A Proposal for a Debate Resolution on

National Health Insurance

to be Debated on the High School CX Circuit
for the 2009-2010 Season

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Introduction

Health care is the most important domestic issue facing policymakers in the United States today.[1] Reform of the health care system is an ideal topic for high school debaters because it offers an opportunity to expose students to divergent views on a crucial topic.

Problems with the Current Health Care System: Cost, Quality and Access

The ongoing national debate over health care in the United States centers on three key problems: cost, quality and access. Total spending on health care has been rising at about twice the rate of national income, increasing from 2.5 percent of gross domestic product (GDP) in 1970[2] to 16.2 percent today.[3] Currently the United States spends about $2 trillion on health care, or $6,500 per year per person.[4] The Government Accountability Office, the Trustees of Social Security and Medicare, and the Congressional Budget Office have each released forecasts about the dire effects of escalating health care spending. An especially troubling estimate by the National Center for Policy Analysis shows that government health spending in the United States will rise to one-third of GDP by mid-century. If we continue on this path:[5]

- Health care spending (primarily through Medicare and Medicaid) will crowd out every other government program by the time today's high school students retire.

- And if private-sector spending keeps pace with government spending (and for the past 30 years it has), health care will crowd out every other form of consumption.

The United States spends more on health care than any other developed country: The McKinsey Global Institute says the United States spends $477 billion a year — $1,645 per person — more on health care than the average developed nations after adjusting for differences in income and wealth.[6]

Despite spending much more, many argue the care Americans receive is no better. For example, according to a recent study by the Commonwealth Fund, the United States lags behind most other developed countries on such crucial health indicators as life expectancy, infant mortality and deaths from preventable causes.[7]

At any one time, 47 million Americans have no health insurance.[8] And many with health insurance through their employer are at risk of becoming temporarily uninsured if they lose their jobs or move to new employers. Lack of insurance is a problem for a number of reasons. First, many studies suggest the uninsured do not visit a doctor on a regular basis and will delay care until they become very ill, making care more expensive when it is sought.[9] Second, some studies suggest that when the uninsured *do*

receive care, it is substandard and often priced higher than services for those with insurance.[10] Third, when the uninsured cannot pay their bills, the cost is shifted to others through higher prices, higher health insurance premiums and higher taxes.

Is National Health Insurance the Solution?

Some groups, like the Physicians' Working Group for Single Payer Health Insurance, say the United States should adopt a single-payer national health insurance program. In their view, a national health insurance program that provides all necessary medical care to all persons in the United States regardless of their ability to pay will fix what ails the current health care system.[11]

Proponents of national health insurance assert that the current market-driven system pits profits against patient care, as insurers and providers seek to avoid unprofitable patients, shifting costs back to patients who *do* seek care. In the process, these systems divert resources from patient care and quality improvements to business needs like marketing, profits and excessive executive compensation.

By contrast, they claim, a national health insurance plan would eliminate the administrative burden and overhead cost associated with the current system, saving hundreds of billions of dollars that could then be put into improving quality and providing universal care for all Americans.

Advocates of single-payer plans frequently point to Canada as a model for U.S. policymakers.

The Negative Response

While almost everyone believes the system needs reform, negative teams may choose to argue that foreign health care systems are not superior to our own and national-health-insurance-type reform would make things worse for several reasons.

First, the United States may not be spending more than other countries if costs were measured in the right way. There are fewer practicing physicians, nurses and acute care bed days per capita in the United States than in the average developed country. Americans do use 54 percent more medical devices—defibrillators, pace makers, coronary stints, hip implants, knee implants and so forth. But U.S. consumption of drugs is 20 percent lower than in other countries. If health outcomes among developed countries are pretty much the same, the United States does not look so bad in terms of resources used to produce those outcomes.[12]

In other developed countries, governments use their buying power to force providers to accept below-market reimbursement, just as Medicaid and Medicare do in the United States. For instance, the income of a physician is 5.5 times that of the average worker in the United States, on average. The ratio for Germany and Canada is 3.4 and 3.2, respectively. The comparable ratio is 1.5 in Sweden and 1.4 in the United

Kingdom.[13] Monopolistic buying power, however, does not lower the real social cost of health care; it shifts those costs to health care providers.

Additionally, even if we spend more on health care, some say we actually get more. A study by Harvard University economist David Cutler claims that extra health spending in the United States has led to better care: The life expectancy of heart and cancer patients has increased, and Americans' quality of life has improved due to joint replacements and other procedures.[14] General mortality statistics are heavily influenced by life-style choices (smoking, drinking, overeating and risk taking).[15] U.S. mortality rates are below those of other countries for conditions for which medical science can make a difference (for example, breast cancer and prostate cancer).[16]

Opponents of national health insurance also say statistics about the number of uninsured are misused. Like unemployment, most episodes of uninsurance are short lived: Three of every four uninsured persons will be insured within a year. And there is debate over how much insurance really matters: A study by the RAND Corporation found that among people who actually see a doctor, insurance coverage has little effect on the quality of care received.[17]

Further, while national health insurance advocates point to Canada as a model, opponents note that Canada is no panacea. Patients may wait months for treatment. For example, in Canada:

- The average waiting time for cancer surgery varies from about a month for bone cancer, about 2 months for cervical cancer, to nearly 4 months for thyroid cancer.[18]

- Average wait time for a CT scan is almost 2 months, while wait time for an MRI scan is almost 4 months.[19]

- In Saskatchewan, patents wait an average of 16 weeks for all procedures, ranging from almost 43 weeks for knee replacements to about 3 weeks for cardiovascular surgery.[20]

Opponents of government-centered national health insurance say the problems of cost, quality and access arise because of *too little* competition and the *absence* of free market forces. They say the health care system works just fine when employers, insurance companies and government agencies are not involved and patients are paying with their own money. For example, according to a study by economist Amy Finkelstein of the Massachusetts Institute of Technology, half of the recent growth in total health care expenditures was due to Medicare, although it services a much smaller fraction of the population than private insurance.[21]

Current Proposals to Reform the Health Care System

Proposals for reforming the U.S. health care system stretch the gamut from socialism to capitalism — and everything in between.

Government-Provided Health Insurance. All other developed countries (with the possible exception of Switzerland) have established national health insurance systems in which government plays a major role. These systems are designed to make health care free to patients at the point they utilize the services. There are two general ways a government-provided national health insurance system could be structured:

Single-Payer National Health Insurance. In a single-payer system, a single entity (almost certainly a government agency) would finance all care. The Physicians' Working Group for Single-Payer National Health Insurance explains:

> An NHI [national health insurance] program, which in essence would be an expanded and improved version of traditional Medicare, would cover every American for all necessary medical care. An NHI program would save at least $200 billion annually (more than enough to cover all of the uninsured) by eliminating the high overhead and profits of the private, investor-owned insurance industry and reducing spending for marketing and other satellite services. Physicians and hospitals would be freed from the concomitant burdens and expenses of paperwork created by having to deal with multiple insurers with different rules, often designed to avoid payment. National health insurance would make it possible to set and enforce overall spending limits for the health care system, slowing cost growth over the long run. An NHI program is the only affordable option for universal, comprehensive coverage.[22]

Sen. Edward Kennedy (D-Mass.) has proposed a single-payer system along these lines; under his plan, Medicare — which current covers the elderly — would be expanded to the entire U.S. population.

Critics claim government-provided health insurance would lead to less care and lower quality care. According to John Goodman, president of the National Center for Policy Analysis:

> Government control of health care usually makes citizens worse off. When health care is made free at the point of consumption, rationing by waiting is inevitable. Government control of the health care system makes the rationing problem worse as governments attempt to limit access to modern medical technology. Under government management, both efficiency and quality of patient care steadily deteriorate.[23]

Multiple-Payer National Health Insurance. Other versions of national health insurance have also been advanced. Rep. Pete Stark (D-Calif.) proposed a system under which all individuals would either be covered through an employer plan or through AmeriCare, an expanded version of Medicare. According to Jacob Hacker, a professor at Yale University, AmeriCare is perhaps the most promising way to achieve universal health care:

> Rather than try to reinvent the wheel or upend parts of our present system that work, AmeriCare builds on employment-based insurance and the Medicare model

> to ensure that every American has access to a secure, affordable, and comprehensive health plan. This valuable legislation—which has the best chance of any proposal for universal coverage—could transform America for the better.[24]

Those who favor single-payer systems argue that multiple-payer insurance would be more expensive and less efficient than single payer because the private insurance industry would still be in place. According to them, only a single-payer system eliminates the administrative burden and expenses of paperwork created by dealing with multiple insurers.

Government Subsidies for Private Health Insurance. About 40 percent of all health care in the United States is paid for directly by the government through programs like Medicare, Medicaid and the State Children's Health Insurance Program, a contribution which totals some $800 billion a year.[25] The government spends an additional $200 billion a year on tax subsidies for private health insurance.[26] Most of these subsidies, oddly, go to those who need them least. The major tax benefit is the ability to exclude employer-paid health insurance premiums from the employees' incomes. This benefit is most valuable to higher-income workers, who are in higher tax brackets and who are more likely to have health insurance. Also, although employer-provided insurance is generously subsidized, people who must buy their own coverage get little tax relief. Reform plans come in three general forms: tax deductions, refundable tax credits and vouchers.

Tax Deductions for All. In his 2007 State of the Union address, President Bush proposed replacing the existing system of tax subsidies for private health insurance with a standard tax deduction of $15,000 for a family or $7,500 for an individual who has insurance, regardless of how it is purchased. The proposal would level the playing field between individual and group insurance, making health insurance more affordable for individuals who are not covered through an employer.[27]

While some praise the plan on grounds of fairness, others argue that it will erode the pooling of large numbers of people into purchasing groups, which reduces costs for individuals with chronic conditions who otherwise might not be able to find affordable insurance in the individual market. Moreover, a uniform tax deduction will *still* provide disproportionate benefits to the wealthy because the value of the tax deduction depends on an individuals' tax bracket. For example, an individual in the 10 percent bracket would receive a much lower tax benefit than an individual in the 30 percent bracket.

Refundable Tax Credits for All. A "refundable" health insurance tax credit would help families with no tax liability: People who do not owe taxes would get cash back from the government, just like the Earned Income Tax Credit. Several different proposals for refundable tax credits have been advanced. Presidential candidate John McCain's health care proposal gives a $2,500 refundable tax credit for individuals and $5,000 for couples. Another leading plan by economists Mark Pauly and John Goodman proposes a tax credit for the purchase of basic catastrophic insurance coverage.[28]

Like critics of tax deductions for health insurance, opponents argue that credits will threaten the employer insurance system, potentially increasing the number of uninsured. Additionally, they warn, the tax credits would most likely be too small to replace the full cost of a health insurance policy.

Vouchers for All. Health care vouchers are another version of a government health care subsidy. A health care voucher would be worth a sum of money from the U.S. Treasury and would be used by individuals for the express purpose of purchasing health insurance. Economists Ezekiel Emanuel and Victor R. Fuchs propose a health care voucher program for every American that would be paid for with a new value-added consumption tax. Emanuel and Fuchs argue such a plan would be efficient, fair and relatively simple:

> The universal benefits package covered by the voucher should be sufficiently comprehensive to provide most Americans with most of their care most of the time. It should not be designed as a safety net to serve only the poor. The benefits provided should be those typically offered by large employers, including inpatient and outpatient hospital services, visits to physicians' offices, well-child care and other preventive measures, mental health care, and tiered pharmaceutical benefits, typically with dollar limits.[29]

As with most other forms of health insurance, this plan has been criticized for lacking economic incentives for patients. Because patients will perceive the services as free, they will over-use them. Also, such proposals have no mechanism to increase quality.

Government Mandated Coverage. To decrease the burden of the uninsured, some states are either requiring individuals to purchase insurance or requiring employers to provide it.

Employer Mandates. An employer mandate would require employers to provide health insurance to their employees. Presidential candidates Hillary Clinton and Barack Obama both include employer mandates in their proposed health care plans. Clinton's plan mandates that only large businesses provide health insurance to employees, while Obama's plan mandates that all businesses provide health insurance to employees.[30] Families USA argues that mandating employer-based coverage is a key part of the effort to reduce the number of uninsured.[31] However, some critics of these proposals note that because the cost of family insurance totals more than minimum wage workers are paid, employers who are forced to provide these benefits will lay off thousands of workers. As economists Robert E. Moffit and Nina Owcharenko of the Heritage Foundation say, mandatory employer health benefits are not free to employees but rather result in a proportional reduction in wages and other compensation.[32]

Individual Mandates. Both Obama and Clinton's proposed health care plans include individual mandates. Obama's health care proposal mandates that children have health insurance while Clinton's plan mandates that everyone purchase health insurance. Most health care reform proposals relying on individual mandates require subsidies for

low-income consumers to purchase health insurance and/or heavy regulation of the insurance market to ensure that consumers are able to purchase a minimum level of insurance at a reasonable cost.

Proponents of this approach often compare mandatory health insurance to mandated automobile insurance. However, Greg Scandlen, president of Consumers for Health Care Choices, notes that even though all but three states mandate automobile insurance more than 14 percent of America's drivers remained uninsured,[33] about two percentage points below the nation's health uninsurance rate.[34]

Opponents also note that individual mandates do not begin to solve the core problems of the U.S. health care system:[35]

> An individual mandate would not address major problems in the organization and delivery of care, nor would it end the squandering of money on lavish executive salaries and perks. And, precisely because an individual mandate would leave the present system for financing medical care fundamentally intact, it's hard to see how it would do much to reduce current overall costs—or future inflation.

Pay or Play. Rather than mandating that individuals carry coverage or employers provide coverage, a "pay or play" mandate allows individuals and employers to choose between providing insurance or paying into a health care fund. Employer "pay or play" mandates that require employers to either contribute to their employees' health insurance plan or pay additional payroll taxes have been proposed in California, Illinois and Pennsylvania.

Consumer-Driven Health Care. Consumer-driven health care is an alternative to an all-government approach to health insurance. The idea behind consumer-driven health care is to allow patients to manage more of their own health care dollars. This usually means a high-deductible insurance plan coupled with a personal health account from which individuals can pay directly for health services. Consumer-driven health care empowers patients to make trade-offs between health care and other uses of their money. This encourages them to shop for the combination of price and quality that will best meet their needs:

> As patients manage more of their own health care dollars, they will begin to seek care that is both convenient and low cost. Empowered consumers will compare medical services and shop for care the same way they shop for other goods and services.[36]

Opponents of consumer-driven health care argue that consumers cannot make informed health decisions because information about the cost of services and the quality of providers is difficult to obtain. In addition, the Commonwealth Fund asserts that consumer-driven health care may lead to poorer health outcomes because people with these plans are more likely to avoid, skip or delay health care because of costs than those with more comprehensive health plans.[37]

The Role of Charity Care. In a sense, many of the uninsured are actually participating in a system of national health insurance through our extensive system of charity care. Parkland Hospital in Dallas, for example, delivers 16,000 babies every year (the most in the nation).[38] Almost all of the mothers are uninsured. The hospital keeps costs down by using nurses to deliver prenatal care and midwives for most deliveries. But through its extensive network of prenatal clinics, and adherence to carefully designed protocols, Parkland delivers very high quality care. Its infant mortality rate is half the national average and its techniques are being studied in other countries around the world.

Key Issue: Right to Health Care

The National Association for Physicians notes that the United States is part of an international system that considers health care an essential human right. Madison Powers and Ruth Faden, authors of *Social Justice: The Moral Foundation of Public Health and Health Policy*, assert that protecting the right to health care for everyone is a matter of justice; in their opinion, the disparities found in health care access, which often fall along ethnic and social lines, are fundamentally unfair. The Physicians' Working Group for Single-Payer Health Insurance claims that only a single comprehensive program can ensure equal access to health care regardless of income or ability to pay.

Critics of government provided health insurance argue that enforcing a right to health care will only lead to more government control. As philosopher David Kelley of the Atlas Society notes:

> If health care is a right, then government is responsible for seeing that everyone has access to it, just as the right to property means that government must protect us against theft. For the past thirty years, the idea that people have a right to health care has led to greater and greater government control over the medical profession and the health care industry…The problems of our current system were caused by government. More government is not the solution. But we must oppose the expansion of government control in principle, by rejecting spurious claims of a "right" to health care. [39]

Philosopher Michael Foucault takes the argument further and asserts that when government gains complete control over health care, it will attempt to coerce individuals to make choices it judges beneficial. Government will idealize an image of a healthy citizen, offer incentives for behavior it deems socially responsible, and penalize other behavior.[40] This may happen in the form of a tax on fast food.[41] In more extreme cases, government may limit who can receive organ transplants or even regulate reproductive choices.

The National Center for Policy Analysis argues that whether or not there is a natural right to health care, there is no legal right to health care in countries with national health insurance. Citizens of Canada, for example, have no legal right to any particular health care service. They have no right to an MRI scan. They have no right to heart surgery. They do not even have the right to a place in line. The 100th person waiting for

heart surgery is not entitled to the 100th surgery. Other people can and do jump the queue.[42]

In addition, there is evidence that government-provided health insurance will not ensure that everyone receives equal treatment. If the experience of other countries is any guide, the elderly, ethnic minorities, and rural population may not gain under a national health insurance system:

- In Britain, one in six people over 65 report they have been discriminated against in health care because of their age.[43]

- In Canada, researchers have found that Inuits and Cree Indians have much less access to health care than Caucasians, despite their greater health needs.[44]

Key Issue: Controlling Costs

As noted earlier in this paper, health care costs in the United States are rising rapidly and outpacing economic growth. This very rapid growth is clearly unsustainable. For example, Medicaid, the joint federal-state health care program for the poor, consumes more than one-fifth of the average state budget, more than the average state spends on education.[45]

In addition, many families are priced out of the health insurance market. For those with employer coverage, rewards for increases in productivity are increasingly going to health care rather than wages. For a minimum wage worker, the cost of group health insurance is almost equal to their entire wage income!

Proponents of national health insurance assert that a single-payer system will decrease health care costs and free up resources to be spent on other priorities.

Prevention. A common argument for national health insurance is that the increased availability of preventive care can decrease overall costs.[46] If health care were free or provided at a low cost, more individuals would readily seek preventive services and money would be saved when doctors catch conditions in their early stages before they develop into more costly to treat diseases.

Against this view is the finding that preventive medicine generally raises rather than lowers overall health care costs. Very few medical procedures pay for themselves in terms of a net lifetime reduction in total health care costs. It is true that diagnosing cancer early lowers treatment costs for the patient found to have the disease. But in order to find that patient through screening, the diagnostic test must be given to thousands of healthy patients. When all costs are considered, the extra costs of screening the healthy swamp the reduced costs of treating the few found to have the disease.[47]

Administrative Costs. A second way in which national health insurance might lower health care costs is by reducing the administrative burden of managed care. According to Physicians for a National Health Program, the average American doctor

employs 1.5 clerical and managerial staff, spends 44 percent of gross income on overhead and devotes 134 hours of his/her own time to billing each year. Canadian physicians in a single-payer system employ 0.7 clerical/administrative staff, spend 34 percent of their gross income on overhead, and trivial amounts of time on billing.[48] Proponents of a national health insurance system estimate that these savings would total at least $200 billion annually, enough to provide care to all uninsured Americans.

Disputing these claims of remarkable savings, Tyler Cowen, professor of economics at George Mason University, asserts that the gains from abolishing the overhead cost of private insurance are an illusion:

> Health insurers cannot just offer expensive tests, technologies, hospital rooms and surgeries for the taking. Doctors will too often recommend these services and receive reimbursement, even to the point of financial abuse. Medicare has this problem to some extent. When it comes to these discretionary benefits, European systems are more likely to make people wait for them, more likely to make the service inconvenient or uncomfortable, or simply not make the services available in the first place…Either way, the overhead costs have been shifted onto patients and their families…Measuring health care expenditures as a share of national income does not count waiting costs or the lack of availability of many advance technologies and treatments.

Key Issue: International Competitiveness

Proponents of national health insurance argue that the high cost of providing insurance to employers is a burden on companies:

> Companies such as General Motors that have factories in both the U.S. and other countries have learned this lesson well; for example, in 2003, the costs of manufacturing a midsize car in Canada were $1,400 less than that of manufacturing the identical car in the U.S., primarily because of much higher health costs in this country. [49]

> According to a 2006 study, Japanese carmakers' profits average out to about $2,900 per vehicle more than American carmakers' profits. A big reason is the cost of health care. General Motors, for instance spends $1,635 per vehicle on health care for workers in the United States. Toyota pays only $215 for its workers.[50]

Advocates of national health insurance argue that health care costs hurt international competitiveness by raising the cost of U.S. products and services. This further lowers economic growth by slowing job growth, suppressing wages for workers, and reducing the quality of jobs. Sarah Reber, an assistant professor of policy studies at the University of California, Los Angeles, and Laura Tyson, dean of the London Business School, studied the problem and concluded that the rising cost of health insurance premiums has driven up the cost of labor. Moreover, in industries where health-insurance benefits accounted for a comparatively large share of total employee

compensation, job growth was slower than in industries where they accounted for a smaller share.[51]

Proponents of a single-payer system argue that national health insurance would cost employers far less in taxes than the costs they currently pay for insurance. Programs that eliminate this burden on the employer have the potential to increase U.S. competitiveness.

Others argue that the cost of private health insurance adds nothing to the price of goods and services sold in the marketplace. Health insurance is simply one element of a workers' total compensation package. It is a non-taxable fringe benefit provided to workers in lieu of money wages:

> Health insurance benefits voluntarily provided by employers do not raise their labor costs. But when employers are required to pay the government for each worker they employ at a rate that has no relation to the cost of health care consumed by those employees or the value of their work, it raises employers' labor costs.[52]

Key Issue: Access to Quality Health Care

Another key issue debaters will discuss on a national health insurance topic is the effects of access to quality health care on health outcomes. The American College of Physicians argues that while there is great admiration throughout the world for the advancements of American medicine, these benefits are only available to those with health insurance. According to them, health care systems that leave many uninsured will undoubtedly have poorer medical outcomes. [53]

A study by the Urban Institute attributes these poorer medical outcomes to poorer care. Uninsured individuals receive only half as much care as privately insured individuals.[54] The study examined chronic conditions such as diabetes, cardiovascular disease, kidney disease, HIV and mental illness. It found that the uninsured receive inferior treatment that results in inferior outcomes. The study estimates that 137,000 people died from 2000 through 2006 because they lacked health insurance, including 22,000 people in 2006.[55]

> Over a 17-year follow-up period, adults who lacked health insurance at the outset had a 25 percent greater chance of dying than did those who had private insurance. Health insurance is a key that provides access to high quality health care and consequently to better health.[56]

In addition, the lack of access to quality health care may substantially increase the risk of a disease pandemic. Millions of uninsured in the United States do not visit a doctor on a regular basis, fail to get the recommended vaccinations and often delay care when they become ill.[57]

> As the United States continues to leave almost 47 million Americans without health insurance and leaves another 75 million at great financial risk for seeking health care, the effect is spilling over into the public health arena. As more and more people go without preventive care, without vaccinations, without the means to eat nutritious food, to store, handle and prepare food safely, to afford utilities and safe housing, and to get prompt health care treatment for minor and moderate illnesses and injuries, more people will harbor infectious diseases, and more people will transmit them.[58]

Proponents of national health insurance argue that gaps in coverage due to job change or employer decisions contribute to the high number of uninsured. They assert that national health insurance has the potential to enhance health by offering continuous coverage to everyone. In the current U.S. health care system, not only are millions uninsured, but even those with insurance often experience interrupted coverage because of a job change or decision of the employer. In a national health insurance system, health insurance would not be interrupted, regardless of an individual's circumstances.

A recent article in Health Affairs notes that many of the uninsured are uninsured by choice:[59]

- 25 percent of uninsured people are eligible for public coverage. Overall, 74 percent of uninsured children are eligible for public coverage.

- Another 20 percent live in households with incomes above $50,000 and could likely afford coverage.

Although many national health insurance proposals intend to expand access to quality health care, critics argue that it may actually have the opposite effect and lead to poorer health care. Because health care is free at the point of consumption in single-payer systems, governments have to control costs by rationing care. People in national health insurance systems often complain they are not able to see specialists when they want to, obtain diagnostic tests, experience obstacles getting approval for surgery and have difficulty getting approval to enter a hospital. They often must wait weeks (sometimes years) for treatments.[60] Because of this, single-payer systems may lead to poorer health:

> Patients queuing for treatment in single-payer systems are often waiting in pain. Many are risking their lives. An investigation by a British newspaper, *The Observer*, finds that delays in Britain for colon cancer treatment are so long that 20 percent of the cases considered curable at time of diagnosis are incurable by the time of treatment. A study of cancer patients in Glasgow, Scotland, finds the same is true for lung cancer patients. Twenty-five percent of British cardiac patients die while waiting their turn to receive treatment. According to government reports, one in six people on the National Health Service waiting lists for elective surgery are removed without ever being treated. [61]

[1] Liqun Liu, Andrew J. Rettenmaier and Zijun Wang, "The Rising Burden of Health Spending on Seniors," National Center for Policy Analysis, Policy Report No. 297, February 2007.

[2] Christian Hagist and Laurence Kotlikoff, "Health Care Spending: What Will the Future Look Like?" National Center for Policy Analysis, Policy Report No. 286, June 2006.

[3] John A. Poisal, Christopher Truffer, and Sheila Smith, et al., "Health Spending Projections Through 2016: Modest Changes Obscure Part D's Impact," *Health Affairs*, Web Exclusive, February 21, 2007; Bruce Steinwald, "Health Care Spending: Public Payers Face Burden of Entitlement Program Growth While All Payers Face Rising Prices and Increasing Use of Services," GAO Testimony Before Subcommittee on Military Construction, February 15, 2007.

[4] "Health Cost Continue Its Upward Spiral," *USA Today*, January 9, 2007.

[5] Christian Hagist and Laurence Kotlikoff, "Health Care Spending: What Will the Future Look Like?" National Center for Policy Analysis, Policy Report No. 286, June 2006.

[6] "Accounting for the Cost of Health Care in the United States," McKinsey Global Institute, January 2007.

[7] "Why Not the Best? Results from a National Scorecard on U.S. Health System Performance," Commonwealth Fund, September 2006.

[8] Sara R. Collins, "Gaps in Health Insurance: An All American Problem," Commonwealth Fund, April 2006.

[9] Mary Sue Coleman, Arthur L. Kellermann, Ronald M. Andersen et al., *Care Without Coverage: Too Little, Too Late*, Institute of Medicine, May 2002.

[10] Mary Sue Coleman, Arthur L. Kellermann, Ronald M. Andersen et al., *Care Without Coverage: Too Little, Too Late*, Institute of Medicine, May 2002.

[11] The Physicians' Working Group for Single Payer National Health Insurance, "Proposal of the Physicans' Working Group for Single Payer Health Insurance," *Journal of the American Medical Association*, 2003.

[12] John C. Goodman, "Does the U.S. Spend More?" National Center for Policy Analysis, John Goodman Health Blog, February 20, 2007.

[13] Ibid.

[14] David Cutler, "Health Care and the Public Sector," National Bureau of Economic Research, Working Paper No. W8802, February 2002.

[15] John C. Goodman, Gerald L. Musgrave and Devon M. Herrick, *Lives at Risk: Single-Payer Health Insurance Around the World* (Lanham, Md: Rowman and Littlefield, 2004).

[16] Ibid.

[17] Steven M. Asch, Eve A. Kerr, Joan Keesey et al., "Who is at Greatest Risk for Receiving Poor-Quality Health Care?" *New England Journal of Medicine*, Vol. 354 No. 11, March 16, 2006.

[18] Public Informationon Wait Times, Ottawa Province of Canada. Data from three-month period encing February 2008. Online at http://www.health.gov.on.ca/transformation/wait_times/public/wt_public_mn.html#

[19] Ibid.

[20] Steven M. Asch, Eve A. Kerr, Joan Keesey et al., "Who is at Greatest Risk for Receiving Poor-Quality Health Care?" *New England Journal of Medicine*, Vol. 354 No. 11, March 16, 2006.

[21] Amy Finkelstein, "The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare," April 2006.

[22] The Physicians' Working Group for Single Payer National Health Insurance, "Proposal of the Physicans' Working Group for Single Payer Health Insurance," *Journal of the American Medical Association*, 2003.

[23] John C. Goodman, Gerald L. Musgrave and Devon M. Herrick, *Lives at Risk: Single-Payer Health Insurance Around the World* (Lanham, Md: Rowman and Littlefield, 2004).

[24] Yoni Cohen, "Stark Introduces Americare: Groundbreaking legislation would provide universal coverage by building on Medicare and the employer system," July 25, 2006. http://www.house.gov/stark/news/109th/pressreleases/20060725_americare.htm

[25] "National Health Expenditures," Centers for Medicare & Medicaid Services.

[26] John C. Goodman, "Answering the Critics of the Bush Health Plan," National Center for Policy Analysis, Brief Analysis No. 579, January 30, 2007.

[27] John Goodman, "The Bush Health Plan," National Center for Policy Analysis, Brief Analysis No. 578, January 30, 2007.

[28] Mark Pauly, John Goodman and Judith Feder, "Incremental Steps Toward Health System Reform," *Health Affairs*, Vol. 14 No. 1, 1995.

[29] Dr. Exekiel Emanuel and Dr. Victor Fuchs, "Health Care Vouchers—A Proposal for Universal Coverage," *New England Journal of Medicine*, March 24, 2005.

[30] "NCPA Analysis of Democratic Health Proposals," National Center for Policy Analysis, 2007.

[31] "Lawmakers Say Employer Mandate is Key to the Massachusetts Health Reform Law," Medical News Today, April 24, 2006.

[32] Robert E. Moffit and Nina Owcharenko, "Understanding Key Parts of the Massachusetts Health Plan," Heritage Foundaiton, Web memo No. 1045, April 20, 2006.

[33] Greg Scandlen, "Will Mandatory Health Insurance Work?" National Center for Policy Analysis, Brief Analysis No. 569, September 6, 2006.

[34] Ibid.

[35] Ezekiel Emanuel and Victor Fuchs, "Vouchsafe," *New Republic*, February 19, 2007.

[36] Devon M. Herrick, "Consumer Driven Health Care Spurs Innovation in Physician Services," National Center for Policy Analysis, Brief Analysis No. 559, June 15, 2006.

[37] Paul Fronstin and Sara Collings, "Early Experience with High Deductible and Consumer Driven Health Plans," Commonwealth Fund, December 2005.

[38] Sherry Jackson, "Parkland Will Treat All Moms-to-Be," *Dallas Morning News*, June 12, 2006.

[39] David Kelley, "Is There a Right to Health Care?" Atlas Society, accessed February 2, 2007. <http://www.objectivistcenter.org/ct-14-Is_There_Right_Health_Care.aspx>

[40] J. Coveney, "The Government and Ethics of Health Promotion: the Importance of Michael Foucault," *Nursing Inquiry*, Vol. 8 No. 3, 1998.

[41] Martin B. Schmidt, "Supertax Me," *New York Times*, October 19, 2006.

[42] John C. Goodman, Gerald L. Musgrave and Devon M. Herrick, *Lives at Risk: Single-Payer Health Insurance Around the World* (Lanham, Md: Rowman and Littlefield, 2004).

[43] Celia Hall, "Shock as Doctors Admit to Ageism," *Telegraph*, February 15, 2007.

[44] Harriet L. MacMillan et al., "Aboriginal Health," *Canadian Medical Association Journal* Vol. 155 No. 11, December 1, 1996.

[45] John C. Goodman, Michael Bond, Devon M. Herrick, Pam Villarreal, "Opportunities for State Medicaid Reform," National Center for Policy Analysis, Report No. 288, September 2006.

[46] The Physicians' Working Group for Single Payer National Health Insurance, "Proposal of the Physicans' Working Group for Single Payer Health Insurance," *Journal of the American Medical Association*, (2003) 290:798-805.

[47] John C. Goodman, Gerald L. Musgrave and Devon M. Herrick, *Lives at Risk: Single-Payer Health Insurance Around the World* (Lanham, Md: Rowman and Littlefield, 2004).

[48] David U. Himmelstein and Steffie Woolhandler, "Why the U.S. Needs a Single-Payer System," Physicians for a National Health Program, 2006.

[49] "Health care Reform in the United States: Arguments for a Single Payer System," Public Citizen Health Research Group, July 28, 2006.

[50] Alex Taylor, "Behind Ford's Scary $12.7 Billion Loss," *Fortune Magazine*, January 26, 2007.

[51] Morton Mintz, "Single-Payer: Good for Business," *The Nation*, November 15, 2004.

[52] John C. Goodman, Gerald L. Musgrave and Devon M. Herrick, *Lives at Risk: Single-Payer Health Insurance Around the World* (Lanham, Md: Rowman and Littlefield, 2004).

[53] "No Health Insurance? It's Enough to Make You Sick—Scientific Research Linking the Lack of Coverage to Poor Health," American College of Physicians, January 2000. http://www.acponline.org/uninsured/lack-exec.htm

[54] Jack Hadley and John Holahan, "How Much Medical Care Do the Uninsured Use and Who Pays for It," *Health Affairs*, February 12, 2003.

[55] Stan Dorn, "Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance Mortality," Urban Institute, January 2008.

[56] Mary Sue Coleman, Arthur L. Kellermann, Ronald M. Andersen, et. al, *Care Without Coverage: Too Little, Too Late*, Institute of Medicine, May 2002.

[57] "No Health Insurance? It's Enough to Make You Sick—Scientific Research Linking the Lack of Coverage to Poor Health," American College of Physicians, January 2000.

[58] Universal Health, "Will It Take a Crisis?" May 30, 2007.

[59] Lisa Dubay, John Holahan and Alison Cook. "The Uninsured and the Affordability of Health Insurance Coverage," *Health Affairs*, Vol. 26 No. 1, 2007.

[60] Nadeem Esmail, Michael Walker, and Dominika Wrona, "Waiting Your Turn: Hospital Waiting Lists in Canada," October 2006.

[61] John C. Goodman, Gerald L. Musgrave and Devon M. Herrick, *Lives at Risk: Single-Payer Health Insurance Around the World* (Lanham, Md: Rowman and Littlefield, 2004).