

A gloved hand is using a pipette to add liquid to a test tube. The test tube is in a rack and contains a red liquid. The background is a laboratory setting with a grid pattern.

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The Public Infrastructure for Care

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The Biden administration has a significant opportunity to make our healthcare system more comprehensive and equitable. Although Biden ran on one of the more limited versions of the various buy-in plans, often referred to as “public options,” instead of championing single-payer, there are many opportunities to improve Biden’s plan to build a stronger public infrastructure for healthcare. This raises the question: what strategy progressives should follow to advance the goal of guaranteeing provision of high quality healthcare, free of price at the point of service, to all United States residents as a right?

A Worst-First Approach

We argue for the adoption of a “worst-first” approach for prioritizing progressive healthcare demands from the Biden administration. We identify two central problems with the U.S. healthcare system, which we believe require action most urgently. They are:

- ▶ Individual-level financial barriers to care created by our dysfunctional system of insurance, which leaves many uninsured or underinsured.
- ▶ Geographic areas which face serious shortages of healthcare capacity, a problem which is worsening as many hospitals across the U.S. have become insolvent.

Our aim is the complete removal of all individual-level financial barriers, administrative barriers, and barriers imposed by queues and travel time to healthcare for all people. By necessity, this will be a gradual process and one that should begin with addressing the needs of those at the bottom of income distribution first. An integral part of accomplishing this is mobilizing public resources to directly expand provider capacity in places where it is lacking, a program which we call the public infrastructure for care. The combination of the public option for insurance and public infrastructure for care would immediately address the worst failings of the healthcare system and also represents the best strategy for winning immediate material benefits for poor and working people. Furthermore, this worst-first approach will also work to move the U.S. towards a system that guarantees healthcare as a right for all.

The remainder of this report is structured as follows. First, we briefly outline the dual roles of a public option for insurance and a public infrastructure for care in our worst-first framework for approaching healthcare under the Biden administration. Second, we discuss why our health policy goals should extend beyond achieving universal insurance coverage and towards guaranteeing the delivery of healthcare. This distinction between care and insurance adds crucial context to discussions about the high national health expenditure in the U.S. and highlights the fact that when we pursue cost efficiency reforms, it shouldn’t be done in a manner that undermines our ability to achieve a system that guarantees delivery of care to all. Third, we explore some of the general factors that shape public opinion on healthcare, and we show that voters are receptive to public ownership and direct provision

of care. Finally, we argue that our public infrastructure for care framework opens up new terrain in the healthcare debate which can break the stalemate between progressives and centrists. For centrists, the public infrastructure for care shores up key flaws in their buy-in proposals, and for progressives, the public infrastructure for care offers a pathway for transformative change, even during an administration that is skeptical of single-payer.

The Role Of The Public Option for Insurance

This report argues that public insurance is not enough to achieve the goal of universal, high-quality healthcare for all U.S residents. To meet this goal, the public sector needs to do more than just act as purchaser and a regulator of privately provisioned healthcare capacity. It must also directly provision healthcare services and badly needed investments in our healthcare infrastructure and our healthcare workforce. If we rely on private markets for investment in healthcare capacity, even the most generous expansions of publicly-provided insurance will be insufficient to ensure that people in underserved areas get the care they need.

A public option for insurance, also known as a buy-in, is, still an essential component of our worst-first strategy. Our priority should be to remove all *individual*-level financial barriers to getting care. This will mean moving costs onto government balance sheets as a functioning insurance system is created, financing care through collective funds and not individual spending.

Private insurance is a fundamentally dysfunctional product and employer-sponsored insurance (ESI) makes no sense. Well designed buy-ins essentially step in at the points of failure of the insurance system. If designed properly, by including automatic enrollment provisions and allowing for employees to “carry over” their employer-contribution towards covering the cost of government-provided insurance, a buy-in can work to reduce the role and power of private insurance until it is ultimately extinguished. This mechanical action in which policy design drives public enrollment in a government-run plan is often referred to as a “glide path” towards single-payer.

Since Sen. Bernie Sanders and Rep. Pramila Jayapal adopted a buy-in period in order to realize a single-payer system, much of the debate among progressives about insurance can be reduced to the speed by which the glide-path does its work. The rate of this transition depends on a complex set of policy design issues. It shouldn't be taken as a forgone conclusion that the buy-in plan advocated by Biden will set us on a glide path. In fact, our work with Professor [Jacob Hacker](#) identifies several key areas where Biden's current plan could be improved, all of which are popular with voters.

It is worth stepping back to note that discussions of health insurance take place one step removed from what we should focus on: the delivering of healthcare to all. The value of the healthcare system is its real capacity to deliver actual services to people. Questions of prices and cost efficiency should always be thoroughly subordinated to the role of real capacity. As a result, we argue that debates about whether an insurance scheme can deliver cost efficiency gains are of limited importance in the short term. Focusing on efficiency can lead us astray and even undermine the progressive goal of guaranteed delivery of care.

Our worst-first approach is, therefore, centered on a set of policies which we call a public infrastructure for care. We see our public infrastructure for care as both supplementing and strengthening any system

of health coverage, whether that's the current system, a buy-in scheme, or a single-payer system. We view the public infrastructure for care not only as means to address the most urgent humanitarian failings of the healthcare system, but also as a critical step that will prepare the ground for the eventual adoption of a single-payer system, an outcome we see a crucial goal.

In the coming months, we will roll out the specific components of the public infrastructure for care in a series of memos. Here we define our proposal in broad terms.

Defining The Public Infrastructure For Care

While universal insurance coverage would likely slow the rate of health facility closures in underserved areas, it may not spur investment for the construction of new facilities. Even worse, a single-payer system would need to rely on private investment in healthcare facilities in those areas, which opens the door to the predatory private equity industry and is less efficient than direct public investment.

The severe limits of private markets to produce healthcare capacity sufficient to take care of everyone is why we emphasize the need for a public infrastructure for care. Just like the private insurance system, the private care system is inherently dysfunctional. For-profit healthcare facilities can't deliver care to everyone and remain profitable. The public infrastructure for care steps in at this point of failure in the *care delivery system*. This intervention provides immediate benefit to those who are most in need while reducing the role and power of private healthcare providers in the long run.

There are large portions of the healthcare system that for-profit providers are structurally incapable of serving. In fact, private providers have been reducing their geographic footprints, leaving even more people underserved. The public sector should immediately move in to fill these gaps.

The public infrastructure for care includes a range of proposals, all centered on the idea that the government should be more active in directly provisioning healthcare to people. This includes proposals for reducing the cost of pharmaceuticals through the creation of public entities that manufacture generic drugs and proposals to steer pharmaceutical research in directions that produce publicly owned patents for drugs with high social benefit as opposed to high potential for private profit. We have already [published several memos on controlling pharmaceutical costs](#) over the past few years, and aggressive measures to control the cost of prescription drugs remains one of the strongest parts of the broader progressive agenda.

The public infrastructure for care also includes several policies for rebuilding and maintaining basic healthcare infrastructure. These include taking failing hospitals into public ownership, building new publicly-owned hospitals, offering federal grants for municipalities to create public ambulance and nonemergency medical transport services, as well as dramatically expanding the size and scope of federally qualified health centers (FQHCs). In addition to increasing the size of FQHCs, we also want them to operate with an expanded scope, so that they include convenient care options such as nurse advice phone services. All care at new and existing public facilities should be made free at the point of use to anyone.

Lastly, the public infrastructure for care would expand the healthcare workforce and address the

doctor and nurse shortage by creating a community health corps and expanding programs that offer free medical school to physicians who become general practitioners instead of specialists. Furthermore, doctors trained in foreign countries should be allowed practice in the U.S., and nurse practitioners should be able to offer certain primary care services directly to patients without the supervision of a doctor. All of these ideas, whether implemented as a whole or in pieces, would significantly improve any plan to expand public insurance.

Why Universal Public Insurance is Not Enough

The healthcare debate is generally dominated by discussions of costs and of insurance coverage. When we talk about healthcare costs, we must carefully distinguish between two perspectives: the individual-level and the national-level. At the individual level, cost barriers to care should be completely removed. The purpose of insurance is to sever the link between individual income and healthcare spending. Whether this is tax-financed or premium-financed makes no difference in principle — funds are pooled collectively and paid out to providers once individuals seek care. The complete removal of all costs at the point of service must be a priority, and any insurance system which fails to protect individuals from incurring expenses at the point of service is not working correctly.

But while we should be obsessively concerned with removing cost barriers at the individual level, the fact that the U.S. spends so much money on healthcare at the national level is a problem not in and of itself. The entire U.S. care system is designed to profit extract profit instead of to provide care to all based on need. However, this does not mean that we can simply use public bargaining power to immediately remove profits from the system. In fact, attempting to do so will cause unacceptable disruptions to care delivery. We can and should work to completely remove administrative inefficiencies, waste, graft, and profit from the healthcare system, but this will require reshaping the entire healthcare system over many years. This extended time horizon demands that we make decisions about priorities. We argue that questions of inefficiencies should not take precedence over the immediate humanitarian disasters of individual cost barriers to care and under-capacity. Prioritizing these factors would not only address the worst failings of the healthcare system, but would also set the stage for future reforms which remove inefficiencies as the role of private actors is systematically minimized.

An ideal healthcare system that removes all individual financial barriers to care would perform two different types of redistributive functions. First, it would redistribute resources horizontally from healthy people to sick people. In other words, healthy people who are working pay into the system to finance care for those who are currently sick or can't work. Anyone can fall ill, so this sort of risk redistribution protects all of us. Second, it would net vertical redistribution as wealth is transferred from the rich to pay for the healthcare that the poor receive. We all should contribute to the financing of healthcare through our taxes, but the rich should pay more. In principle, any system that meets these two requirements could remove all individual financial barriers to care while equitably funding the care system at the national level. In practice, this can only be accomplished in systems where tax-financed public insurance is the form of insurance used by most people.

The primary failing of health insurance in the U.S. is that it does not function like a proper social insurance system. Millions aren't insured and millions more still face financial barriers despite being

insured. The ESI system also means that many people are only covered if they are able to work. This completely undermines the ability of the health insurance system to provide its most critical function: redistribution of resources from the healthy to the ill. However, prices do not constrain our ability to completely remove all cost barriers to care for every single U.S. resident. Removing these cost barriers is purely a matter of changing the way care is financed.

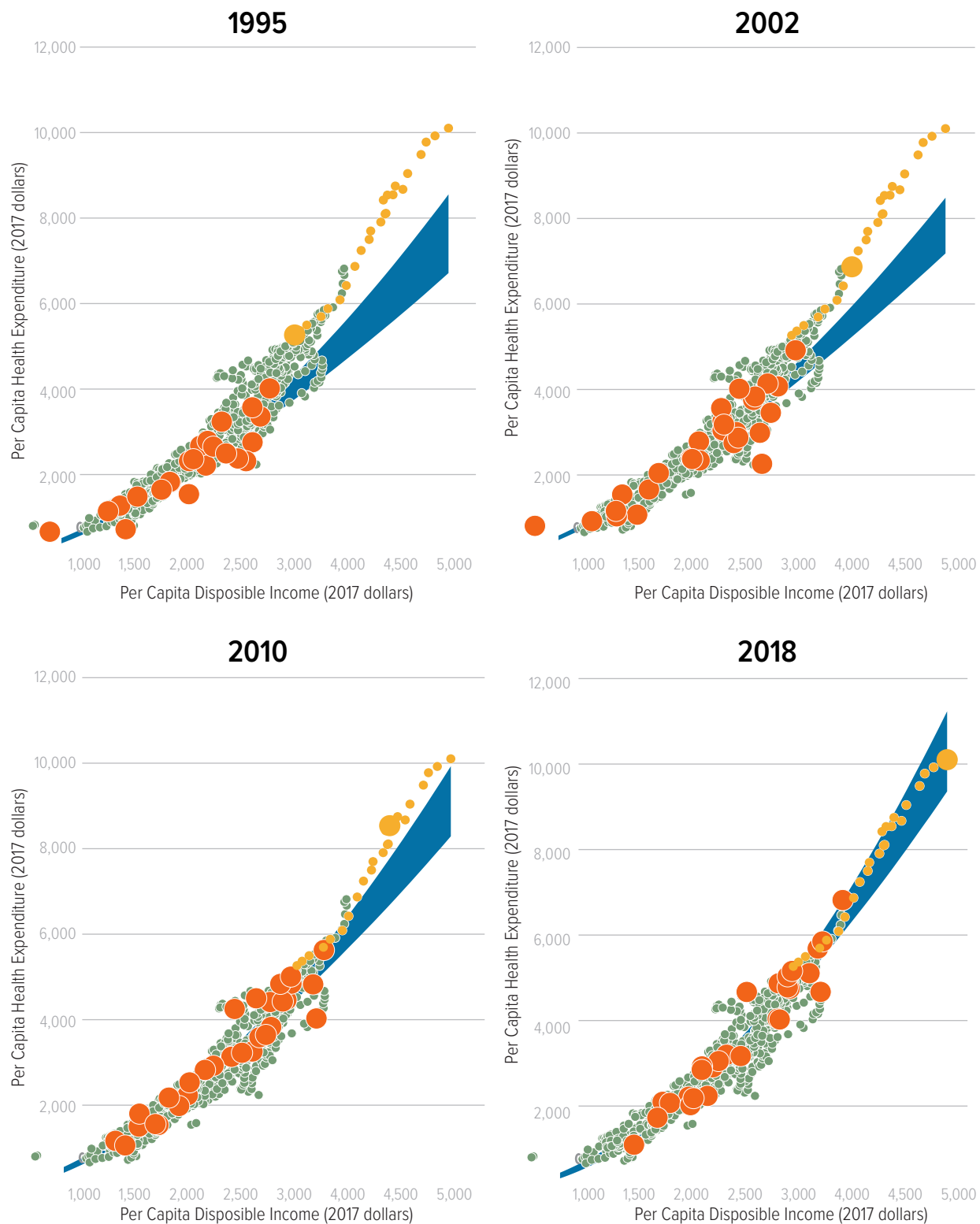
Guaranteeing healthcare as a right is first and foremost a guarantee that every person has a claim on the social product in the form of healthcare services that fully meet their needs. To guarantee healthcare as a right, we need to have the capacity to deliver healthcare in such abundance that rationing by prices imposed at the point of service, by administration, or by non-economic costs such as queues becomes irrelevant and unnecessary. Doing so is going to cost money, but we are a rich nation, and as a nation we should be happy to pay a large and rising share of our GDP on healthcare as long as no person is denied care if they can't pay for it themselves. There are many instances of pure graft in the healthcare system such as surprise billing and price gouging by pharmaceutical companies. Other cost inefficiencies arise from fragmentation of the healthcare system. Under the current system, the costs of these inefficiencies are often borne by the most vulnerable people in society. However, since we do not need to reduce prices for care to insure everyone, increasing cost efficiency and removing profit and waste from the system must be done in a way that does not disrupt care delivery. Adam Gaffney, the president of a single-payer advocacy group called Physicians for a National Health Program, [cautions us](#) that price reductions must be done carefully to avoid destructive consequences for care:

We should be talking about the things we want hospitals to spend less of their revenue on, rather than focusing on the individual prices of services. If we're going to say 'we want to shrink hospital budgets, well, what things do we want the hospital to spend less money on?' If you just take the average hospital and simply shrink its budget, you have to make sure it's happening in the right way.

The way I think about it is we need a new way to finance hospitals. We need to transform them. We can achieve savings in administration costs, and we can finance new capital projects from a different source that isn't hospital profits. But beyond that I think it's not feasible to make claims about more dramatic reductions in national health expenditures.

Comparisons of U.S. national health expenditures to other countries are tempting to make but can be misleading. It's not clear that other nations give us a very useful yardstick that we can use to judge whether our own aggregate expenditures are in line with international expectations. Below we show a simple model that predicts U.S. per capita health expenditure as a function of per capita disposable income. The data comes from the OECD and instructions for extracting it can be found [here](#). The U.S. has been held out from fitting the trendlines and the model was fit on the log-log scale, then transformed back to the original scale for plotting. The U.S. is shown in orange dots while other countries are in black. The animation cycles through several time periods, with the data for the current

Rising incomes have coincided with expensive but effective improvements in healthcare technology



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time period darkened and enlarged, to trace out the path in spending that these countries have followed over time.

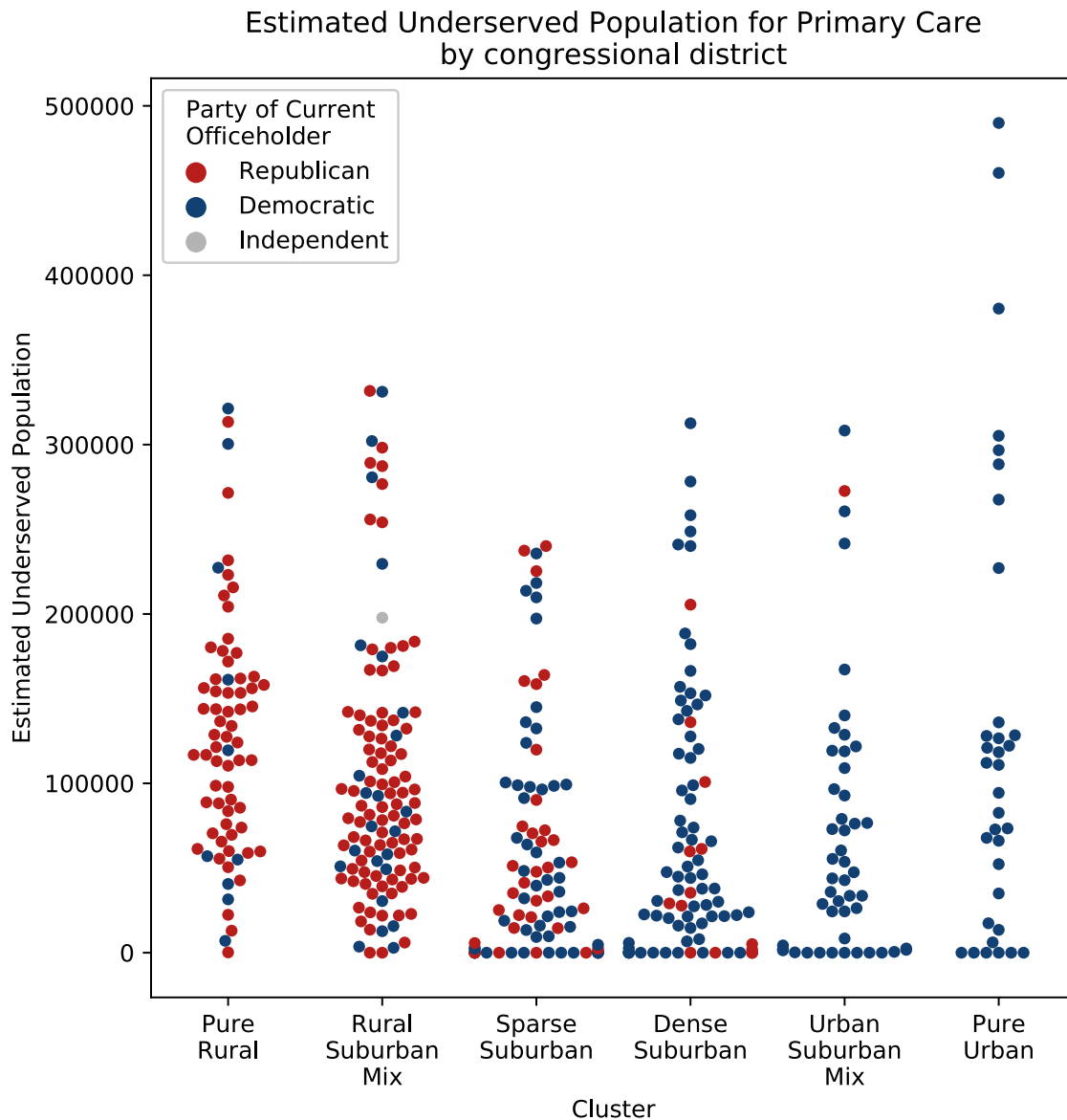
This model suggests that for many years the U.S. is overpaying for care (indicated by the orange dots representing the U.S. sitting well above the predicted trendline) by thousands of dollars per person per year. But over the long run, all countries in the world seem to ultimately be following a very similar trajectory. Each year, the slope of the regression line we estimate from other countries increases, and by 2018 the U.S. even appears to be a “normal” country under the assumptions of this model. This casts doubt on the usefulness of cross-country comparisons of aggregate national health expenditure as a means to judge if the U.S. spends too much or not.

The model uses aggregate data, meaning that it papers over the effects of income inequality and disparate healthcare usage within countries. Nonetheless, it can still tell us useful information. The secular rise in incomes across the developed world coincided with [technological improvements](#) that are [very expensive](#) but ultimately [have made healthcare much better than ever before](#). This makes it very difficult to set a baseline of what “normal” levels of healthcare spending should look like at the *national level*, even though we can point to many specific instances where the U.S. clearly overpays due to large markups.

What is abnormal about our system is not aggregate spending. Instead, it is the fact that not everyone is covered and not everyone can get good quality care. The tragedy of this chart is not that costs are rising, but rather that improvements in healthcare technology have failed to benefit everyone, simply because our system is designed to deny care to the millions in the U.S. who can’t pay. We will never guarantee healthcare as a right with policies that target reductions in national health expenditure, and doing so could even make the current system less equitable, as private providers for vulnerable populations may seek to maintain profits under reduced payment rates by cutting critical staff or skimping on the latest medical tech.

While we can remove all cost barriers to care for everyone regardless of the prices for care, this is not enough to meet our healthcare goals. Coverage alone does not guarantee the delivery of care. Our current healthcare capacity shortages are horrific: tens of millions of U.S. residents are underserved, even for the [most basic primary care services](#).

These shortages are most acute in rural areas as well as low-income urban areas, which are disproportionately populated by people of color. However, shortages are so widespread that they cut across both population density and political geography. Uneven development of the physical footprint of our care infrastructure has placed significant burdens on many vulnerable and marginalized populations. Capacity shortages and cost barriers to care disproportionately penalize people of color and the poor, and we must fix both of these problems. Difficulty accessing care due to an inability to find



Source: CityLab provided density classification.

transportation to a facility, inability to take sufficient time off of work, or inability to make caregiving arrangements should be viewed as failings on par with difficulty accessing care due to an inability to pay..

Our understanding of the [social determinants](#) of healthcare outcomes as well as [structural racism](#) in the healthcare industry highlight that many of the problems of our healthcare system arise from deep societal failures that universal healthcare alone can not fix. However, we should adapt our healthcare proposals to address these circumstances as best as we possibly can. This means that we must work to remove all barriers to high quality care, whether they arise from costs or from local capacity shortages.

Direct public provision of high value care that is free at the point of service would ensure that no critical service of the healthcare system is being neglected because it is unprofitable. At the same time, it would vertically redistribute resources from rich to poor, reduce coverage gaps for rural areas and low-

income urban areas, and ensure that no patient is turned away due to inability to pay. Below, we review several arguments for why public investment is the ideal policy mechanism for many of our healthcare goals.

Public investment in our infrastructure for care protects us from the chaos and greed of unrestrained private financial markets

Healthcare facilities are extremely capital intensive, and they will only become more so as technology improves further. Again, this is a good thing because it means that on average healthcare will get better. However, increasing capital intensity creates less favorable conditions for private investors seeking a profit, whom the current system relies upon for investment. The social benefits of healthcare investment increase over time, but the market signals to investors that lower rates of return on capital mean that they could invest more profitably elsewhere. It is therefore critical that the public sector step in to directly invest in our healthcare infrastructure in addition to playing a significant role to direct private investment to where it is needed most as opposed to where it can maximize investor returns. This will ensure that everyone can enjoy the best care that modern technology can offer, regardless of cost.

According to the consulting firm [Deloitte](#), hospitals tend to get fairly low returns on capital. Overall, returns on capital across all healthcare sectors have been declining recently owing to a variety of factors. Furthermore, general hospitals as well as hospitals specializing in cancer treatments and children's care tend to have below average returns on capital compared to other types of specialty hospitals, which can make them less attractive to profit-seeking investors. In addition to the U.S. government's general underinvestment in healthcare, the system's dependence on profitability often leads private healthcare corporations to abandon certain geographic regions and less profitable critical care services, engage in abusive billing practices, and take various shortcuts that undermine the quality of care.

No individual investor has perfect information about their investment prospects or the investment plans of their potential competitors and partners, which creates additional challenges for the ability of private markets to sufficiently invest in healthcare. In his book [Information and Investment](#), economist George Richardson describes how the dispersal of economic information throughout individuals and organizations in the economy implies that firms may face high uncertainty about the revenue they can expect to take from an investment decision. A profitable investment may turn unprofitable if multiple firms invest at once and intense competition drives the price of their new good or service down below what owners need to stay out of the red, but firms are left to guess about the level of future competition they will face from rivals.

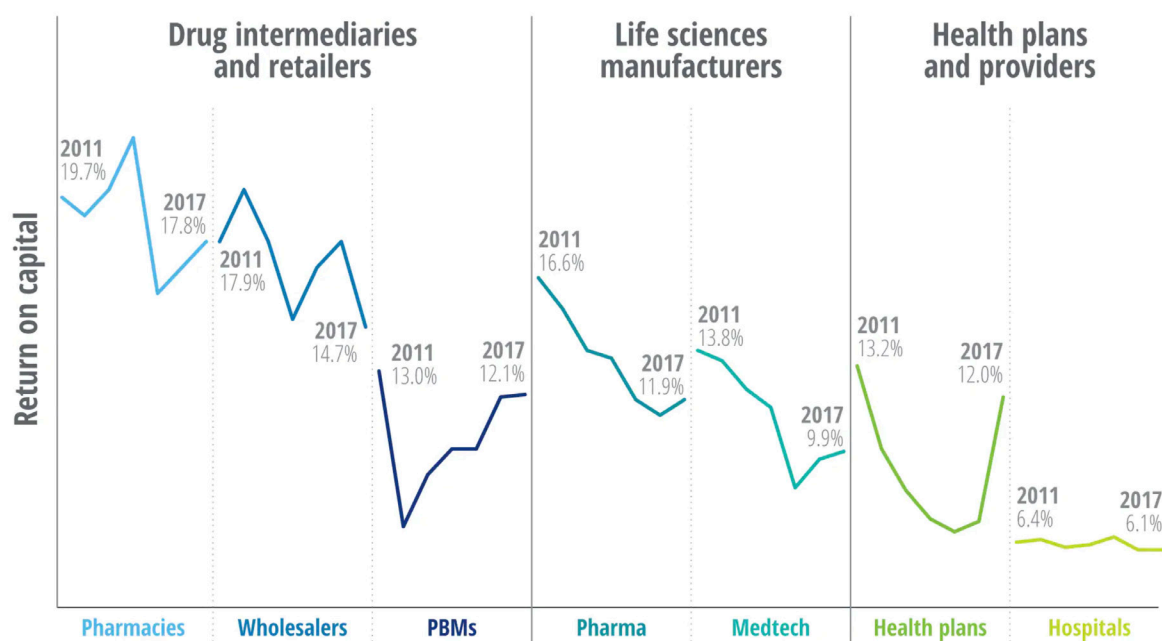
Profitability may also hinge on providers' ability to improve techniques in ways that reduce costs over time, a factor that injects additional uncertainty into investment prospects. Private firms

can mitigate this uncertainty by coordinating investments in complementary goods. For example, investment in medical equipment compliments investment in hospitals, because reducing the costs of medical equipment in turn reduces the costs of hospitals. However, freely contracting firms may fail to coordinate because the costs associated with bargaining for such contracts may become very high or because individual firm incentives do not align well enough to make cooperation workable. The problems of uncertainty in investment become even more serious when we consider the fact that the broader societal benefits of healthcare investment in terms of quality of life for real people do not even factor into calculations of expected profits of individual firms. In light of these problems, the notion that we can reach the socially optimal program for investment in healthcare spontaneously as the result of uncoordinated private actors seeking to maximize their respective profits is simply not realistic.

This is not mere theory. For example, Deloitte describes a [“prisoner’s dilemma” in medical tech innovation](#), where price competition encourages med tech firms to focus their energies on their core products to try to expand or maintain their market share, which makes it harder to justify committing resources to riskier investments in new technology with high costs and uncertain payoffs. While competition for market share reduces prices for current products, it ends up penalizing potentially transformative innovations in new products. High social value innovations are further penalized by the

FIGURE 1

Return on capital declined across all health care sectors between 2011 and 2017



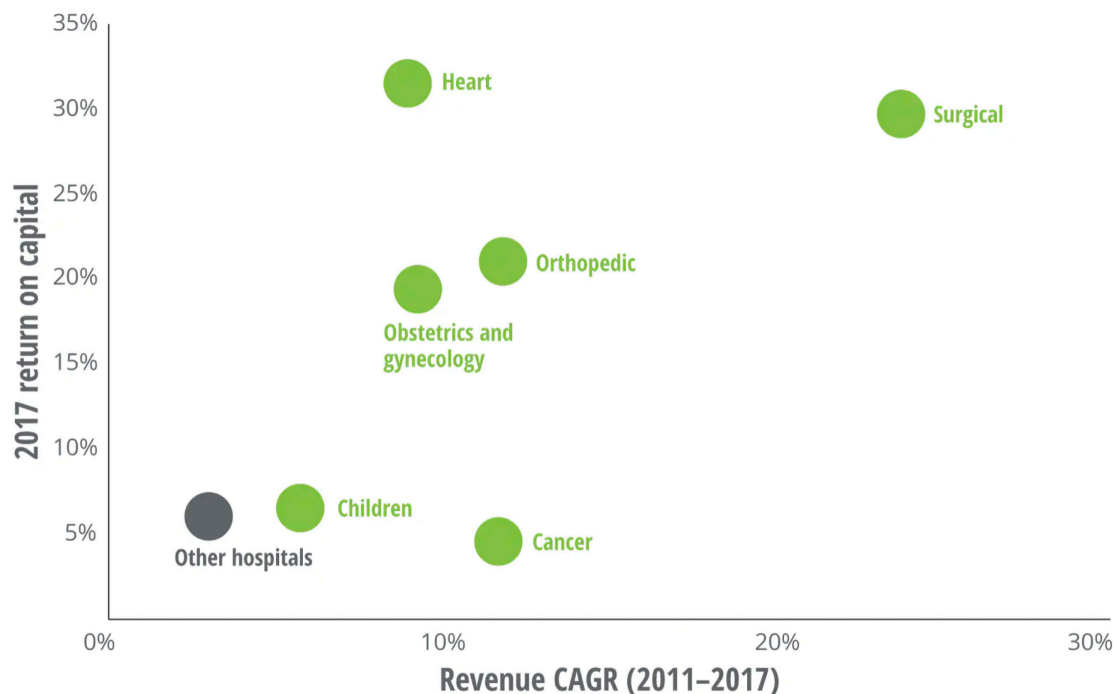
Sources: Deloitte analysis of the SEC filings through S&P Capiq; NAIC and DMHC filings through S&P Market Intelligence; Medicare cost financial filings through Truven Health Analytics; American Hospital Association annual surveys; EvaluatePharma.

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fact that hospital purchasing managers are mostly interested in negotiating for the lowest costs possible as opposed to the highest value based on patient outcomes. The public sector therefore must not only directly invest in healthcare infrastructure and research, but it must also take action to break log jams in private investment and provide inducements for private investment in long-term innovation. For example, [medical innovation prizes](#) and [advance market commitments](#) can significantly reduce firms' investment uncertainty while steering private investment towards socially beneficial innovations and providing an alternative to the harms of [patents](#) and other intellectual property rights.

Private investment is often justified on the basis that competition between producers provides a mechanism to protect consumers. However, in healthcare, excessive competition can be harmful. Competition, including forms of competition between different public facilities, must be [structured very carefully](#) to avoid these harms. As consumers, patients are [not very responsive](#) to things like hospital death rates, which are typically hidden to them. Instead, they are more responsive to what they can see, such as the size and comfort level of their recovery room. This means that healthcare providers compete for patients in the same way that restaurants compete for customers. This does not guarantee better care, and in fact can lead to worse care. The impulse to maximize profits can lead providers to misallocate resources to provide concierge type treatment for well-to-do patients at the expense of quality of care for those in need. This dynamic leads to uneven development as affluent areas are

Hospitals focused on specific conditions such as heart, surgical, and orthopedics outperformed other general acute care hospitals



Note: The bubbles represent hospitals with primary service focus on pediatric, heart, cancer, orthopedic, ENT, gynecology, and other specialty areas (based on Truven classification of Medicare cost reports).

Sources: Deloitte analysis of the Medicare cost financial filings through Truven Health Analytics; American Hospital Association annual surveys.

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prioritized, creating extreme geographic healthcare segregation, which is most clearly visible in our ongoing crisis of [hospital closures](#). Further, it creates a brittle system that is not robust to shocks. By disrupting the funding streams that hospitals rely upon for cash, the coronavirus has [severely impacted hospital profitability](#), jeopardizing critical care infrastructure.

These are deep issues that even the most generous expansions of public insurance only partially resolve. Expanding public insurance would slow and even halt hospital closures in some areas, and providers would adapt their facilities to handle increased uptake in usage, as they have done when Medicaid was expanded. But it is unlikely that this will be sufficient to bring back facilities where healthcare infrastructure is already gone, or never existed in the first place.

When the original Medicare program was established, it gave many seniors life-saving care. It also had the effect of inadvertently socializing many of the risks and reducing the uncertainty of for-profit investment in hospitals. Some of the architects of Medicare envisioned it as a step towards an increased degree of public planning of capital investment in healthcare infrastructure. The neoliberal turn that the Reagan administration inaugurated thwarted this project. The combination of public funds for financing care for seniors and the absence of public coordination of investment in facilities led to private financial markets becoming the primary means of allocating capital in the hospital industry ([see chapter 10](#)).

Medicare is one of most significant achievements in U.S. history and public insurance is one of the best policy tools we have to eliminate cost barriers to care. To be sure, some private health corporations might judge that expanded public insurance and the promise of guaranteed payment from the government means that there is profit to be taken from investing in healthcare facilities in underserved areas. But if we are going to continue to rely on the private sector for capital investment then we will once again be faced with an unavoidable conflict between the goal of reducing prices for care and the goal of meeting all unmet needs. Proposed decreases in reimbursement rates included in many plans to expand public insurance make it less likely that the private sector will be willing to sufficiently invest in underserved areas to meet everyone's needs. The core issue here is that we have left the critical role of directing capital investment in our healthcare infrastructure in the hands of private markets. We must correct this by increasing public sector investment and management.

Public ownership also provides a bulwark against the rapacious private equity (P.E.) industry, which drives the worst abuses in the healthcare industry, such as surprise billing and the selling off of critical healthcare infrastructure. More recently, private equity set its sights on [Medicare reimbursement](#) as a potential cash cow. P.E. will always threaten care unless they are completely shut out from the ownership of care facilities. The long-term care industry relies heavily on reimbursements from public

insurance programs for revenue, and yet is still able to bilk the government while subjecting senior citizens to horrific conditions and substandard care which has led to [mass death](#) during the coronavirus pandemic.

The Political Economy of Publicly Provisioned Care Puts Patients First

Many health policy experts note that physicians and their professional associations exert disproportionate political influence, exhibited by their ability to maintain statutory restrictions on the supply of doctors as well as professional licensing requirements which generally do not serve the public interest. This state of affairs is directly linked to how we finance both care and investment in care facilities. Physicians need access to capital intensive facilities which they are unable to fund themselves, not to mention high education costs.

The combination of private payments for care and privately run medical facilities allows physicians to get the best of both worlds by working as independent contractors within care facilities. The public then suffers. Doctors can access facilities to run their practices while operating with autonomy to set their own prices and to avoid any form of control from above. The costs of the resulting inefficiencies are dumped onto patients and the public.

To understand how we got to this point, we have to understand the history of the medical profession. The industrial revolution began a process that transformed healthcare from predominantly family labor to a professionalized and paid service performed at dedicated facilities such as hospitals. In the U.S., care remained primarily privately financed. The first hospitals emerged as privately funded charities serving mostly the poor, and over time the hospital industry began to take on more and more characteristics of typical for-profit businesses. Owing to their position of authority in society, physicians have a unique ability to convince the general public that the personal financial interests of doctors are always aligned with the general public interest, even if they are not. This disproportionate cultural power combined with the mainly privately financed U.S. healthcare system which subjects physicians to many of the financial risks of independent entrepreneurship has allowed physicians to [slowly but surely](#) rise to a position of economic and political dominance as the care system evolved into a large for-profit industry. As a result, physician groups have consistently impeded and even blocked outright any alternative public or private model for care that would limit their professional autonomy.

Europe took a different path. Generally speaking, European countries responded to the transformation of healthcare from domestic labor to a capital-intensive, professionalized service by doing three things: first, implementing tax-financed compulsory insurance plans for financing care; second, creating tax-financed public hospitals; and third, using non-market institutions for regional and national planning of capital allocation in the healthcare sector. Private for-profit insurance and care did and still does exist in Europe, but it has never played the role that it has in the U.S., nor have for-profit investors ever had anything like the degree of autonomy they enjoy in the U.S. Indeed, what private insurance does exist in Europe bears little similarity to how the sector functions in the United States. In the European model of heavy regulations and tax-financed insurance and hospitals, doctors were typically ordinary employees,

not autonomous entrepreneurs, which made it much harder for physicians to reach a position of economic, cultural, and political sovereignty. It is therefore likely not an accident that European countries with a higher degree of socialized medicine than the U.S. also tend to have [more liberalized physician licensing requirements](#).

We need the public sector to invest in physician training and to build and operate public facilities where physicians are ordinary employees, not independent entrepreneurs who are free to bill as they wish. This would give physicians job security, predictable scheduling, manageable workloads, and shelter from the risks of high education costs and high fixed costs of care facilities. At the same time, it does not afford them the autonomy that has historically allowed them to act against the public interest.

Public investment in care infrastructure also gives us the opportunity to expand inclusive models for patient-centered governance. Federally Qualified Health Centers (FQHCs) are required to have at least 51 percent of their boards consist of patients and community members, giving them a direct say in their management of the care center which rightfully belongs to them. Democratic control of healthcare is also in operation in other countries. In Wales, for example, the National Health Service gives patients a voice in their care through Community Health Councils. The councils consist of appointees from local public offices and patient advocacy organizations. We emphasize in this report that the public sector possesses substantial capacity to mobilize resources in ways that would be unthinkable through pure market coordination. Moreover, we must also ensure that public investment serves the public first and foremost. This can be achieved through use of inclusive governance models with proven track records both at home and abroad. [Proper governance](#) makes public care facilities directly accountable to the communities they serve and should become the norm in healthcare.

Public healthcare investments create broadly shared prosperity and economic growth

Trade liberalization has played a significant role in offshoring of jobs and deindustrialization in many of the Rust Belt counties that ended up supporting former President Donald Trump. In general, public investment can act to counterbalance the loss of jobs overseas through the direct creation of permanent domestic jobs. Healthcare in particular is a good public investment for this purpose. First, it creates good-quality union jobs in the healthcare, building trades, and service sectors. Second, health facilities have also been shown to have [large local economic multiplier effects](#).

Creating millions of good-quality union jobs is not just a positive side effect of our proposed healthcare investments. Instead, it is critical to the achievement of our goal of guaranteed delivery of quality care for all. A [stunning paper](#) from earlier this year found that minimum wage increases improved patient health outcomes in long-term care facilities and reduced job turnover for many of the low-wage nonmedical workers who are critical to the delivery of quality care. Providing pathways to a stable middle class life for workers and provisioning high-quality care to all go hand in hand. Public investments in care offer a wealth of noneconomic benefits, but also can reinvigorate the declining economies where people have turned towards the right to Trumpism, as well as finally creating new opportunities in many poor communities of color which have been deliberately excluded from sharing

in economic prosperity for this country's whole history.

Our public infrastructure for care proposal can also serve as a component in a comprehensive industrial policy for the United States. In the post-war United Kingdom, the Labour government established the National Health Service (NHS). In the subsequent decades, the combination of

domestic healthcare spending, drug safety regulation, selective regulation on foreign direct investment, and public spending in research and development helped [propel the British pharmaceutical industry to global competitiveness](#).

Healthcare-driven industrial policy is more promising today than ever before. In contrast to when the NHS was established, modern care facilities involve sophisticated imaging and diagnostic equipment, complex information systems, and a long list of additional supplies. Meeting our domestic healthcare needs will require procurement programs for these supplies, many of which would be purchased from high-tech American firms. This large cash infusion to United States industry can be combined with strategic investments in public research and development and additional policies to set quality standards to boost the competitiveness of these firms in the global market.

The coronavirus pandemic has highlighted the need for medical supply chains to be resilient amid disruptions. Addressing this will require domestic capacity and a wide range of public policy mechanisms to directly and indirectly steer production in the event of another pandemic. While industrial policy can be used to help accomplish many of our social goals, there are limits to this approach. At its core, industrial policy is a tool for development of private industry. The drive towards the accumulation of inhuman profits must never take precedence over human needs. This means that industrial policy must be designed and administered to ensure that the industries that benefit are always held directly accountable to the public, who they serve.

The benefits of these investments should not be forced to remain within the borders of the U.S. If the federal government is to provide a windfall to domestic industry, this must be used as an opportunity to aggressively negotiate for additional medical equipment to be given, without charge, to developing nations who can not afford to pay. In addition, any provisioning of medical supplies or equipment ought to be paired with programs to facilitate the absorption of new medical technology in developing nations, accounting for their existing levels of technological capability.

In short, public investment in healthcare is one of the best tools we have to accomplish a number of different progressive policy goals. We almost universally recognize the need for public investment in transportation and communications infrastructure. Healthcare infrastructure should be viewed no differently. The public sector can and must directly expand and maintain our infrastructure for care. Failing to do so is to deny ourselves the best care modern technology can offer, to invite the irrationality of private capital markets to disrupt care, and to rob the economy of well-paying middle class jobs.

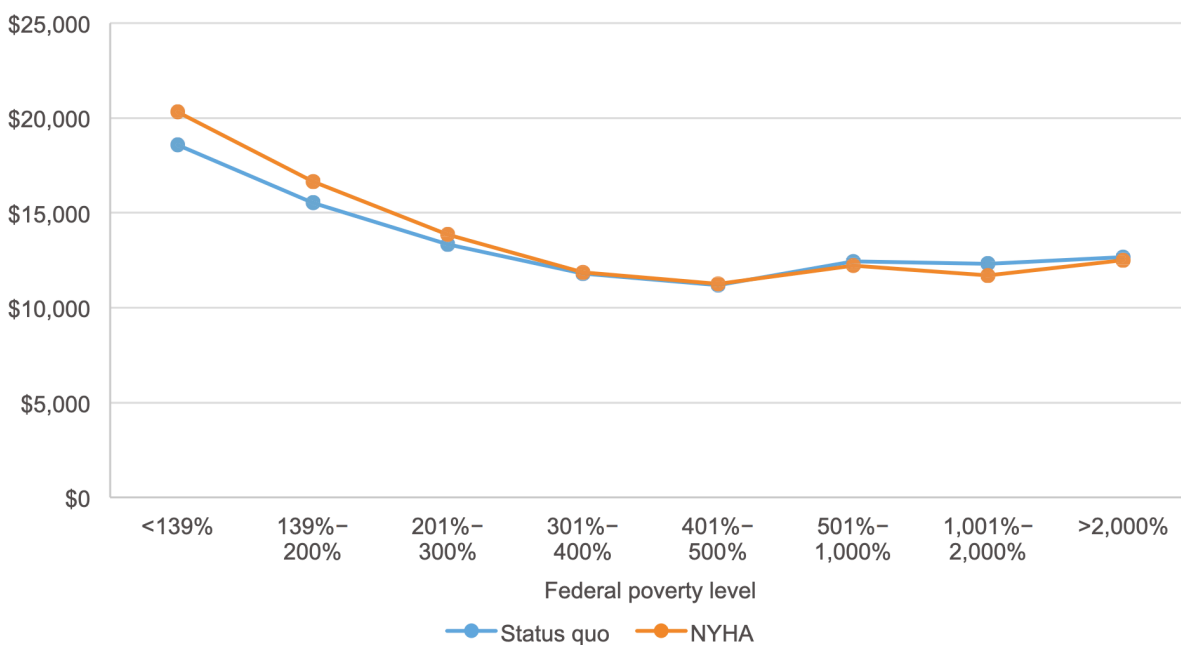
Redistribution Within the Healthcare System

Individual-level financial barriers to care are inherently regressive, since they force the poor to pay a high proportion of their income on necessary care. Following a “worst-first” principle means that we

should first remove financial barriers to care for the poor and people with disabilities, which we can do with a generously subsidized public option for insurance that automatically enrolls low-income families and gives them comprehensive coverage without deductibles, premiums, or copays. However, even if we remove all individual-level financial barriers through universal insurance, we still have to carefully consider the distribution of who pays what into the healthcare system via taxes and premiums. This distribution is largely a matter of policy design. It can be improved by changing the progressivity of the funding sources. It can also be improved from the spending side, by distributing savings from reductions in prices for care in the form of reduced taxes or subsidies.

Single payer is often promoted as a way to reduce national health expenditures since it affords the government a substantial amount of bargaining power to negotiate prices as well as the ability to

Figure 5.1. Per Capita Health Care Spending for Services Received, by Income Group, 2022

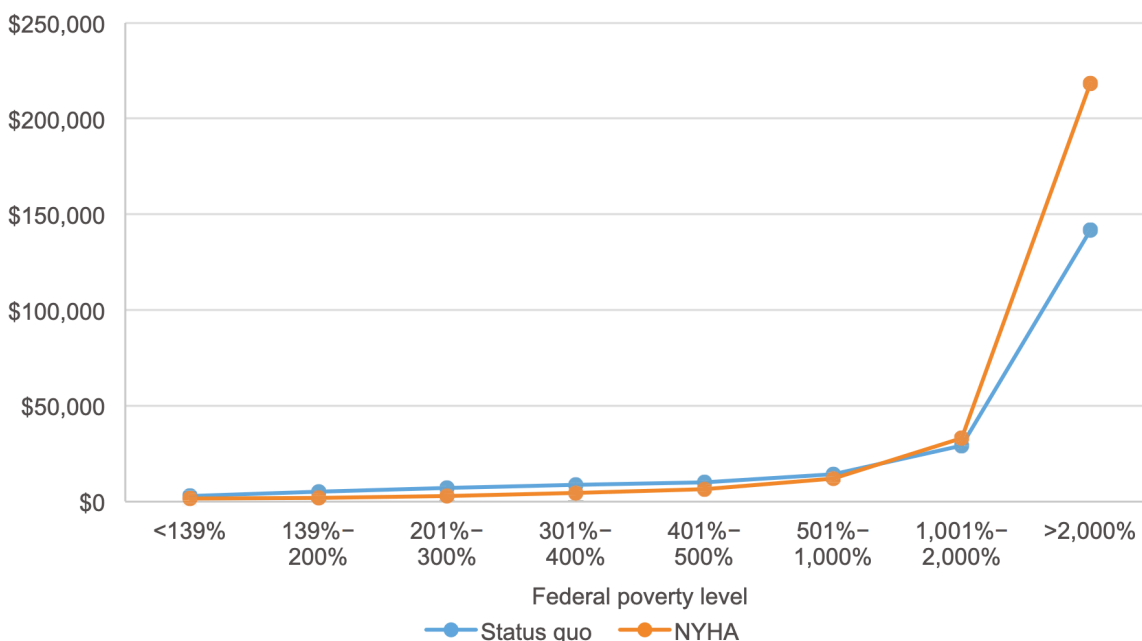


NOTES: We estimate that 100 percent of the FPL will be \$13,350 for a single individual and \$27,610 for a family of four in 2022; see Table A.3 for the distribution of the population by income group. For both the status quo and the NYHA scenarios, the x axis shows the income group for individuals in the status quo, without accounting for changes in wages under the NYHA, so that the same group of individuals is compared within each income group.

eliminate certain inefficiencies in administration and delivery of care. But if we take a look at how these financial savings are distributed, it further shows why we should prioritize capacity expansion over net reductions in national health spending. Different distributional changes resulting from single-payer have been explored by economists from [UMass Amherst](#) as well as economists from the [RAND corporation](#) who studied a universal public insurance plan for New York State.

This figure shows the dollar value of healthcare services received by each income group. Note that this is not what individuals actually pay for healthcare — it's the value of what they get. The universal plan increases the amount of care received by low-income families, since the plan removes the financial barriers that have blocked them from getting care that they need. Turning

Figure 5.3. Per Capita Health Care Payments, by Income Group, 2022



NOTES: Payments include premiums paid by individuals, out-of-pocket payments, tax payments supporting health care programs, and premiums paid by employers (forgone wages), minus the value of the tax exclusion for ESI and the NYH payroll tax. We summed payments for all individuals within each income group and divided by the total number of individuals in the income group. For both the status quo and the NYHA scenarios, the x axis shows the income group for individuals in the status quo, without accounting for changes in wages under the NYHA, so that the same group of individuals are compared within each income group. We estimate that 100 percent of FPL will be \$13,350 for a single individual and \$27,610 for a family of four in 2022. We estimate that household income for the 2,000-percent FPL group begins at \$267,000 for a single individual and \$552,200 for a family of four, and average household income in this group will be about \$1,654,700 in 2022.

to what families pay, which includes premiums, out-of-pocket expenses for care, and taxes that finance healthcare programs, we see that speaking strictly in absolute dollar terms, the poor pay relatively small amounts under both the status quo and the universal plan. However, relative to their income, these costs represent severe constraints on the ability of the poor to receive care. Middle-income families on average get the same value of care but pay less, and high-income families pay significantly more for the same care through progressive taxes.

This illustration is broadly in alignment with the economists from UMass Amherst as well, summarized in table S6 of their report. The highest income households are net payers, which is obviously great. The largest net *financial savings* from single-payer in absolute dollar terms accrue to middle-income households. Lower-income households receive less net *financial* benefit in absolute dollar terms, but get significant financial benefits relative to their income, and additionally are finally able to get care that would have been unattainable for them otherwise.

TABLE S6
Summary Figures: Impact of Transition to Medicare for All on Families

	Health care spending as share of income		Change in health care spending as share of income (= column 2 – column 1)
	Existing System	Medicare for All	
LOW-INCOME FAMILIES			
\$13,000 in income with Medicaid	3.5%	-0.1%	-3.7%
\$35,000 in income, uninsured	2.5%	1.7%	-0.8%
MIDDLE-INCOME FAMILIES			
\$60,000 IN INCOME			
Underinsured	8.0%	1.6%	-6.4%
Individually insured	15.5%	1.6%	-14.0%
Insured by employer	4.2%	1.6%	-2.6%
HIGH-INCOME FAMILIES			
Top 20 percent: \$221,000 in income	-0.1%	3.7%	+3.9%
Top 5 percent: \$401,000 in income	-0.9%	4.7%	+5.6%

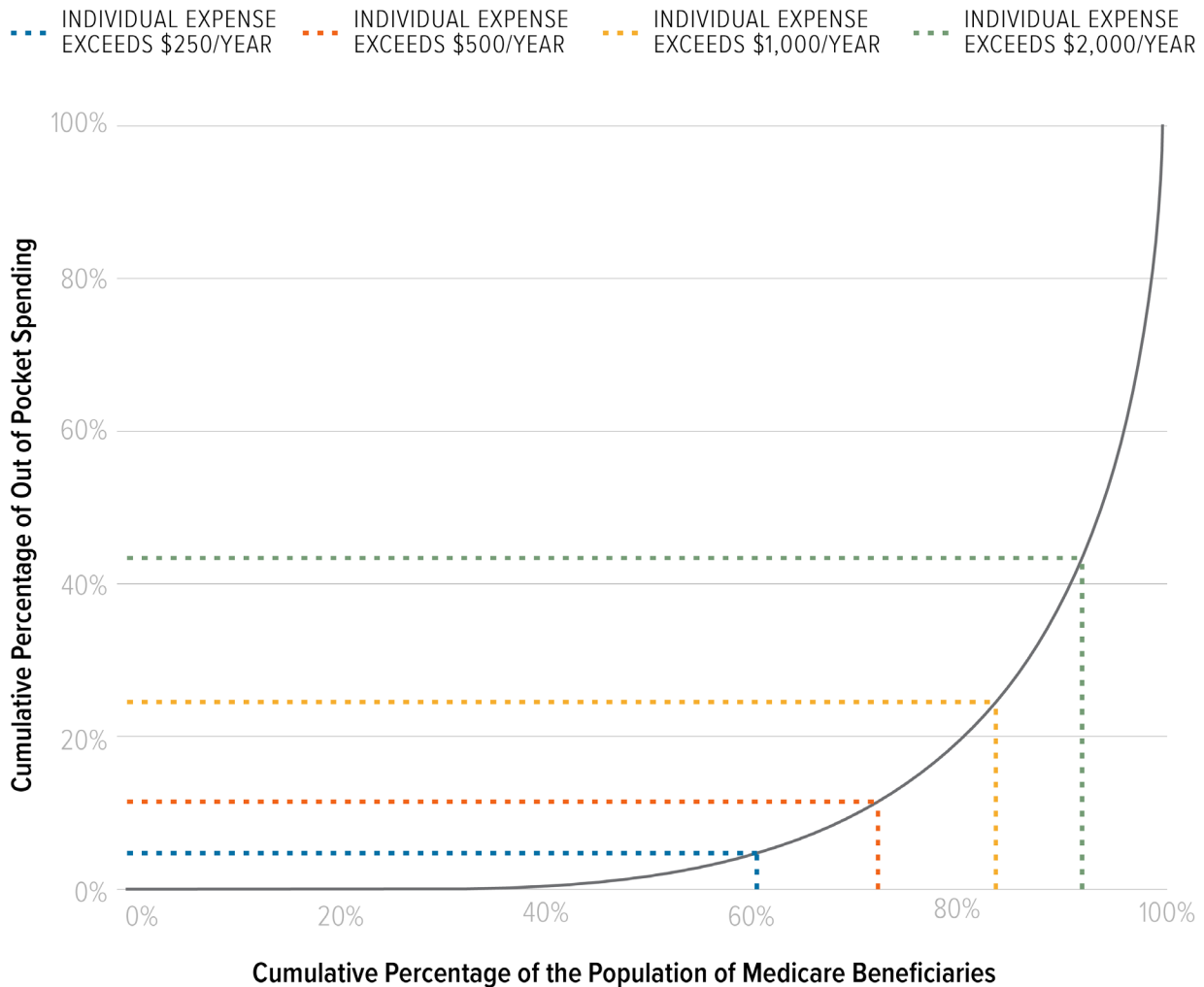
Source: Table 25. Differences in column 3 figures relative to columns (2-1) are due to rounding.

To reiterate, it's not necessary to reduce prices for care in order to completely remove all financial barriers to care for everyone, and to make things like medical bankruptcy a thing of the past. Achieving this is solely a matter of creating a functioning insurance system that is financed through taxes and would automatically be progressive by virtue of the fact that the poor already are forced to pay devastatingly large portions of their income for care. However, reducing health care prices with the intent of increasing the disposable incomes of middle class families does not advance any progressive healthcare goal.

The situation we have described is the same policy conundrum that healthcare reformers have always faced. The principles of universality as well as long-term political stability and overall effectiveness require that we find ways to win over middle- and upper-middle-income families to the coalition pushing for universal healthcare. Lowering their average healthcare costs could be one way to appeal to them. But at some point this means that political effort and public power that could be used to address the most serious failings of the healthcare system, which mostly affect low-income families, are being expended on people who are more self-sufficient. Despite standing to gain the most in pure dollar terms from single-payer, many of these middle-income families are [the most opposed to it](#). While progressives tout the savings benefits of single-payer, middle-income families react much more strongly to what they essentially *perceive* as austerity in the form of more limited choices in terms of fast access to care.

While we advocate for policy designs that focus all available resources on the poor and underserved before distributing financial savings to middle-income families, that does not mean that our proposal has nothing to offer these families. Many of these families would also benefit from expanded capacity and some of the free convenient care options we are advocating for. In addition to this, even in the absence of financial savings, the buy-in offers them a great deal. Employer-sponsored health insurance is a form of “fringe welfare,” which means that it is a fringe benefit of employment meant to approximate the function of a welfare state, except that it is worse in every imaginable way. Attaching insurance to employment is completely nonsensical because then insurance can't protect people in the event of an

Out of Pocket Spending Follows an Exponential-type Distribution



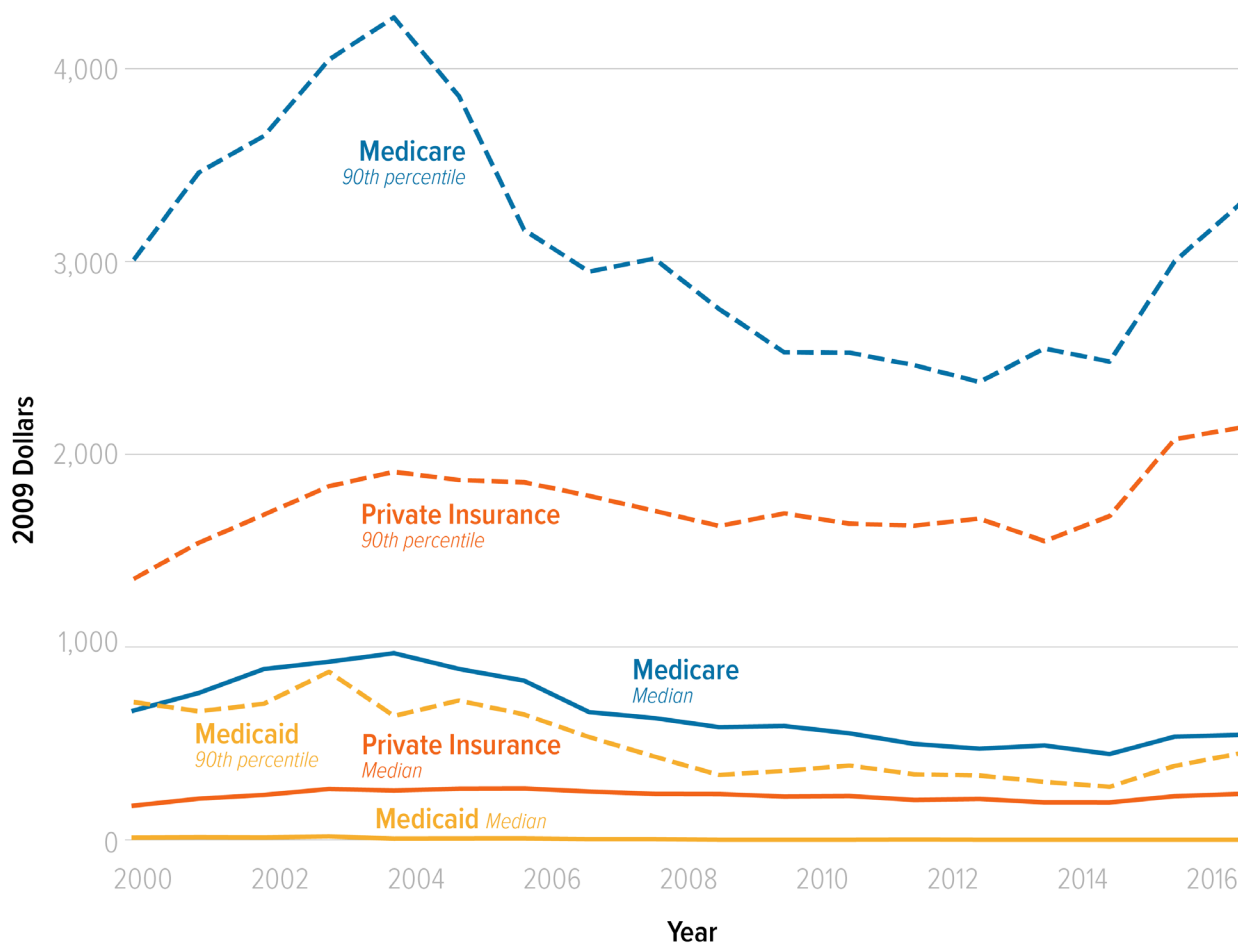
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illness or injury that makes them incapable of working. Our insurance system exposes a small portion of the population to massive out-of-pocket costs for care, and many of those people are already covered. Even worse, patients typically get hit with most of their yearly out-of-pocket costs in [short time periods](#), creating a greater financial burden than if out-of-pocket costs were planned and spread throughout the year. While automatically enrolling people on employer-sponsored insurance does not appear to be worth the political risk, it would not make much sense for anyone to choose to remain on ESI if they had the option for a quality public plan.

As we discussed before, the entire purpose of insurance is to break the link between individual spending

and care by financing care through collective funds. This extreme distribution of out-of-pocket spending shows that the system is failing badly. There's not much sign that private insurance can fix this problem, either. Out-of-pocket spending for the privately insured has been increasing, and it is not clear that there are any policy levers we can pull to make private insurance reduce out-of-pocket costs that don't involve the public backstopping private insurance. On the other hand, we have a very simple mechanism for reducing out-of-pocket costs for public insurance beneficiaries: expanding it. We should add a note of caution not to overinterpret this chart, since insurance status is correlated with other factors such as age and health which can also affect spending patterns over time.

Trends in Out of Pocket Spending by Coverage Type



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This chart highlights the absolute necessity of expanding Medicare coverage to include comprehensive long-term services and supports, as well as the importance of designing a buy-in that offers a comprehensive public plan with no cost sharing to everyone. A high-quality buy-in offers middle class families who are currently covered privately the option to buy public insurance which actually works. But even without the offer of net savings, the chance to get actual functioning insurance is an attractive deal for almost everyone. If we can offer middle-income families insurance that actually works like insurance is supposed to in addition to a public infrastructure for care, do we really need to throw in an additional \$5,000 per year on top of that?

It is instructive to look at the path that was taken in the UK and Scandinavia to achieve some of their most cherished universal social programs. Many of these programs started out as means-tested benefits, but reformers were concerned that means testing penalized the poor by creating scenarios where [increases in their income would cause them to lose benefits](#). Meanwhile, the middle classes realized that the means tests made them redistributive losers since they had to pay taxes to finance benefits which they themselves could not receive. This set of circumstances created the political pressure for universalism. Below is excerpted from *The Politics of Social Solidarity* by Peter Baldwin (emphasis is ours)

Because the needy of most classes already belonged [in the social insurance programs], universalist reform in Britain and Scandinavia involved a vertical movement that drew in those who had not formerly been the object of statutory attention. Anglo-Scandinavian universalism, in effect, meant giving what had previously been reserved for the poor alone also to the better-off. Need was eliminated as a prerequisite for entitlement by abolishing the means tests and relaxing the earnings rules that otherwise disqualified the well-off from measures targeted at the poor. The arguments advanced for such reform were various, but the most important concerned the relationship between benefits that were statutory and needs-based, on the one hand, and private, unconditional provision on the other. As long as their stigma was not prohibitive, targeted arrangements helped the poor most. The great disadvantage of entitlement determined by need, however, was the discouraging effect it had on self-help. Voluntary provision diminished eligibility for targeted benefits. Attempts to raise statutory pensions above a miserly minimum were therefore resented by the well-off, not only as the taxes necessary to finance reform increased, but because the direct penalties, within the field of social provision itself, for self-help were sharpened. The more ample the means-tested benefits became, the more painfully the unimpoverished felt their exclusion.

But with a public option middle-income families need not feel the pain of exclusion — they can simply take the buy-in. Voluntarily choosing the buy-in would give people on ESI freedom from the control that employers exert over them by dictating their options for insurance. Everyone on ESI currently would

benefit from buying in, which in turn would make the public plan stronger. In the event that a buy-in is passed, we plan to work to convince as many people as possible that buying in will free them from the chaos of ESI, and we challenge progressives to do the same.

The experience of the Affordable Care Act contains lessons which we think are important. Cost control was initially among the top priorities of the ACA policy architects. Peter Orszag, who ran the Congressional Budget Office before then-President elect Barack Obama picked him to run the Office of Management, came to personify this approach, which came to be summarized with the call to bend the cost curve. The ACA's cost control provisions were ultimately defanged as a result of political resistance.

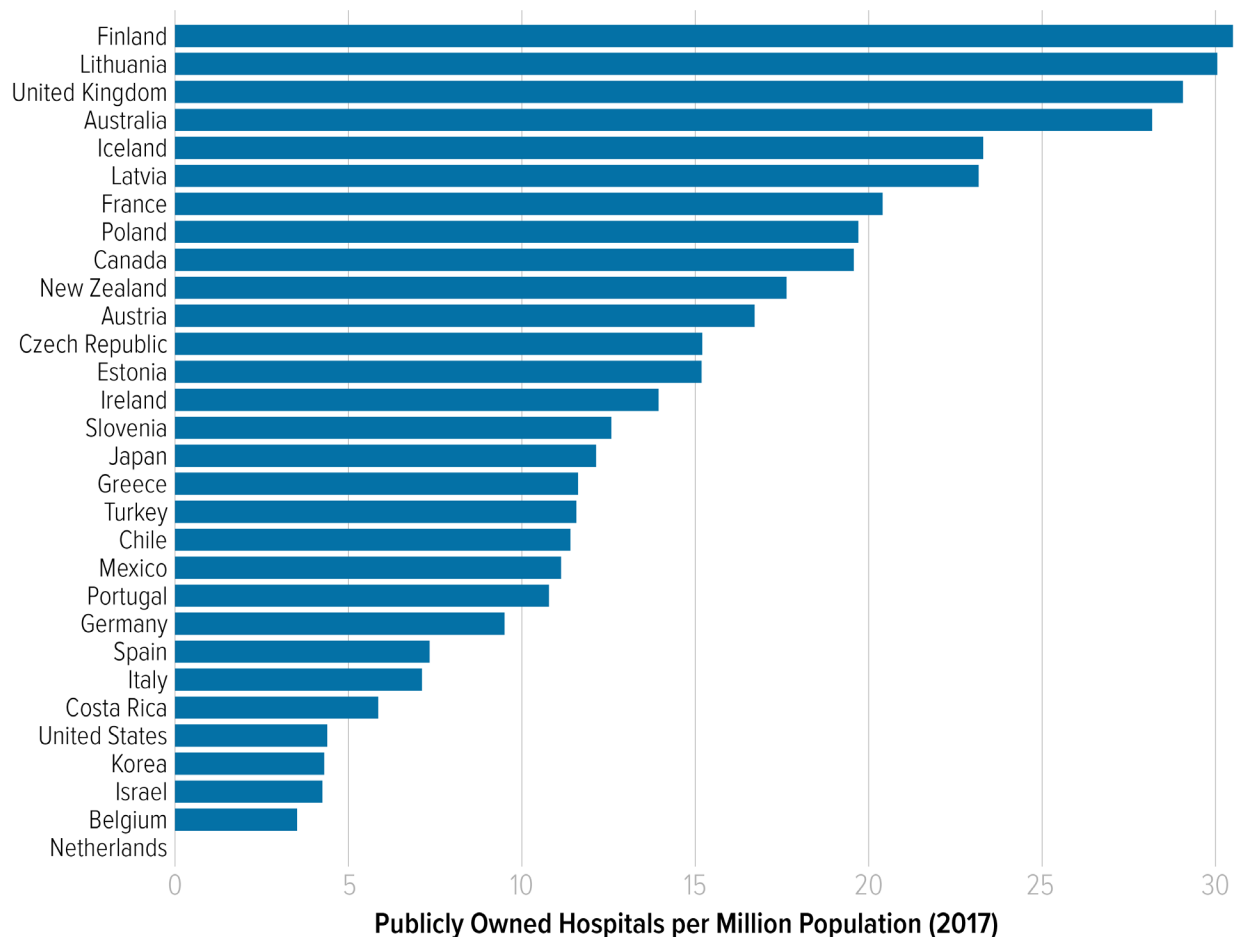
Now, progressives should not take a maximalist position on cost control. At the time, Senator Sanders did not throw his full weight behind the crush-the-curve approach. In fact, his big ask was increased funding for federally qualified health clinics, an approach that expands capacity through direct provision. We should similarly prioritize patient welfare.

The healthcare system is not a closed system, and what we spend on it is not lost to us. The entire economy and indeed all of society depends on us being able to care for everyone, and as a society we can and should spend a rising share of GDP each year to give every person the best quality care possible. At the moment, it appears that everyone across the ideological spectrum agrees that the share of GDP the U.S. spends on healthcare is too high. We believe what we spend is too low. We can make care more cost-efficient, and we can root out profit extracting companies who don't add value, but as long as we are able to eliminate the possibility that any individual is denied care due to inability to pay, then progressives should seek to *increase*, not to decrease, the proportion of our country's resources that are dedicated to caring for people.

Voters Welcome Public Ownership When it Can Fix the Failings of the Status Quo

Public ownership and direct provision is a relatively small part of the U.S. healthcare system, but it does exist through the health departments, the public health service, the Indian Health Service, public hospitals, and the VA. Generally, the US lags far behind other advanced countries in direct provision of public care. For example, the US has much fewer public hospitals per capita than other advanced

The US Lags Behind Other Countries in Public Hospitals per Capita



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nations. Perhaps the nearest system to the U.S. in this regard is the Netherlands, which has a system of mostly private not-for-profit hospitals and significant for-profit provision of outpatient services. While the Netherlands has been [consciously ramping down their per capita hospital capacity](#) since the 1970s in a move towards seemingly permanent austerity, to do the same in the U.S. would be unthinkable given that we already have large underserved populations while private providers continue to shrink their geographic footprints. Capital allocation for Dutch hospitals is also regulated under [regional and national public planning](#), while nothing of the kind exists in the U.S. In short, while there are a wide variety of universal health systems employed around the globe, the role of the public in provisioning care and planning investment is uniquely low in the U.S.

Demands to expand existing forms of publicly provisioned care have not been as prominent as demands to expand public insurance in the decades-long progressive campaign for universal healthcare, though there have been some [notable and exciting exceptions to this](#). While public ownership and direct provision might read as more left-wing solutions (and by implication more politically risky) to some,

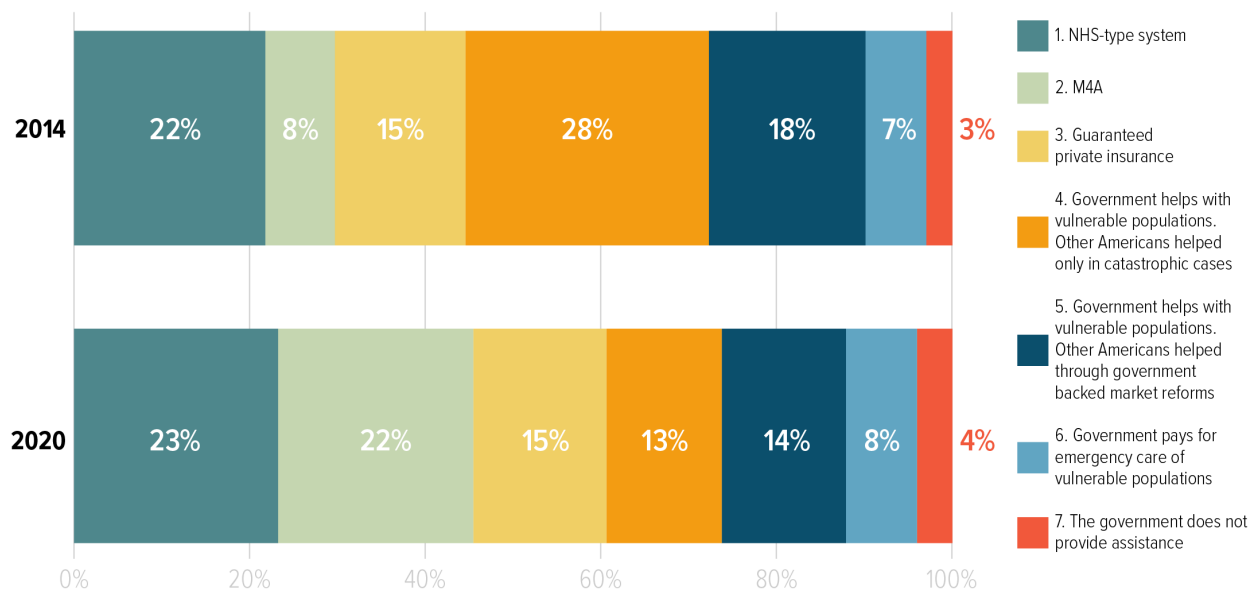
the public does not view healthcare policy with this same ideological valence. It is not commitment or opposition to any leftist principles that drives opinion in healthcare, it is *loss aversion*. Loss aversion is what makes many people balk at the idea of being automatically enrolled in a public plan but welcome the option to buy in. Loss aversion also makes many people who would oppose the nationalization of a financially solvent hospital welcome a public rescue of an insolvent hospital or the construction of a new public hospital in an underserved area.

Stepping back, one of the major problems with healthcare delivery in this country is that insurance functions as a middle man which separates people from their doctors. Fundamentally, what people want is the ability to see their provider when they need to and to afford their medications and treatment. Public insurance plans offer the public another middleman, albeit a middle man of superior quality, and so is a somewhat indirect way to speak to what people actually want in health care. As a result, we routinely find that a public option for healthcare polls better, even under counter messaging, than the best versions plans to expand public insurance. This is simply because public care cuts out the middleman entirely.

The polling on the specific public infrastructure for care items will follow in the upcoming series of memos. Here, we will show a one generic data point which highlights the fact that the public is open to public care facilities just like they are open to public insurance. In 2014, [Ahler and Brookman](#) asked respondents to choose between seven different healthcare systems among the following choices. In the spring of 2020, Data for Progress retested this identically.

1. *The United States should move to a system like Great Britain's, where the government employs doctors instead of private companies and all Americans are entitled to visit government doctors in government hospitals free of charge.*
2. *The government should expand Medicare to cover all Americans, directly providing insurance coverage for all Americans free of charge.*
3. *The government should guarantee full private health insurance coverage to all Americans, regardless of their age or income.*
4. *The government should help pay for all health care for vulnerable populations like the elderly, children, and those with low incomes. Other Americans should only receive assistance in paying for catastrophic illnesses.*

Public Provision as Well as Public Insurance Have a Strong Base of Support



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5. *The government should help pay for some health coverage for vulnerable populations like the elderly and those with very low incomes, including prescription drugs. However, other individuals should not receive government assistance. The government should primarily pursue market reforms (e.g., tort reform, increasing tax deductions, allowing citizens to buy across state lines) to make insurance more affordable.*
6. *The government should only help pay for emergency medical care among the elderly and those with very low incomes. Other individuals and any routine care should not be covered. Instead, the government should pursue market reforms to make insurance more affordable.*
7. *The government should spend no money on health care for individuals. Those who cannot afford health care should turn to their families and private charity for help.*

The net gain for universal programs — from 45 percent in 2014 to 60 percent in 2020 — is truly staggering. This is mostly driven by a phenomenal increase in support for Medicare for All, which is a testament to the efforts of the single-payer movement since the Sanders primary campaign of 2016. Note that in 2014 a NHS style system was significantly more popular than Medicare for All, and in 2020 the NHS system did not lose any ground, but Medicare for All caught up to it fully.

To be clear, the wholesale nationalization of the entire healthcare system presents at least as many political difficulties as the wholesale nationalization of insurance. However, it should be clear that there is no reason to leave public ownership and direct provision off the agenda. It's worthwhile to pause for a moment and consider the profound implications for these findings. We see clear proof that progressives have already dramatically reshaped public opinion, and if it is possible for support for Medicare for All to increase, then it is possible for support for public ownership to increase as well. There are still millions of people who have not yet been won over to the left, but who are looking for a new path.

Progressives should be willing to make public ownership and direct provision central components of our healthcare proposals, and we should also make this a central component of our persuasion message to the public.

Breaking the Stalemate

The Affordable Care Act showed that requiring insurance companies to provide some minimal level of quality requires the federal government to backstop them financially to maintain their profitability. There is not much more that can be done at this point to improve insurance or care that does not negatively impact the bottom line of for-profit insurance companies. The industry knows this and both single-payer and buy-in plans have already provoked industry backlash, which will only escalate during the Biden administration. In fact, we expect that industry attacks would be essentially identical regardless of what sort of public insurance expansion plan the Biden administration advances.

When it comes to public opinion as opposed to industry resistance, all plans to expand public insurance face identical kinds of political challenges and the differences are purely in degree. Buy-in plans contain all of the unpopular aspects of single-payer — tax increases, automatic enrollment for certain people, and rate cuts for certain providers — but in smaller doses.

However as currently constituted, the buy-in misses certain policy advantages of single-payer that could be recovered by adding on the public infrastructure for care, which would make the buy-in both more popular and more effective. A critical component of making a buy-in workable is to have generous subsidies to make the plan completely free for as many people as possible, starting with the bottom of the income distribution and working its way up. This requires increased taxes, provider rate cuts, or both, and these are thorny subjects politically. We emphasize that provider rate cuts can quickly become politically toxic and destructive to delivery of care, and that price reductions are not required for us to give comprehensive coverage to everyone at zero out-of-pocket costs. However, a selective approach to price reductions for drugs can be useful.

Pharma prices are one of the few areas where significant savings via price reductions on certain drugs could be realized quickly without disruptions in care. These pharma price reductions could be accomplished via single-payer but likely not with a buy-in unless it is paired with the pharma policies in our public infrastructure for care framework. Similar recommendations on pharma were made by the Biden-Sanders unity commission. It is deeply unpopular for the government to reduce rates for doctors, and doing so could have negative consequences for care in some instances. Pharma companies are not perceived as sympathetic characters by the public, and high pharma prices are often the result of pure patient gouging. Every policy we have tested for reducing pharma costs, including policies that would create a public entity that would strip pharma companies of their intellectual property rights and directly manufacture or subcontract the manufacture of generic drugs, polls off the charts and holds strong in the face of the usual right-wing attacks. An “I welcome their hatred” approach to doctors is bad politics, but — and we can not stress this enough — it is absolutely the correct approach to the pharmaceutical companies who abuse intellectual property protections and gouge patients.

We should not accept the idea that there is a fixed quantity of healthcare capacity that the public

can only influence by negotiating for prices. Bargaining power does have a role to play, but the public sector can itself rapidly expand healthcare capacity by increasing the supply of doctors and building new care facilities. As it stands now, the public sector not only declines to directly expand capacity, but places many senseless restrictions on the availability of primary care practitioners. Direct expansion of healthcare capacity is the only way to guarantee care is received in underserved communities, but it is also bargaining by other means in the sense that it reduces the market and political power of private healthcare providers.

The debate over single-payer vs a buy-in is purely a debate over the degree of risks and rewards of what amounts to fundamentally the same strategy for healthcare reform by expanding public insurance. This debate can only end in stagnation, but the public care for care brings several new dimensions to the debate by directly addressing many of the policy flaws and political difficulties inherent to plans which expand public insurance. In short, if centrists want the public option for insurance to work, they'll need to include a public carefor care as well.

The public care for care also gives us a more surefire pathway to ultimately achieving the progressive goal of guaranteed delivery of healthcare to all, free of price at the point of service. Even in European countries with universal healthcare, the [well-off have better access to care](#) in private hospitals, which creates inequities in delivery of care. Public hospitals, on the other hand, are at least as efficient as private ones, all while providing high quality care for all. Unless we are willing to directly provision care in places that the private sector has deemed to not be profitable enough for them to notice, we can never fully realize the values of universal healthcare.