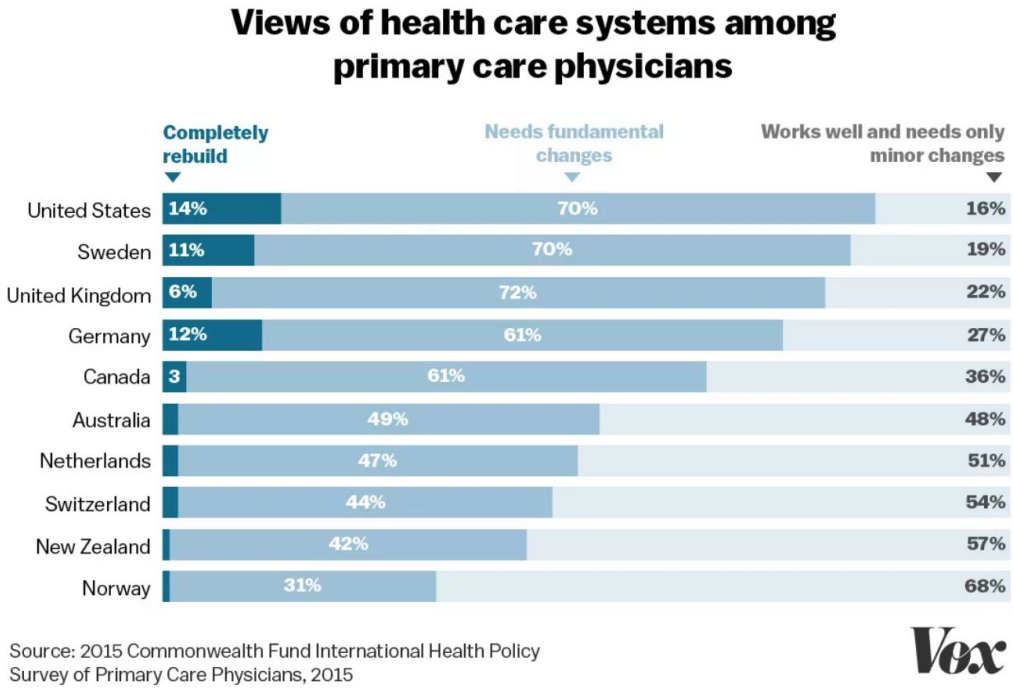
Solutions:

We can't fix the future, but it is up to the future to fix and keep up with what is happening. However, the United States healthcare system "spends nearly 20% of its gross domestic product on healthcare- more than twice the average of its developed countries" (p 2).[12] In fact, "the U.S. health system generally delivers worse health outcome than any other developed country, all of which spend on average about half what we do per person" (p 3).[12] "Unless you're part of the 1% you're only ever one unlucky step away from medical financial disaster" (p 241).[12] Data shows that as the complexity has increased, we found that the most expensive care is not necessarily the best care. And vice versa, the best care often turns out to be the least expensive -- has fewer complications, the people get more efficient at what they do.[1]

Another reason as to why I picked these choices is because I volunteered at Bellevue Hospital on the hospitalist and infection control floor. I worked there for 3 months 3 times a week for 2-3 hours. I saw the ins and outs of the hospital before this pandemic took over. Here are some of my insights that altered and shaped my solutions.



Quality/Cost

Knowing the right time to receive health care is ideal. But once people go in to receive the help they need, they end up with different bills that don't composite all charges so there is an abundance of bills that you get with large numbers on them. It would be ideal for all the costs/charges to be on one bill and a layout of what you are paying for. "Patients and physicians are freed of inefficient administrative and billing tasks, documentation requirements are simplified, payments and charges are more transparent and predictable, and delivery systems are redesigned to make it easier for patients to navigate and receive needed care conveniently and effectively."[2]

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[1] Gawande, Atul. "How Do We Heal Medicine?" *TED*, www.ted.com/talks/atul_gawande_how_do_we_heal_medicine/details?referrer=playlist-what_doctors_worry_about.

[2] "Envisioning a Better U.S. Health Care System for All: A Call to Action by the American College of Physicians." 21, Jan. 2020.

Working Together

By having a united public healthcare system for all Americans we could use the examples of other countries with such systems to figure out what works best and what does not. We could create allies that would prevent our system from falling behind. I believe that having a bi-lateral agreement with other countries would not only help us have better healthcare, it would also help us to have a better economy where workers felt secure that they could keep their healthcare even if they lost their jobs. We could be leaders and create a world community that could work for all nations.

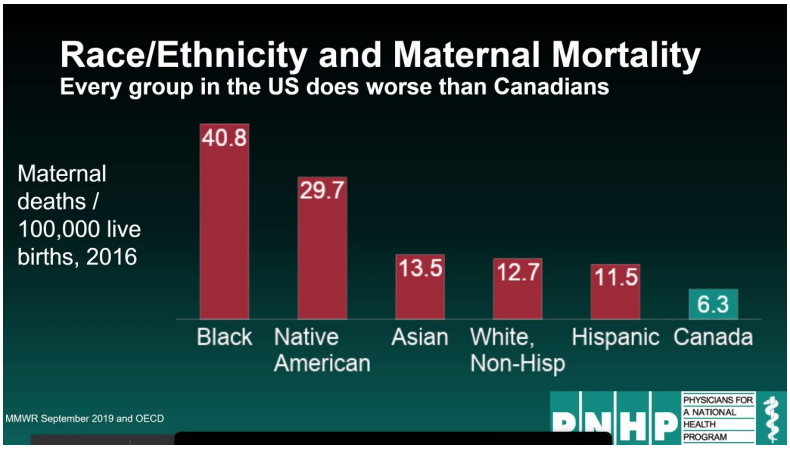
This also ties in with what is set up in France. As of 2016, they instituted a new healthcare system for foreigners, known as Protection Universelle Maladie (PUMA), which allowed access to state healthcare after three months of residence. If we had this in place, it would allow easier access to healthcare for people visiting and on working visas to the US. Although this might seem costly, it would prevent the possibility that infected visitors would avoid getting treatment and be more likely to transmit an infectious disease which would be more expensive to the system in the end.

Telehealth/TeleMedicine[3]

Increased use of telehealth and telemedicine would allow people to access their doctors and resources from anywhere. People living in remote locations and people who need to travel for their jobs often can't afford all the trouble just for a check up, but this would make it easier for them to receive treatment. However there is the down factor that some people do not have access to an electronic device. This can also be addressed by public policy.

Medicare:

"U.S. health care costs too much; leaves too many behind without affordable coverage; creates incentives that are misaligned with patients' interests; undervalues primary care and public health; spends too much on administration at the expense of patient care; fails to invest and support public health approaches to reduce preventable injuries, deaths, diseases, and suffering; and fosters barriers to care for and discrimination against vulnerable individuals."[4][5] Medicare in the United States has been successful in allowing more people with good healthcare and controlling the costs of treatment. However, it is said that once people turn 65 and have medicare, their life expectancy rises. (picture)[1][5]



Medicare has also allowed access to healthcare to people who would not have it otherwise. For these reasons I think that the Medicare for All Act of 2019 would be a great fit. Here are the parts that I agree with that should be placed into our system:[4]

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https://www.acpjournals.org/doi/10.7326/M19-2411.

[3] Madu, Ernest. "World-Class Health Care." *TED*, www.ted.com/talks/ernest_madu_world_class_health_care/details?referrer=playlist-what_doctors_worry_about#t-3282.

[4] Sanders, and Bernard. "Text - S.1129 - 116th Congress (2019-2020): Medicare for All Act of 2019." *Congress.gov*, 10 Apr. 2019, www.congress.gov/bill/116th-congress/senate-bill/1129/text?q=%7B%22search%22%3A%5B%22Medicare%2Bfor%2BAll%2BAct%2Bof%2B2019%22%5D%7D&r=1&s=1#toc-id543f8d72ce1c4b05b7d6e4c41b0d31ee.

- SEC. 101. ESTABLISHMENT OF THE UNIVERSAL MEDICARE PROGRAM.
    - There is hereby established a national health insurance program to provide comprehensive protection against the costs of health care and health-related services, in accordance with the standards specified in, or established under, this Act.
- SEC. 102. UNIVERSAL ENTITLEMENT.
    - In General.—Every individual who is a resident of the United States is entitled to benefits for health care services under this Act. The Secretary shall promulgate a rule that provides criteria for determining residency for eligibility purposes under this Act
        - may make eligible for benefits for health care services under this Act other individuals not described in subsection (a) and regulate their eligibility to ensure that every person in the United States has access to health care; and shall promulgate a rule, consistent with Federal immigration laws, to prevent an individual from traveling to the United States for the sole purpose of obtaining health care services provided under this Act.
- SEC. 104. NON-DISCRIMINATION.
    - In General.—No person shall, on the basis of race, color, national origin, age, disability, or sex, including sex stereotyping, gender identity, sexual orientation, and pregnancy and related medical conditions (including termination of pregnancy), be excluded from participation in, be denied the benefits of, or be subjected to discrimination by any participating provider as defined in section 301, or any entity conducting, administering, or funding a health program or activity, including contracts of insurance, pursuant to this Act.
- SEC. 105. ENROLLMENT.
    - Include a process for the automatic enrollment of individuals at the time of birth in the United States or upon the establishment of residency in the United States
        - The individual is a resident of the United States.
        - The individual is—
            - a citizen or national of the United States; or
            - an alien lawfully admitted for permanent residence.
    - Include a process for the enrollment of individuals made eligible for health care services under section 102.
    - Issuance Of Universal Medicare Cards.—In conjunction with an individual's enrollment for benefits under this Act, the Secretary shall provide for the issuance of a Universal Medicare card that shall be used for purposes of identification and processing of claims for benefits under this program. The card shall not include an individual's Social Security number.
- SEC. 106. EFFECTIVE DATE OF BENEFITS.
    - For any eligible individual who has not yet attained the age of 19, benefits shall first be available under this Act for items and services furnished on January 1 of the first calendar year that begins after the date of enactment of this Act. (NOTE/FIXTURE: give until their 19th birthday, at 18 they should be looking to switch over, giving them a year. Also if they have ongoing treatment when this happens or is taking a prescription see if it can carry over until you're done but also have a different provider, unless they are going to medicare, then it would be fine.)
    - Any person who is eligible to receive benefits as any coverage described in section 901, private health insurance coverage, or coverage offered pursuant to subtitle A of title X (including the amendments made by such subtitle) until the effective date described in subsection
- SEC. 107. PROHIBITION AGAINST DUPLICATING COVERAGE
    - Construction.—Nothing in this Act shall be construed as prohibiting the sale of health insurance coverage for any additional benefits not covered by this Act, including additional benefits that an employer may provide to employees or their dependents, or to former employees or their dependents.
- SEC. 201. COMPREHENSIVE BENEFITS.
    - In General.—Subject to the other provisions of this title and titles IV through IX, individuals enrolled for benefits under this Act are entitled to have payment made by the Secretary to an eligible provider for the following items and services if medically necessary or appropriate for the maintenance of health or for the diagnosis, treatment, or rehabilitation of a health condition:

        - Hospital services, including inpatient and outpatient hospital care, including 24-hour-a-day emergency services and inpatient prescription drugs.
        - Ambulatory patient services.
        - Prescription drugs, medical devices, biological products, including outpatient prescription drugs, medical devices, and biological products.
        - Mental health and substance abuse treatment services, including inpatient care.
        - Laboratory and diagnostic services.
        - Comprehensive reproductive, maternity, and newborn care.
        - Pediatrics, including early and periodic screening, diagnostic, and treatment services
        - Oral health, audiology, and vision services.
        - Short-term rehabilitative and habilitative services and devices.
        - Emergency services and transportation.
        - Necessary transportation to receive health care services for individuals with disabilities and low-income individuals.
        - Home and community-based long-term services and supports (to be provided in accordance with the requirements for home and community-based)
- SEC. 206. STATE STANDARDS.
    - Nothing in this Act shall prohibit individual States from setting additional standards, with respect to eligibility, benefits, and minimum provider standards, consistent with the purposes of this Act, provided that such standards do not restrict eligibility or reduce access to benefits or services.
    - States may not prohibit an individual or entity from participating in the program under this Act, for reasons other than the ability of the individual or entity to provide such services.
- SEC. 302. QUALIFICATIONS FOR PROVIDERS.
    - A health care provider is considered to be qualified to provide covered services if the provider is licensed or certified and meets
        - all the requirements of State law to provide such services; and applicable requirements of Federal law to provide such services.
- SEC. 401. ADMINISTRATION.
    - The Secretary shall establish uniform State reporting requirements and national standards to ensure an adequate national database containing information pertaining to health services practitioners, approved providers, the costs of facilities and practitioners providing such services, the quality of such services, the outcomes of such services, and the equity of health among population groups. Such standards shall include, to the maximum extent feasible without compromising patient privacy, health outcome measures, and to the maximum extent feasible without excessively burdening providers
    - The Secretary shall regularly analyze information reported to it and shall define rules and procedures to allow researchers, scholars, health care providers, and others to access and analyze data for purposes consistent with quality and outcomes research, without compromising patient privacy.
    - ANNUAL REPORT
        - Beginning January 1 of the second year beginning after the effective date of this Act, the Secretary shall annually report to Congress on the following:
            - The status of implementation of the Act.
            - Enrollment under this Act.
            - Benefits under this Act.
            - Expenditures and financing under this Act.
            - Cost-containment measures and achievements under this Act.
            - Quality assurance.
            - Health care utilization patterns, including any changes attributable to the program.
            - Changes in the per-capita costs of health care.
            - Differences in the health status of the populations of the different States, including income and racial characteristics, and other population health inequities.

                - Progress on quality and outcome measures, and long-range plans and goals for achievements in such areas.
                - Necessary changes in the education of health personnel.
                - Plans for improving service to medically underserved populations.
                - Transition problems as a result of implementation of this Act.
                - Opportunities for improvements under this Act.
            - make statistical and other studies, on a nationwide, regional, State, or local basis, of any aspect of the operation of this Act
- SEC. 601. NATIONAL HEALTH BUDGET.
    - By not later than September 1 of each year, beginning with the year prior to the date on which benefits first become available as described in section 106(a), the Secretary shall establish a national health budget, which specifies the total expenditures to be made for covered health care services under this Act.
    - DIVISION OF BUDGET INTO COMPONENTS.—In addition to the cost of covered health services, the national health budget shall consist of at least the following components:
        - Quality assessment activities under title V.
        - professional education expenditures.
        - administrative costs.
        - Innovation, including in accordance with section 1115A of the Social Security Act (42 U.S.C. 1315a).
        - Operating and other expenditures
        - Capital expenditures.
        - Prevention and public health activities.
- SEC. 611. PAYMENTS TO INSTITUTIONAL AND INDIVIDUAL PROVIDERS.
    - Except as otherwise provided in this section, the Secretary shall establish, by regulation, fee schedules that establish payment amounts for benefits under this Act in a manner that is consistent with processes for determining payments for items and services under title XVIII of the Social Security Act including the application of the provisions of, and amendments
- SEC. 614. PAYMENTS FOR PRESCRIPTION DRUGS AND APPROVED DEVICES AND EQUIPMENT.
    - The prices to be paid for covered pharmaceuticals, medical supplies, and medically necessary assistive equipment shall be negotiated annually by the Secretary
        - The Secretary shall establish a prescription drug formulary system, which shall encourage best-practices in prescribing and discourage the use of ineffective, dangerous, or excessively costly medications when better alternatives are available.
- TITLE VIII—CONFORMING AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974
- SEC. 1011. MEDICARE PROTECTION AGAINST HIGH OUT-OF-POCKET EXPENDITURES FOR FEE-FOR-SERVICE BENEFITS AND ELIMINATION OF PARTS A AND B DEDUCTIBLES.
    - the term ‘out-of-pocket cost-sharing’ means, with respect to an individual, the amount of the expenses incurred by the individual that are attributable to
        - coinsurance and copayments applicable
    - Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 1001, is amended by adding at the end the following new section: “PROTECTION AGAINST HIGH OUT-OF-POCKET EXPENDITURES
        - if the amount of the out-of-pocket cost-sharing of such individual for a year (effective the year beginning January 1 of the year following the date of enactment of the Medicare for All Act of 2019) equals or exceeds $1,500, the individual shall not be responsible for additional out-of-pocket cost-sharing occurred during that year.
- SEC. 1102. DEFINITIONS.
    - the term “Secretary” means the Secretary of Health and Human Services;
    - the term “State” means a State, the District of Columbia, or a territory of the United States; and
    - the term “United States” shall include the States, the District of Columbia, and the territories of the United States.

Universal Healthcare - The Arguments Against It

To complete my analysis of Universal Healthcare I decided to look at some of the most popular arguments against it.

- Universal health care, also known as free health care, is not actually free because the registered members must pay it using certain taxes.
    - That is true, but I think we should tax people based on income so the expense could be shared more fairly.
    - Employee sponsored healthcare that we have now is not free either as employees use this as a bonus and therefore pay their employees lower salaries.
- Individual ingenuity, competition, and profit motives always lead to bigger cost effectiveness and control.
    - This would be true if we had real competition in the insurance marketplace but the entire US market is controlled by a few insurance companies who set rates based on what the competitors charge.
- There will be no patient flexibility because healthcare is controlled by the government.
    - I thought about a way to come up with a system in which anyone opposed to the concept doesn't have to participate. Such as a member of the Libertarian Party. There would be the placement of private insurance. This is what politicians refer to as "The Public Option".
- The procedure from the government will make doctor flexibility reduced and there will be a chance for patients to get poor care.
    - Right now we have a two tiered system for rich and poor and the fact is that private care is more useful for the wealthy. But maybe with the help of telehealth, electronic medical record keeping and the website option it might become easier for poor people to get quality care as well. But also we just need more doctors and healthcare professionals.
- Anyone who feels healthy but needs a health care plan must still pay for the expense of those who are obese, smoke, and much more.
    - Help everyone not just yourself, it creates a better society. But again, tax based on income. Also, if more people have access to treatment we can concentrate on wellness rather than sickness. People will see doctors for regular checkups and get diagnosed earlier in the illness cycle. This will ultimately eliminate expensive hospitalizations and surgeries.
- The cost of malpractice lawsuits can increase because the government controls it and exposes the government to legal liability as well as a chance to sue somebody with a low budget will give more lawsuits.
    - The government has the ability to regulate this whereas private practitioners do not. A large percentage of current medical costs are for doctors' liability insurance protection.
- Since the government controls universal health care, access to drugs, health care equipment, and medical services can become more limited if they choose to regulate certain conditions.
    - This is true, but other things such as listed above and below will be in place. Also, private insurers often choose not to pay for certain procedures.
- Anyone who is part of a universal health care member may have extremely long waits when needing treatment.
    - If we have more doctors this will help. Also we can utilize nurse practitioners and physician's assistants.

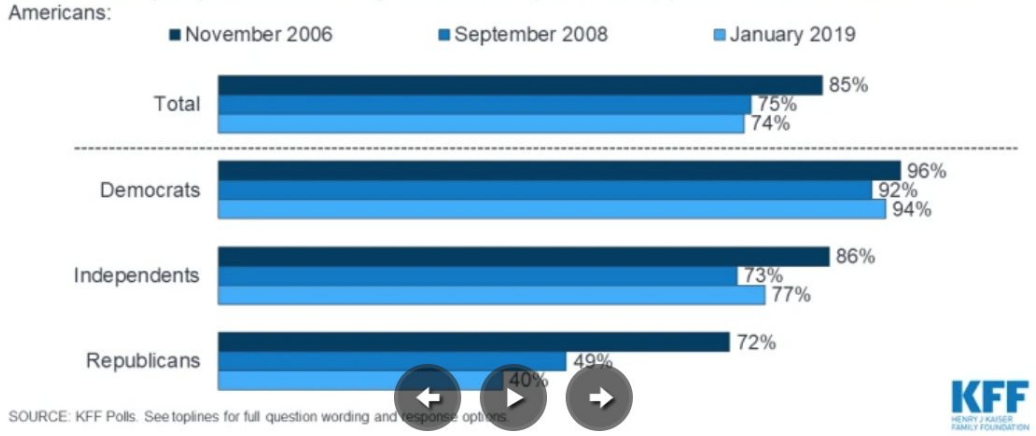
Here are some graphs to put it into perspective[5]

[5] Published: Apr 03, 2020. "Public Opinion on Single-Payer, National Health Plans, and Expanding Access to Medicare Coverage." *The Henry J. Kaiser Family Foundation*, 3 Apr. 2020, www.kff.org/slideshow/public-opinion-on-single-payer-national-health-plans-and-expanding-access-to-medicare-coverage/.

Figure 1

Most Support Federal Government Doing More To Help Provide Health Insurance, But Republican Support Has Declined Over Time

Percent who say they **favor** the federal government doing more to help provide health insurance for more Americans:



SOURCE: KFF Polls. See toplines for full question wording and response options.

KFF
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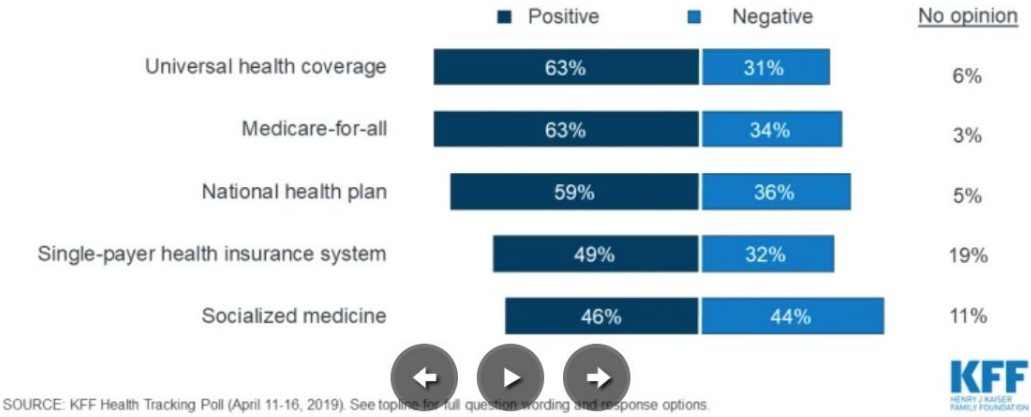
Figure 5

Chartpack Single Payer 04-03-20 Figure6

Terminology Affects Public Opinion On A National Health Plan

Do you have a positive or negative reaction to each of the following terms?



SOURCE: KFF Health Tracking Poll (April 11-16, 2019). See toplines for full question wording and response options.

KFF
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Figure 8

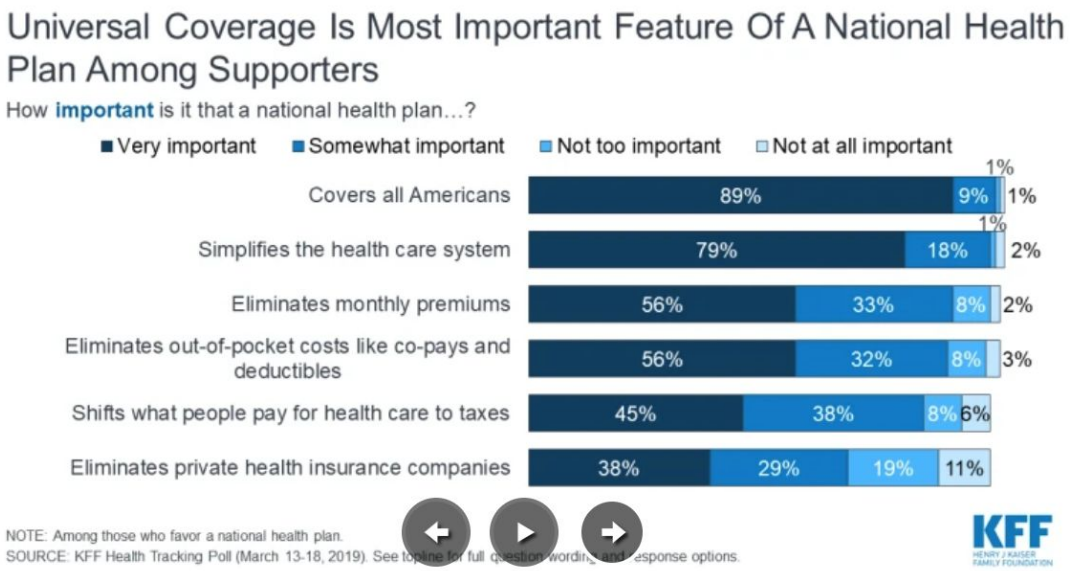
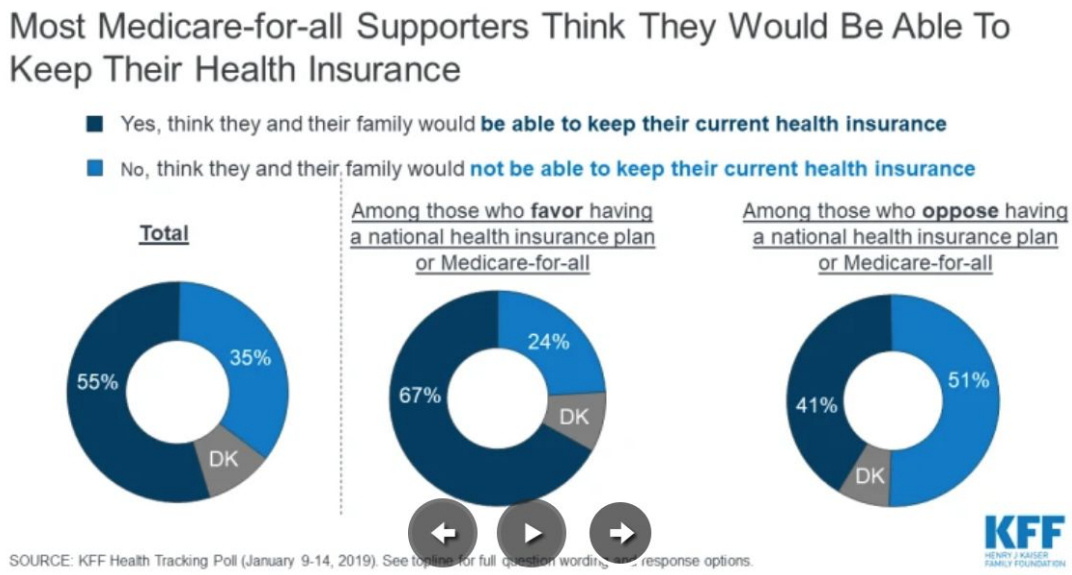


Figure 11



Fixed Pricing

By having fixed pricing for procedures, medication and with the overall system in place it would allow for a more affordable and equal system. "We accept the drugmaker's argument that they have to charge twice as much for prescriptions as in any other country because lawmakers in nations like Germany and France don't pay them enough to recoup their research costs" (p 1)[12]. It is making the argument that if we replaced the word prescriptions with cars or films things would be different. Why is health okay to switch? Hospitals should have a fixed amount depending on the diagnosis. "Many countries, Germany, Japan, Belgium, and more -- set national fee schedules for some combination of medical encounters of supplies and medicines...National fee schedules inevitably yield prices that are far lower than those in the Unites Stare because a nation has far greater negotiating clout than a single insurer or an individual." (p 244).[12] For example, sonograms can cost between $1,000-$8,000 in the US whereas in

Japan and Belgium they have a fixed price of under $150. I feel as if fixed pricing could work in the United States, however, it should be negotiable depending on your income - but the price can't go up.[12]

Covered insurance:

I believe that if you hold private insurance and a procedure is covered, then all the tests, screenings, and treatments related to that procedure should be covered as well. Insurance policies are designed to meet patients' needs. Although the government will still need to make enough money to pay for the expense of the service they are providing they will not be trying to make a profit and can therefore bring down costs. Even if everything associated with a procedure is not covered, there should be a fixed price or a lowered price set by Medicare. There can also be package deals that are 20-25% lower than the actual cost.

[6]Insurance could also be used for economic purposes There should be more expansive unemployment insurance. For instance, in the UK employees are receiving 80% of their salary; this is the reason as to why in the UK unemployment didn't rise as much as it did in the US, they had the policy that their labor department would subsidize salaries during an emergency like an epidemic. Unfortunately in the U.S. the government subsidies had to go through big bank corporations which delayed the process so that by the time some companies received the money it was too late and they had already laid people off.

New Government website:

I think there should be a new government website that allows everyone to log on (similar to the telehealth/telemedicine websites previously discussed). But this website would inform everyone with information about generic medicine brands and alternative treatments. This could be partnered up with WebMD, or a program like that. These brands and treatments would not include surgical procedures, as one can do their own research. This would strictly be for over the counter drugs and non-medical treatments. There could also be another section on the portal where prescriptions could be received and fulfilled. There could also be a Reddit section where people from all over could give recommendations and reviews (shows age, place where they got it, and rating). There could also be information and advice about insurance. This would help inform and unite people.

Broader Workforce/Doctor Training:

I also think that our doctors need to have additional training regarding patient relationships and that we need a broader workforce including more RN's, PA's, technicians and medical clerks. This training/session should be a course set in place to form relationships with the patient in order for them to get the best care they need. In order to create more jobs and to make it easier for people who can't afford to go through medical school, we could have helpers in the waiting room. This job would include helping out the patient with their paperwork as well as just getting to know the patient more on a personal level. This could even be a college student, just being able to make a connection to a patient. A cure isn't always based on medicine, it could be housing, a balanced relationship, food supply, transportation etc. Doctors would prescribe something but the underlying factors are at home or can't be seen. "A simple model where doctors and nurses can prescribe nutritious food, heat in the winter and other basic resources for their patients the same way they prescribe medication. Patients then take their prescriptions to our desk in the clinic waiting room where we have a core of well-trained college student advocates who work side by side with these families to connect them out to the existing landscape of community resources."[7] One of the few positive outcomes of this terrible pandemic is that people have learned to appreciate and value healthcare workers. I think this will inspire many young people to want to take up a career where they can service others and be of help to society.

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[6] Why we're seeing mass layoffs in the US but not the UK vox." *Youtube VOX*, 5 May. 2020, https://www.youtube.com/watch?v=HaraFkhonFo.

[7] Onie, Rebecca. "What If Our Health Care System Kept Us Healthy?" *TED*, 2020, www.ted.com/talks/rebecca_onie_what_if_our_health_care_system_kept_us_healthy/up-next?referrer=playlist-what_doctors_worry_about#t-5675.