effects, in practice. The stigma of socialized medicine is taken advantage of regularly by conservative politicians to undermine universal healthcare.

IV. What is the ethical framework of universal healthcare, and why does this framework define universal healthcare as the most moral methodology for distributing healthcare?

Prior to examining the logical framework that defines universal healthcare, it is important to understand the ethical framework which differentiates the immorality of the current American healthcare system from the morality of a universal healthcare system. As briefly mentioned before, the argument for universal healthcare is predicated on utilitarianism and deontology.

Utilitarianism is the most empirically relevant ethic to universal healthcare. First, though, we must accept the premise that a lack of medical care is intrinsically harmful, and that if it is within the scope of government to correct this wrong without burdening the majority of the population, then we must do so (Maruthappu 2013). The association between universal healthcare and utilitarianism is based in this assertion that we have a moral obligation to address disparities in healthcare distribution.

In many cases, ethics literature assails health disparities as a moral wrong that must be corrected, and that "social-contract theories and contractarian ethical theories generally claim that social institutions and laws are necessary and that members of a society receive societal benefits in exchange for burdens, such as paying taxes and following the law" (Jones 2010). This notion of burden for

societal benefit is consistent with the principle of universal healthcare, which demands that in exchange for taxes on citizens, universal health benefits are provided to maximize the amount of good for the maximum amount of citizenry.

Utilitarianism is often criticized as being more of a consequentialist approach to healthcare, with it being a more outcome-oriented than process-oriented methodology. In the pursuit of universal healthcare, one must be cognizant of what we sacrifice—and, in the case of healthcare, a compulsory tax on all Americans would be required. This is where the deontological ethic must be considered. In moral philosophy, deontology refers to duty-based ethics (Beauchamp 1991). It is an ethic that provides a contrast to consequentialism, but is equally important when considering the philosophy of universal healthcare.

The consideration of duty-based ethics is multifaceted. On a surface level, the U.S. government has an obligation to avoid unnecessary and burdensome taxes, as higher taxes have the potential to hinder upward mobility for lower- and middle-class Americans. Deontology emphasizes the importance of adhering to predefined rules; rather, if an action stands in contradistinction to the moral framework of a society, then it is immoral.

Taxes are within the moral framework of the United States if they achieve a higher purpose. This is where utilitarianism provides a complement to deontology: the higher purpose of a compulsory tax for universal healthcare is to maximize the

amount of good for the maximum amount of people in the country. Those who are wealthy or do not need insurance stand to lose with universal healthcare. However, millions more Americans stand to gain, and in combination with the United States' human rights obligation to provide an adequate standard of healthcare to its citizens, universal healthcare is clearly within the correct ethical framework.

V. Why is universal healthcare the most practical system from an economical standpoint? How does public health insurance compare to a private healthcare market in terms of providing optimal service quality and cost efficiency?

With an ethical framework established, it is prudent to now examine the logical framework which defines universal healthcare. The World Health Organization (WHO) has a defined metric for determining whether a system constitutes universal healthcare. A universal healthcare system must meet each of the following criteria: equity in healthcare access; quality healthcare that overall improves the public health of the population; and, finally, comprehensive protection against financial risk (WHO 2018). Moreover, the premise for universal healthcare was solidified by the WHO in 1948, declaring that healthcare is a human right, and not a privilege.

For most industrialized countries in the post-World War II era, this premise was seamlessly integrated into their healthcare systems. Not to belabor this point, but the United States of America was a notable exception to this trend, with only it and South Africa being industrialized countries without universal healthcare. Following 2015, though, even South Africa made universal healthcare a major developmental goal for healthcare delivery (Fusheini 2016).

It is not a coincidence that industrialized countries have opted for universal healthcare over a privatized system of insurance and distribution. One need not look any further than the United States to recognize that privatization results in significant negative externalities: the "United States spends twice as much on healthcare as a percentage of gross domestic product as other industrialized countries," yet is still "behind the other countries in providing its citizens with good health outcomes, quality of care, access to care, efficiency, and equity" (Tanne 2006). Furthermore, the United States ranked last among twenty-three industrialized countries regarding infant mortality, fifteenth out of nineteen with respect to the number of deaths before the age of seventy-five from "conditions that [were] at least partially preventable and treatable," and tied for last place on healthy life expectancy at sixty years.

Certainly, even a superficial examination of the United States healthcare system would conclude that it is not a practical one—rather, it is clearly one that is not producing a return on investment. Why is this? Aside from the fundamental inefficiencies that were highlighted earlier regarding the United States healthcare system (such as a lack of coordinated care mechanisms, high levels of uncompensated care, and out-of-pocket costs), the answer is quite simple: having more people insured creates better odds for increasing life expectancy and providing adequate compensation for healthcare (Ranabhat 2018).

This is, perhaps, an ambitious statement regarding universal healthcare. However, it is an observation that is based on data:

Regression analysis between predictors and healthy life expectancy.

Independent variables	Dependent variable (Healthy life expectancy)							
	Model 1		Model 2		Model 3		Model 4	
	Std coff.	*P*-value	Std coff.	*P*-value	Std coff.	*P*-value	Std coff.	*P*-value
(Constant)	64.2	<0.001	36.5	<0.001	36.0	<0.001	45.4	<0.001
SOCIAL DETERMINANTS OF HEALTH								
Combined gross enrollment of education in all age %	0.206	0.005	0.183	0.003	0.171	.019	0.04	0.562
Economic growth rate %	0.197	0.003	0.135	0.015	0.103	.100	0.01	0.601
Population growth rate %	−0.331	0.001	−0.255	0.016	−0.161	.058	−0.28	0.002
ACHIEVED UNIVERSAL HEALTH COVERAGE (YES - REFERENCE)	0.430	<0.001	0.420	<0.001	0.418	<0.001	0.407	<0.001
DISEASE PREVENTION								
Sanitation coverage in %			0.334	<0.001	0.324	<0.001	0.311	0.001
DPT-3 vaccine coverage in %			0.220	0.006	0.230	.000	0.182	0.041
HEALTH BEHAVIOR								
Adult alcohol consumption per year per liter					0.090	0.225	−0.10	0.420
Prevalence of youth smoking in %					0.021	0.785	−0.02	0.574
HEALTH FINANCING POLICY								
Percent of OPP on health among total expenditure							−0.18	0.045
Total health expenditure as percent of GDP							0.01	.617
Government expenditure in health %							0.14	.081
R^2	0.32	0.54	0.58		0.68			
Adjusted R^2	0.28	0.51	0.56		0.64			
p-value	<0.001	<0.001	<0.001		<0.001			

Figure 1: Regression analysis between predictors and healthy life expectancy (Ranabhat 2018)

This analysis—done as a multi-country cross-sectional study from data sets provided by the World Health Organization, UNDP-Education, and the World Bank—found that "[universal healthcare] has the greatest influence on [life expectancy at birth] and [healthy life expectancy]" of any of the other predictors included in the study. Not to mention, the data also reveals that countries which have achieved universal health coverage have approximately a 20-year gap between life expectancy at birth and healthy life expectancy, whereas countries

without universal health coverage have a 34-year gap. This disparity is statistically significant, and is often not discussed by legislators and advocates who are opposed to universal healthcare.

Universal healthcare not only enhances healthy life expectancy in major industrialized countries around the world, but also healthcare cost-efficiency. Unsurprisingly, universal healthcare provides the foundation for a healthier population—and healthier populations support economic growth by avoiding the costs associated with preventable, infectious diseases (Beattie 2016). Annually, it has been estimated that 100 million households fall into poverty due to medical and health expenses world-wide (Evans 2010). A consequence of this is the requirement for increases in government health spending to improve outcomes among the "poorest and most marginalized districts…within populations."

As a contrast to uncoordinated health spending, universal healthcare addresses public health inequities via pooled government funds. This notion is best represented by an Imperial College, London, study which found that a "a 10% increase in pooled government health spending led to a reduction of almost 8 deaths per 1000 children under 5" (Gruber 2014). Increases in public funding allows for service quality and availability to be enhanced at the lowest expense to underserved households—rather, the more public funds available to finance healthcare, the less out-of-pocket costs incurred by ordinary citizens. The out-of-

pocket costs associated with private insurance are one of the primary reasons that health services are impoverishing in the United States.

There is no more salient example of public health financing reducing out-of-pocket expenditures than Asia:

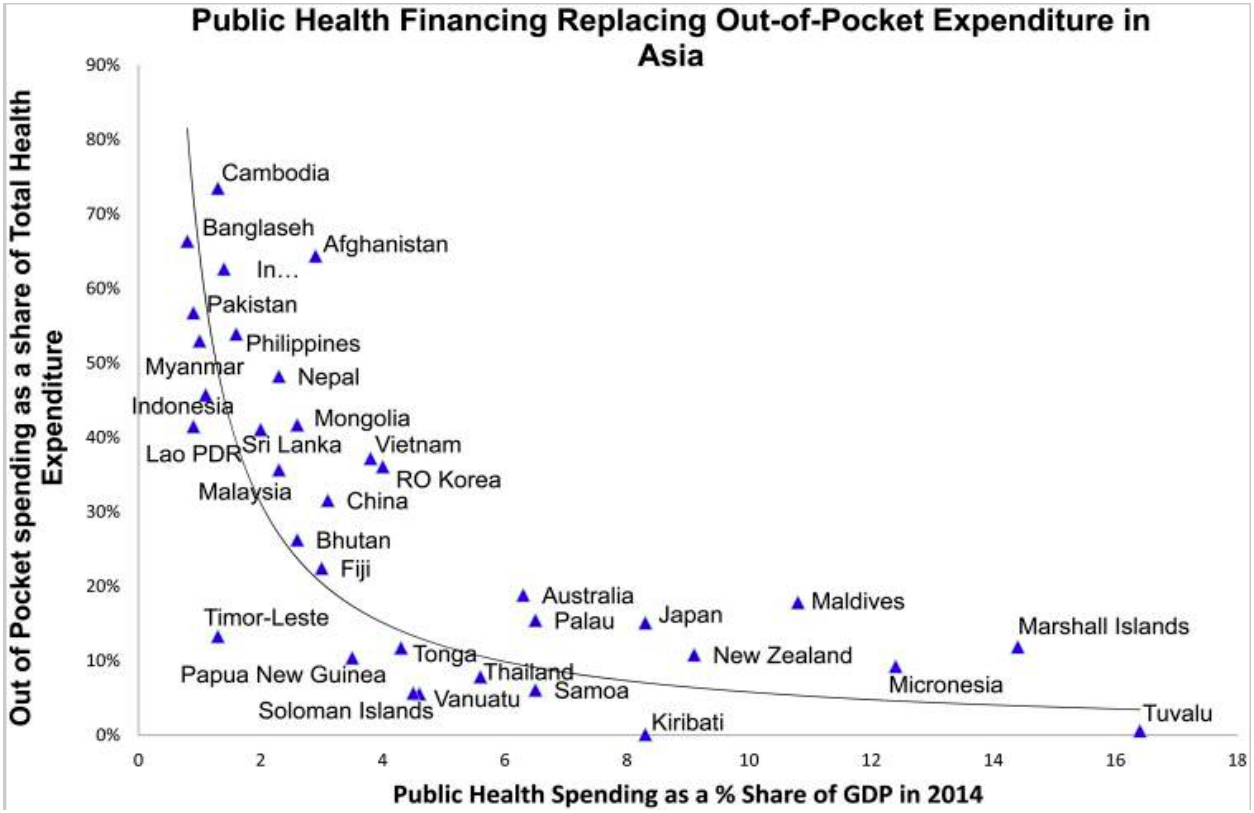

Figure 2: Public health financing replacing out-of-pocket expenditure in Asia and the Pacific World Bank 2014 (Beattie 2016).

The trend depicted in the above graph correlates public health spending as a percent share of GDP with a decrease in out-of-pocket expenditures by members of the public. While Asia is not North America, and Micronesia is not the United States, it is clear that increased public health financing reduces individual burdens with regard to healthcare. Unsurprisingly, population growth accompanying

economic growth creates more demand for health services; of course, the question is how a government chooses to address this demand. As long as healthcare spending is increasing, it is prudent to manage such spending responsibly and efficiently—and, as demonstrated above, empirical data suggests that pooled funds increase both efficiency and equity in healthcare financing and distribution (Beattie 2016). Not to mention, reduced out-of-pocket expenditures disproportionately support marginalized and underserved communities, while also mitigating the "financial risk of paying for services."

In summary, the practicality of universal healthcare is based on two points:

1. Universal healthcare systems enhance life expectancy at birth as well as healthy life expectancy.
2. Universal healthcare systems reduce out-of-pocket expenditures, mitigate financial risk associated with health services, and cover the larger population in a more cost-effective manner than privately financed healthcare systems.

VI. What are the considerations for implementing universal healthcare in the United States?

The primary consideration for implementing universal healthcare—with the assumption that political capital necessary to pass it is available—is whether it would be better to pursue a single-payer universal healthcare system, or a multi-payer universal healthcare system in the United States. Both systems have their unique advantages and disadvantages. An effective comparison between the two systems can be found by examining Germany and Canada, where Germany provides universal healthcare via a multi-payer approach, and Canada via a single-payer approach. On a basic level, the difference between the way the two countries distribute healthcare is in degree of centralization; rather, Germany operates via a more decentralized h`1`ealthcare system, and Canada via a centralized healthcare system.

This notion of healthcare centralization is an important one to consider, as much of the efficiency and effectiveness of the German multi-payer healthcare system comes from decentralizing responsibilities. Because of this decentralized institutional framework, the German healthcare system, in principle, is not entirely dissimilar from the United States healthcare system—insofar as coverage is provided through “a large number of relatively small and independent plans” and that delivery is provided by agreements between “large numbers of employee

groups, independent insurers, and providers" (Ridic 2012). In addition to this, there are effective cost-sharing practices that compound the efficiency of these coverage options, by virtue of having a publicly financed healthcare system. Whereas Germany has both publicly and privately financed elements of its healthcare system, the United States is dominated by private insurance, with inefficient and underfunded options like Medicaid and Medicare for certain members of the population.

The decentralized multi-payer healthcare model is contrasted by the centralized single-payer healthcare model employed by countries like Australia and Canada. The fundamental difference in this centralization is that with single-payer, one entity—which is usually the federal government—manages all healthcare claims. In the United States, Medicare functions as a pseudo-single-payer system. That said, because only certain members of the population are insured under Medicare, its universality is limited, causing its function to diverge from how Australia and Canada manage their healthcare systems.

In Canada, as opposed to Germany, while there are different provincial plans for healthcare, they are all public avenues for insurance (Ridic 2012). They are "public sector monopsonies," where there is a single buyer for medical services and subsequent distribution mechanisms. The benefit of this single buyer method is that costs for care are held below market rates, which is favorable to the general

populace. Similar to Germany, though, physicians receive a relatively small amount of compensation for the services they provide, compared to the United States.

Because the United States emphasizes the private sector in healthcare and in matters external to healthcare, competitive rates and non-standardized costs for care ensure that physician salaries are quite substantial. At this point, it is prudent to revisit that the ethic of universal healthcare is predicated on utilitarianism. While physicians would likely experience a reduction in salary in the case of a multi-payer or a single-payer system, the benefit to the majority of the population would achieve the utilitarian standard of the "greatest amount of benefit for the greatest amount of individuals" (Mandel 2016).

This assessment of multi-payer and single-payer healthcare can be interpreted in several different ways. However, when considering what constitutes a practical path towards implementing universal healthcare—without reinventing the wheel—a multi-payer system appears most feasible. More specifically, the regulated competition that defines Germany's multi-payer system is consistent with the market-based culture of the United States. Not to mention, the decentralization of Germany's healthcare system allows for a multitude of private health insurance options to compete with the government's statutory health insurance, allowing for both universal coverage and competitive rates.

VII. Conclusion

One of the fundamental issues with James Madison's vision and design of the United States Constitution is paradoxically one of its greatest strengths: the separation of powers to reduce the threat of tyranny by either the majority or minority party in government. Each branch of government—the executive, legislative, and judicial—in theory possesses sufficient powers to balance those of the others, preventing absurd policy from gaining traction. The issue with this is that it does not consider the destructive impulses of partisanship. It does not consider how partisan bias is a larger decider of what constitutes an absurd policy than logic in today's politics.

This dysfunction has disabled our ability, as a country, to address the needs of those "of poor and mean condition," particularly in the sector of healthcare. While it is, perhaps, unsavory to assign blame to one political party, it is a reality that the Republican Party—and even certain members of the Democratic Party—have blockaded efforts to make healthcare a right, and not a privilege. Utilizing the powers of Madison's constitutional model, efforts to universalize health insurance have been consistently undermined. Despite the mountains of evidence suggesting that universal healthcare is a practical pursuit, an irrational fear of the "invisible hand of the government," as well as blind party allegiance, has dismembered the integrity of conservative lawmakers.

The Universal Declaration of Human Rights is quite clear in its assertion that humans have a "right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care." To this day, at least 15.5% of the American population are not being afforded this right by their government. In its utterance, this notion is morally reprehensible; in its practice, it is a human rights violation.

One could contend that this argument is based in philosophy, or that liberal bias informs research in favor of universal healthcare. However, to the 44 million Americans who have no health insurance—along with the 38 million with inadequate health insurance—it is profoundly evident that the United States government is not fulfilling its human rights obligation (Lubhy 2018). When approximately one-third of the American population faces healthcare insecurity, while their government spends more per capita on health insurance than any other country in the world, it is empirically obvious that something is not working (OECD 2018). Conservative members of Congress may contend that the Affordable Care Act is responsible for skyrocketing costs, but this is a red herring. Healthcare expenditures are increasing in most countries, yet the United States is the only industrialized country with millions of its citizens without health insurance.

The argument that universal healthcare advocates wish to remove market forces entirely from the equation is flawed, as well. Indeed, it is a strawman: between Germany's regulated competition, Great Britain's internalized insurance markets, and Canada's Community Care Access Centers, healthcare markets still exist (Brown 2003). The difference, however, is that the baseline proposition in all these countries is that every citizen is insured, and that markets can be regulated in such a way to keep costs down. The priority is a universally insured citizenry, not a maintaining of the laissez-faire healthcare status quo.

It was Adam Smith's belief that the neglect of "persons of poor and mean condition is the great and most universal cause of the corruption of our moral sentiments." In denying millions of Americans what should be a fundamental human right, the U.S. Government is actively complicit in this corruption. One does not need to compromise the merits of market forces in order to compromise on healthcare. It is past time to set aside this red herring, once and for all.

VIII. Personal Sentiments

In the Summer of 2016, I interned in the Washington, D.C., Office of U.S. Senator Jeff Merkley. I learned many things from this 8-week internship, but perhaps the most important lesson was not found in the grandeur of the United States Capitol, or via correspondence with powerful individuals in Congress. It was found in the smaller, more menial tasks; it was found in attending briefings and hearings; it was found in answering questions and taking calls from constituents; and, of course, it was found in conversations with the true backbone of a congressional office: the staff.

The most important lesson I learned during this internship was that partisanship has eroded our ability, at the federal level, to provide meaningful reforms for the American people—a constituency that demands certain obligations from a government that consistently fails to meet them. Congressional staffers and policy wonks can craft incredibly meaningful legislation. However, none of it means anything if the bill doesn't receive a hearing, or if those in favor lack the political capital to pass it.

Frankly, I find little to be more demoralizing than watching the hard work of congressional staffers be completely in vain. Observing these results in concert with the political circus that is the United States House of Representatives and Senate is particularly frustrating—but no issue compels me to write a thesis like

healthcare. We have made providing affordable healthcare to American citizens a partisan issue, despite the mountains of empirical data supporting the efficacy and efficiency of universal healthcare systems.

Not unlike the many other college liberals who find this notion frustrating, I am also quite upset about this—but even more than that, I am disillusioned. Disillusioned with a political climate which has disabled our ability to provide proper medical care to every citizen in our country; disillusioned with a political party that refuses to adopt a more reasonable position on government intervention; and now, more than ever, disillusioned with the number of people willing to abandon the values that make America the greatest country in human history. Indeed, it was this disillusionment with our present system that fanned the flames of my research.

During my research process, I spent considerable time deciding which route I wanted to take in my analysis. At first, I wanted to do a historical examination of healthcare in the United States. Given the unique healthcare situation in the United States, I believed an investigation into its historical roots would provide more academic merit than merely regurgitating the many economic analyses that have been done regarding UHC. Naturally, the historical context behind our healthcare system is rich and full of things to talk about. That said, my own curiosities were less so with the history of healthcare in the United States, and moreso with the

philosophies behind UHC, and why they have been inconsistent with the culture of the United States.

Not to mention, I find it truly fascinating that despite the mountains of evidence supplementing the efficacy of UHC, we have still arrived at a point in history where partisanship supersedes practicality—which is a demoralizing policy reality. Consequently, I decided to take my research in a different direction: I decided to write a treatise arguing for why universal healthcare is a practical, and not partisan, pursuit. President Barack Obama coined the "practical, not partisan" nomenclature in the 2015 State of the Union Address, and while these remarks fell on deaf ears in the Republican Party, the sentiment remains important: we need to pursue policy that is empirically sound, and utilitarian, in nature. While I do not expect opponents to universal healthcare to walk away from this paper with a liberal epiphany, it was my aim to at least convey the importance of UHC through a data-centric, objective lens.

I hope that we institute a federal public option and embrace a multi-payer universal healthcare system. As I wrote in this thesis, it is not necessary to eradicate private insurance, and it is unreasonable to remove market forces from the conversation on healthcare affordability. Market forces enable competition—and there is no reason why private insurance cannot compete with the federal government to provide affordable care to every American. We live in a time of

record profits for insurance companies. The public option will expand health insurance access to every citizen in the country; private insurance companies and competition will give us more affordable rates. This method is convincingly in practice in countries like Germany, Sweden, and Denmark. We can do it in the United States, too.

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