

M6 Written Assignment

HLAD 3005: Community Health

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The way health care in the United States is treated, is unlike the processes used in other countries of the world. Other developed countries have national health insurance run or organized by the government and paid for, in large part, by general taxes; moreover, in these countries almost all citizens are entitled to receive health care services, including routine and basic health care (Seabert et al., 2022). In the presidential campaign of 2016, Bernie Sanders proposed a federally administered, single-payer program providing universal coverage without private health insurance called “Medicare for all” (Grant, 2016). Conversations about Universal Health Care coverage have been around for a while, and in this paper, we will be discussing the varying perspectives associated with “Medicare for All.”

In 1994, President Bill Clinton created the American Health Security Act of 1993, where opposition kept it from ever reaching the floor of Congress for a vote: resulting in the sixth time in U.S. history that the concept of universal coverage was defeated (Seabert, et al., 2022). The closest the United States has reached to universal coverage was the Affordable Care Act (ACA) enacted in 2010 (Isola & Reddivari, 2023). The primary goal of this Act was to achieve universal health care coverage by facilitating cooperation among employers, citizens and the government (Isola & Reddivari, 2023). There are many opposing players who have interest in private insurance companies, but let’s dive in to figure out why the United States cannot reach equanimity around proposing a true universally covered health care plan.

First, let’s dive into some of the keys issues the country is currently facing around healthcare. The U.S. has the lowest life expectancy at birth, the highest death rates for avoidable or treatable conditions, the highest maternal and infant mortality, and among the highest suicide rates (Gunja, et al., 2023). Despite these horrifying statistics, the healthcare system is enormous and complicated with many contradicting stakeholders and intertwining policies. For example, it is represented by the cost containment, access, and quality triangle noted by Kissick: a perfectly shaped triangle with 60-degree angles that represent equal priorities. (Seabert et al., 2022). Access is just as important as quality and cost containment and vice versa, an expansion of any one of the angles compromises one or both of the other two (Seabert et al., 2022). Keep this in mind as we continue analyzing the “Medicare for All” policies.

The Medicare for All Act plans to expand the Medicare program to guarantee access to healthcare with comprehensive benefits. This includes freedom to choose providers without worrying about whether they are “in-network”; no private insurance premiums or co-pays; long-term services and support for people with disabilities and older Americans; Reducing health care spending and improving care; reducing the cost of prescription drugs; and healthcare for veterans and Native Americans (PNHP, 2025). On the surface it sounds like accessibility, quality, and cost containment are balanced within this act; however, we will analyze current health care spending and how “Medicare for All” plans on approaching a reduction of health care spending.

The proposed plan would fundamentally restructure the U.S. healthcare system by eliminating most private insurance and consolidating coverage under a single federal program (CRFB, 2020). Functionally, this would simplify administration, reduce overhead, and centralize policy decisions. The financing would shift from a fragmented mix of private payments, employer contributions, and federal subsidies to unify a tax-based system (CRFB, 2020). This transition might be costly and complex, requiring a reallocation of trillions of dollars currently flowing through private insurers into public funding streams.

Health care spending, both per person and as a share of GDP, continues to be far higher in the U.S. than in other higher-income countries; yet the U.S. is the only country that doesn't have universal health coverage (Gunja, et al., 2023). The U.S. is a world outlier when it comes to health care spending. As of 2021, the U.S. spent 17.8% of GDP on healthcare compared to the second highest spending in Germany at 12.8% (Gunja, et al., 2023). Enacting Medicare for All is expected to decrease federal spending by cutting provider payment cuts, lowering prescription drug costs, decreasing personal health spending, and reducing federal health subsidies (Blahous, 2018). A study conducted by Yale epidemiologists found that Medicare for All would reduce U.S. Health care spending by around 13% annually, or \$450 billion a year (Galvani et al., 2020). The financial burden of medical expenses would be reduced, and significantly improve access to healthcare by eliminating financial barriers.

It is noted that under a universal health care policy, individuals will have to pay a higher increase in taxes. Most wage income is subject to a 15.3 percent payroll tax divided evenly between workers and employers; however, Medicare for All suggests a new 25 percent payroll tax evenly (CRFB, 2020). This would significantly impact all families, despite knowing that medical expenses would decrease out of pocket, taking away a significant chunk of pay with every paycheck. For example, imagine a single 40-year-old making \$100,000 and paying \$10,000 in premiums and cost sharing would end up paying \$15,000 more; meanwhile, a family of four making \$60,000 and paying \$25,000 in premiums and cost sharing would end up paying \$10,000 less (excluding tax and wage interactions) (CRFB, 2020). The increased payroll taxes could be especially burdening, especially for those who already have employer-sponsored insurance. This would have significant impact on vulnerable populations like women and children.

It is known that uninsured women receive fewer prenatal care services and report greater difficulty in obtaining the care they need, as they are also more likely to have poor outcomes during pregnancy and delivery than are women with insurance (Institute of Medicine Committee on the Consequences of Uninsurance, 2002). Women would especially benefit from expanded prenatal and reproductive care services, in turn reducing maternal and infant mortality rates. However, there are concerns that remain about whether the program could meet increased demand without sacrificing timeliness of care.

The impacts reach beyond just women, as most patients would benefit from broader access, fewer financial barriers, and lower out-of-pocket costs. Providers may face lower reimbursement rates, which could create financial strain on some facilities, especially for rural hospitals. Private insurance companies would lose much of their market, potentially forcing layoffs and industry downsizing. Employers would no longer need to provide health benefits, reducing labor costs and potentially freeing resources for wage increases or other investments. Lower healthcare costs overall could increase disposable income and economic productivity, but the transition may cause disruptions in the insurance and pharmaceutical industries.

Implementing Medicare for All in the U.S. seems low in the short term due to strong political opposition, private insurance interests, and public concerns about tax increases. Barriers include the cost of transitioning, lobbying efforts by insurance and pharmaceutical companies, and fears around government efficiency. Public opinions seem divided; while many Americans support universal healthcare in principle, enthusiasm wanes when the discussion turns to higher taxes or elimination of choice.

Considering the framework of Medicare for All, the proposal aims to strike a delicate balance among the three critical dimensions of healthcare policy: cost containment, access, and quality. On the one hand, it promises to reduce the financial burden on millions of Americans by cutting overall healthcare spending and eliminating out-of-pocket costs. On the other, it ensures that care is not just available, but also equitable, extending coverage to historically underserved populations, such as women. However, the question of quality remains intertwined with cost and access. While patients face fewer financial barriers and gain wider access to essential services, challenges such as provider reimbursement rates, staffing shortages, and potential wait times must be carefully managed to preserve high-quality care. Ultimately, Medicare for All underscores the reality of Kissick's triangle: gains in access and affordability must be carefully aligned with strategies that sustain quality while containing costs. If implemented with thoughtful planning and widespread public support, this policy could move the United States closer to the level of equity and efficiency achieved by other developed nations.

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