The Truth About Government-Controlled Health Care

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Washington's health policy decisions directly affect the life and well-being of every American.

Americans care deeply about health care. While they admire and respect their doctors, Americans are frustrated with bureaucratic paperwork, the lack of transparency in the pricing of medical services, surprise billing and rising health care costs. As a general rule, most Americans are still satisfied with their private or employment-sponsored health insurance, which is financing their access to medical care. Nonetheless, too many still do not have either good coverage or access to the best care.

A major part of the problem is the impact of increasing government domination of the health care sector of the economy. Today, approximately 143.3 million persons are enrolled in, or heavily subsidized by, the big federal health programs: Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Obamacare health insurance exchange plans. In other words, out of a total estimated population of 331 million Americans, 43.3 percent of the legal residents of the nation are enrolled in these large federal health programs or

entitlements. While private businesses and households are still responsible for most American health care spending (55 percent), the total government share of 45 percent is expected to grow while the private-sector share is on track to shrink.

Mere numbers, however, do not tell the entire story. As University of Pennsylvania economist Mark Pauly has demonstrated, government policies, ranging from regulatory interventions to tax policies, directly affect how Americans spend their money on health care; and this "government-affected" spending, as opposed to "market-like" spending, reached "close to 80 percent" in 2016 alone. This growth in the government share of health spending has been accompanied by a rapid growth in government control, which has spawned often ill-conceived, economically inefficient, and outdated government interventions in American health care financing and delivery. The result: health care that is too costly, and health insurance programs, in both the public and the private sector, that patients often find too bureaucratic, complex, and confusing.

Today nearly every American citizen, regardless of income or medical condition, has access to either public or private health insurance coverage, financed by large taxpayer subsidies or generous federal tax breaks. Many Americans, however, do not have a choice of health plans that provide personalized, patient-centered care, meaning the kind of health coverage and care that they personally choose and control and that is directly accountable to them. Key decisions on the kinds of health plans, benefits, and payment arrangements that are available are legally reserved to government officials, corporate human resources officials, or health insurance executives.

On the supply side of the equation, federal and state government policies have contributed to the increasing consolidation of health care markets among health insurers and hospital systems, reducing the number of independent medical practices, restricting patient choices and thus driving up consumer costs. In sharp contrast to other sectors of America's more open market economy, there is far too little price transparency in health care; consumers and patients often do not know the price of medical goods and services until the mysterious bill arrives.

Americans are also anxious. They worry over whether they, and their loved ones, will be able to access the care they need, when they need it. As noted, health care costs are high for a variety of reasons; but these costs are also inflated by government rules, regulations, and mandates that distort the markets, restrict personal choice and create inefficiencies. For example, under the Affordable Care Act (ACA), millions of middle-class Americans, ineligible for the law's taxpayer subsidies, are being priced out of the market for health insurance. At the same time, these ACA plans have narrow networks of doctors and hospitals, and choice in these markets is constrained. Today, in 71 percent of the nation's counties, individuals and families have either no choice, or a choice between only two insurers offering coverage in the ACA health insurance exchanges. Lower-income Americans who have no choice but to rely on Medicaid, a welfare program, do not fare any better. Indeed, many Medicaid recipients struggle to find doctors who will take care of them, largely because physicians cannot afford to take the program's low payment rates.

Health care reform is warranted, and indeed necessary. The debate is not about whether American health care needs serious reform—policy analysts of all political persuasions agree that it does. Rather, the question is whether Congress should dramatically improve the existing system of public and private coverage, expanding Americans' personal choice and control, or whether Congress should instead outlaw private and employment-based health coverage and launch a total government takeover of American health care.

A total government takeover would be a massive and disruptive enterprise, consolidating the federal government's direct control over the entire health care sector of the economy, currently valued at approximately $3.6 trillion. That would be an unprecedented expansion of government power, and it would inevitably increase costs and the burdens on providers, stifle innovation, and inevitably limit access to high-quality care, especially for patients in need of complex and technologically advanced medical services.

The policy choice is stark. For all Americans, at issue is whether their health care is to be government-controlled, centralized, and monolithic, or whether health care financing and delivery is to be driven by the decisions of individuals in

consultation with their doctors in an open and pluralistic set of markets governed by consumer choice and competition. In the introduction to this volume, Marie Fishpaw and Meridian Paulton outlined a blueprint to achieve such a consumer-driven, patient-centered system.

The vision of reform that generally animates the various contributors is likewise one that would maximize personal freedom in health care, meaning the ability of all Americans to choose the care and the coverage that they determine is best for themselves and their families. This national debate is not only a clash of competing visions; it also an exercise in public education: It exposes the Left's internal contradiction in making lofty promises of universal and high-quality care with the hard reality of routine, politically engineered, government limitations on patient access to that promised care.

The vision of total government ownership and control over health insurance and care delivery takes concrete form in the comprehensive and detailed legislation of congressional progressives. Senator Bernie Sanders (D–VT) and Representative Pramila Jayapal (D–WA) are sponsoring "Medicare for All" legislation (companion bills H.R. 1384 and S. 1129) to establish a "single payer" health care system for the United States. The legislation has not only attracted the co-sponsorship of prominent Senate Democrats, such as Elizabeth Warren (MA) and Kamala Harris (CA), but also a majority of the Democratic Members of the U.S. House of Representatives.

Senator Sanders, Representative Jayapal, and the co-sponsors of their bills leave little doubt about the nature and scope of the health care system that they envision. Both bills would abolish all private and employer-sponsored health plans as well as traditional Medicare and most other government health programs. Instead, Americans would get health care through a new, single, national health insurance program, which would also restrict the ability of patients to engage the services of physicians outside of the government program.

The advocates of Medicare for All promise a universal program of publicly financed health care that would be fairer, more equitable, more economical, and more efficient than the current system. Practical experience, as already

indicated, tells a very different story. In "single payer" countries, such as Britain and Canada, millions of patients have faced frustrating delays and denials of medical care, experiencing long and often painful waits for needed medical services.

Because such a radical government takeover of heath care becomes politically unpopular when the trade-offs are made clear, it is not surprising that congressional co-sponsors of "Medicare for All" legislation resort to a temporary fallback as an incremental step toward their ultimate goals and vision: the so-called public option. Currently, there are a half dozen "public option" bills in the House and the Senate.

Such an approach is presented as a moderate compromise. It is not.

The carefully designed provisions of these bills set dynamics in motion that will secure the same objective—a government-takeover of virtually all American health care on the installment plan. As Representative Jan Schakowsky (D–IL), a single-payer advocate who has also co-sponsored legislation to advance a public option, declares: "I know that many of you here today are single payer advocates, and so am I.... Those of us who are pushing for a public health insurance option, don't disagree with the goal.... This is a fight about strategy for getting there and I believe we will." Exactly.

Conceptually, the public option would be a new government health plan that would compete directly against private health insurance plans in the individual, group, or small group markets, or all three; it would be armed with special statutory and regulatory advantages that private health plans would not enjoy. As Nina Owcharenko Schaefer shows in Chapter 1, in most instances, Congress would authorize the new government plan to set artificially low provider payment rates, enabling the plan to offer premium rates below the private market rates; it would be able to compel provider participation, directly or indirectly; and, unlike private health plans, it would have access to the federal Treasury to make up financial losses and "stay in business" at taxpayer expense. Over time it would come to dominate the health insurance markets and displace private health plans altogether.

Voila! Single payer on the installment plan.

Progressives' passion, energy, and legislative efforts, however, are focused on achieving single-payer health care, as embodied in the House and Senate Medicare for All bills. If Congress were to impose such total government control over nearly one-fifth of the entire health sector of the American economy, creating a health insurance monopoly, Americans would have to accept the inevitable consequences of that policy choice.

Major Impacts

High aspirations or congressional declarations of good intentions amount to little or nothing. In the case of the single-payer proposals, the central issue is how such proposals would work in practice. As contributors to this volume have emphasized, there are inevitable trade-offs that must accompany its adoption. Such trade-offs would include the true costs to individuals and families in taxes following the abolition of all private payment, and whether Americans will pay more or less for health care. They would also include the financial and operational impacts on doctors, nurses, and other medical professionals under a government payment system. Finally, there is the primary issue of patient access to timely medical care: What happens to people who do not and cannot get the care they want or need from the government program? This is a crucial question in a system where government exercises monopoly power over health insurance, and alternatives to private coverage are outlawed and private medical care is restricted.

Medicare for All legislation would affect Americans in a variety of ways—in ways that belie the promises made by advocates of the proposal.

Impact on Provider Payment. Congressional champions of Medicare for All promise serious cost control, but the history of America's own experience with government price controls and payment caps shows that politicians' promises of cost control are often false.

Cost control in markets is secured through intense price competition among suppliers of goods and services to meet and satisfy consumer demand. Cost

control in the single-payer system is secured by shifting costs to doctors and medical professionals in the form of payment reductions, thus either reducing the supply of available medical goods and services or reducing compensation and profit margins. Government officials cannot control patient demand for medical benefits or services, so they control their supply through global budgets (a government cap on aggregate health care spending, which often results in waiting lists and a denial of timely access to needed medical care), caps on spending or government administrative payment systems or price controls (a very old political strategy that almost inevitably results in shortages of medical goods and services), or some combination of these.

Champions of Medicare for All point to traditional Medicare as a model, but they often neglect to say that Medicare "works" because it is dependent on the private sector. Medicare reimbursement for hospitals currently covers 87 percent of hospital costs, while private health insurance reimburses hospitals at 145 percent of costs. In effect, Medicare payment policy shifts costs to private health insurance and providers, and privately covered enrollees subsidize Medicare services through higher private insurance premiums, as well as federal payroll and income taxes. If there is no private market at all, then, of course, the cost shift has only one place to go—ultimately to the patients themselves; once again, mostly in the form of delays and denials of care.

Senator Sanders's bill (S. 1129), for example, would apply Medicare rates to the reimbursement of medical treatment of almost 330 million Americans. Such a policy would, in fact, be definition, secure a major reduction in America's high health care spending. Former Medicare Trustee Charles Blahous estimates that the Senate bill would reduce provider payment by 40 percent. Emphasizing that the United States spends more in aggregate and per capita than any other economically advanced country, Senator Sanders, along with certain single-payer supporters in academia and the media, have proudly acknowledged and applauded such an outcome.

Achieving such severe "cost control" would depend on the vicissitudes of congressional politics. Medicare for All legislation, if enacted as drafted, would result either in an unprecedented cut in American health care spending, with a

negative impact on the supply of medical goods and services, thus jeopardizing patient access to care, or in health spending increases in excess of the government's pre-set spending targets.

There is a reason why prominent independent analysts, such as Blahous, are skeptical of this approach to cost control. Based on the history of the Medicare program, as well as more recent experiences with the ACA, it is doubtful whether ordinary Americans, let alone physicians and other medical professionals, would tolerate dramatic provider payment reductions. Congress has back-tracked, resisted, or refused to enforce Medicare payment reductions of much lesser impact.

Americans should consider the record. After Congress enacted the Balanced Budget Act of 1997, slashing payment for medical providers, particularly home health agencies, more than 3,000 home health agencies left the program. In subsequent budget cycles, Congress, step by step, reversed these Medicare payment reductions. In 1997, Congress also designed and enacted the sustainable-growth-rate (SGR) formula, tying physician payment to the growth of the economy, to update annual physicians' payment and to control Medicare Part B costs. When faced with the physician payment cuts required by its own formula, Congress routinely blocked their implementation—no fewer than 17 times between 2002 and 2015 alone. The result: Year after year—over a period of 17 years—when faced with impending Medicare physician payment cuts, Congress blocked implementation of cost-control mechanisms.

Likewise, with the ACA of 2010, Congress created a powerful agency, the Independent Payment Advisory Board (IPAB), to control the growth in Medicare spending by establishing a formula to bring Medicare spending growth in line with the growth in the general economy as measured by gross domestic product. Since the ACA's inception, however, IPAB generated intense bipartisan opposition. In 2018, Congress repealed it.

Under the ACA, Congress has already authorized 10-year payment reductions in Medicare Part A, the part of the program that pays hospitals, amounting to more than $800 billion. Both the Congressional Budget Office and the Medicare Actuary have publicly expressed doubt as to whether Congress would actually

follow through on these payment reductions for hospitals, nursing homes, home health services, and hospice care. Under the most realistic scenario, according to the 2019 Medicare Trustees report: "By 2040, simulations suggest approximately 40 percent of hospitals, roughly two thirds of skilled nursing facilities, and nearly 80 percent of home health agencies would have negative total facility margins, raising the possibility of access and quality of care issues for Medicare beneficiaries."

If Congress were to fail to impose the provider payment cuts envisioned in Senator Sanders's Medicare for All legislation, a major source of program savings would disappear. As Blahous observes: "Unless lawmakers are willing to impose far more sudden and potentially disruptive provider payment reductions than they have historically been willing to implement, M4A's coverage expansion should be expected to further increase national health spending growth."

Impact on National Health Spending. Single-payer advocates often claim that under their program America would not only improve the health of its citizens, but also that the United States would spend less overall than it does today on health care. While estimates vary, the most prominent independent analysts—at the Urban Institute, the Rand Corporation, and the Mercatus Center at George Mason University—project that the United States would spend even more.

Single-payer advocates routinely low-ball their spending estimates. Based on a 2016 version of his Medicare for All proposal, for example, Senator Sanders initially estimated that his national health insurance program would require additional federal spending of $13.8 trillion over 10 years. Since that time, a variety of independent estimates have emerged, all differing dramatically from Senator Sanders's initial assessment. According to the National Health Expenditure Survey, conducted by the Centers for Medicare and Medicaid Services, health spending under current law is projected to be $52 trillion between 2020 and 2029. Based on that estimate, Urban Institute analysts determined that a single-payer program would require an increase in federal spending of $34 trillion over that same period, while private and state government spending would decrease by $27 trillion. In other words, total American health care spending would increase by $7 trillion.

Urban Institute analysts concede that the proposed single-payer program would lower administrative costs, and that reimbursement for doctors and other medical professionals as well as prescription drugs would be lower, but they also conclude that the demand for new and generous "free" care would outweigh all of these savings, and that overall national health spending would thus increase.

Among independent analysts, with a few notable exceptions, there is a consensus on this vital point. In 2016, Urban Institute analysts estimated that the Sanders proposal would require $32 trillion in additional federal spending over 10 years, but, based on the Senator's proposed financing, the program would be left with a shortfall of $16.6 trillion. Writing for the Mercatus Center, Blahous initially estimated an additional $32.6 trillion increase in federal spending. Blahous warned that the sheer size of the additional federal obligation would require "[d]oubling all currently projected federal individual and corporate income tax collections," which would still "be insufficient to finance the added federal costs of the plan." The Center for Health and the Economy estimated a cost ranging from $34.6 to $47.5 trillion over a 10-year period, generating deficits ranging between $1.1 to $2.1 trillion annually. A Rand Corporation study estimated that if the program were implemented in 2019, the initial increase in national health care spending could range, depending on utilization, anywhere from 1.8 percent to 9.8 percent.

Profound uncertainty exists in predictions of future health spending and costs, and naturally, operating under different assumptions, estimates vary significantly. But the most prominent experts, as noted here, project higher spending, and the funding for this comprehensive program would require massive tax increases on working families—not just the "rich"—to cover the anticipated costs.

Impact on the Pocketbooks of Individuals and Families. Single-payer proponents often claim that with the substitution of broad-based federal taxation for private health insurance premiums, deductibles, and out-of-pocket costs, American households would pay less for health care than they do today.

House and Senate sponsors often emphasize the need for already heavily taxed "rich" folks to pay their "fair share" to cover the cost of the program. However, given the sheer magnitude of this program, including the absorption of all outstanding obligations to fund existing entitlements, it would be impossible for Congress to finance it without substantially taxing middle-class and even lower-income citizens.

Senator Sanders makes clear that his proposed program would involve broad-based taxation on the general population, not just the economically advantaged few. In examining an initial version of the Sanders' proposal, Professor Kenneth Thorpe of Emory University estimated that the Sanders proposal—if it were fully funded—would require a 14.3 percent payroll tax, as well as a 5.7 percent income-related premium; in other words, a level of taxation equal to 20 percent of payroll. Professor Thorpe concluded that 71 percent of all working families would pay more for health care than they do under the current system.

Confirming Thorpe's general findings, Heritage Foundation analysts report in Chapter 16 that the federal taxation required to finance Medicare for All would mean a hefty tax of 21.2 percent on earnings. Altogether an estimated 73.5 percent of Americans would have less money in their pockets as a result of this level of taxation. American households losing employer-sponsored health plans would experience an average income reduction of $10,554, and about 87 percent of these households would be worse off.

Impact on Access to Care. Single-payer advocates often imply that the costs of a system of universal government coverage are worth it because the new system would secure universal access to care. In fact, universal coverage for all will not guarantee universal access for all, let alone timely access to high-quality care.

The internal logic of the program contradicts universal provision. If health care is a legal right, meaning universal government entitlement, free at the point of service, for nearly 330 million Americans, then it is, for all practical purposes, what economists call a free good. If health care is indeed a free good, then of course the economic demand for this free good is unlimited. But unlimited demand, at any given point in time, must collide with limited supply. This means that government officials—not doctors or patients—are going to have to make

big decisions about who gets care, how they get care, when they get care, and under which circumstances they get care. The key decisions in such a system, in other words, are inevitably political, budgetary, and bureaucratic decisions—not medical decisions.

Government rationing is inevitable in such a system—as the experience of patients living in similar systems has shown. There would be delays or denials of care, and these restrictions would be engineered and enforced by government officials. As Bacchus Barua and Steven Globerman of Canada's Frasier Institute, a prominent think tank, show in Chapter 12, Canadian patients have the longest wait times among patients of developed countries of the world. This is especially true for patients trying to get needed care from a medical specialist.

Likewise, as Professor Timothy Evans of Middlesex University reports in Chapter 10 on Britain's National Health Service (NHS), patient waiting lists are lengthening both for specialty and emergency care, where far too many British patients are forced to wait four hours or more in overcrowded and understaffed British hospitals. This longstanding problem of lengthening NHS waiting lists is dramatically worsening as the NHS tries to cope with the COVID-19 pandemic.

The British media report faithfully on the periodic crises that plague the NHS. British patients are not only routinely subject to long waiting lists, but there is also a shortage of medical specialists, and competition for intensive care beds. In 2017, for example, 4.1 million British patients were on NHS waiting lists, including waiting lists for cancer surgery. As Sally Pipes of the Pacific Research Institute reports: "More than one in five British cancer patients waits longer than two months to begin treatment after receiving a referral from a general practitioner. In Scotland, fewer than 80 percent of patients receive needed diagnostic tests—endoscopies, MRIs, CT scans, and the like—within three months."

Patients will face costs if America trades its public–private combination of health insurance arrangements for a monolithic system similar to that of Britain or Canada. In 2018, a team of researchers writing for the Journal of the American Medical Association detailed the international metrics of access to care, including specialty care, in a timely fashion. For the United States, only 6 percent

of patients had to wait more than two months to see a medical specialist, compared to 39 percent of patients in Canada, and 19 percent of patients in Britain. Congress would do well to avoid a replication of either the British or the Canadian experience.

Impact on the Quality of Patient Care. Single-Payer advocates promise to improve the quality of patient care. Experience, particularly in Britain and Canada, shows a relatively poor performance in delivering it in a timely fashion.

For example, compared to American performance on the delivery of timely medical interventions in treating heart disease and cancer, two of the world's deadliest killers, single-payer countries do relatively poorly in securing access to crucial components of high-quality care. For example, screening for breast cancer was higher in the United States than in all other high-income countries. In treating heart disease, Americans lead other high-income countries in the availability of coronary bypass surgery at a rate of 79 per 100,000 population; Canadians have a rate of 58 per 100,000 and the British have a rate of just 26 per 100,000. Likewise, only France leads the United States in the performance of coronary angioplasty, at a rate of 393 per 100,000 compared to 248 for the United States. Canada registered 157 per 100,000 and Britain only 128. These are comparative measures of advanced medical care, and they show that Americans have greater access to the surgeries they need than patients in other countries.

These comparisons go beyond access to care and extend to access to drugs as well. In the United Kingdom, the oldest of Western single-payer systems, Britain's National Institute for Clinical Effectiveness (NICE), approved the availability of Herceptin, a very effective breast cancer drug, for British women in 2002, while it had been made available to American women as early as 1998. These access restrictions for new pharmaceutical therapies have been a continuing feature of both the British and the Canadian systems, as well as other countries with government control over health care financing. For example, while 90 percent of new anti-viral drugs are available in the United States, only 60 percent of these new drugs are available in Britain and only 46 percent in Canada. While 91 percent of new cardiovascular drugs are available in the United States, only 73 percent of these therapies are available in Britain and Canada.

When access and quality performance measures are broken down by payer, the comparative performance of the United States is compromised by the plight of Medicaid enrollees. Not surprisingly, according to the research team writing in the Journal of the American Medical Association, the Medicaid cohort registered the highest number of asthma-related hospital admissions. This is not surprising. Compared to patients in private-sector health insurance, Medicaid patients have historically had a difficult time getting doctors and medical specialists to take care of them because of excessive regulations and low Medicaid reimbursements, and they have thus failed to secure the same level of access to high-quality care and the superior medical outcomes enjoyed by private-sector patients.

In the absence of the interaction of supply and demand as a mechanism for setting prices in a market, government officials administering a single-payer system control health care spending and pricing by constraining the supply of medical goods and services. They can, and do, for example, eliminate certain drugs from the government formularies. But in financing medical care, single-payer systems usually adopt one or both methods of constraining supply—a global budget (a government cap on aggregate health care spending, which often results in waiting lists and a denial of the timely access to needed medical care), and price controls (government caps on the prices of specific medical services, a very old political strategy that almost inevitably results in shortages of medical goods and services). In both cases, patient care is often compromised because of the reduced availability of needed medical services, particularly those requiring the use of advanced medical technology in the treatment of complex or difficult cases.

Impact on Patient Freedom. Not all single-payer systems are the same with regard to the ability of persons to exercise their personal freedom in caring for their health. In Britain, as Professor Evans notes, patients can, and indeed do, go outside of the government system to enroll in alternative private insurance and contract privately with British physicians. In Canada, as Barua and Globerman explain, provinces either prohibit or discourage the provision of private health care.

For the United States, the sponsors of the House and Senate legislation would narrow the exit ramps from the government system. No alternative private insurance would be allowed to compete with the government program; nor could an American citizen contract privately with a physician, unless that physician refrained from participating in the national health insurance program for one full year. Moreover, the leading House and Senate single-payer bills would also mandate compulsory taxpayer funding of abortion, coerce doctors and nurses to participate in medical practices and procedures that they consider to be unethical, and eviscerate their personal rights of conscience. Altogether, these proposed legislative restrictions on Americans' personal freedoms would be unprecedented.

Impact on Medical Professional's Ability to Practice Medicine, and on Their Morale. American doctors and allied medical professionals are already undergoing enormous pressures in trying to care for their patients. Faced with a variety of external stresses, many are demoralized not only because of the impact of government payment schemes in the large federal entitlements, Medicare and Medicaid; they are also on the receiving end of a steady stream of decisions from third-party administrators, struggling with bureaucratic paperwork in both the public and private sectors, that progressively weaken their professional independence and autonomy.

The metrics tell a stark story. According to the Association of American Medical Colleges, America is already faced with a serious physician shortage by 2030; the estimate is wide ranging, between 42,600 and 121,300 doctors. The reasons for this shortage are in a cluster of work-related pathologies, including physician burnout, early retirements, and a deepening pessimism among physicians over the future of the medical profession itself. The main culprit, however, is the growing and deepening demoralization among doctors who are wrestling with administrative burdens, including excess paperwork. These burdens are imposed by both public and private payers, including the largest payers, Medicare and Medicaid, the giant federal entitlement programs. Based on the provisions of the two leading House and Senate single-payer bills, the existing physician compliance and reporting requirements and the level of government intrusion

into medical practice would be even worse than it is under today's more pluralistic practice environment.

Under the House and Senate single-payer legislation, physicians and other medical professionals would not only be required to endure unprecedented reimbursement reductions, they would also be subject to an even more comprehensive regulatory regime that would detail their conditions of medical practice and the limited circumstances in which they might be able to pursue the independent care of patients outside of the government program.

American doctors and nurses should not be fooled into believing that a single-payer health care program, meticulously regulated by distant federal officials, will somehow improve their working conditions. And the continued deterioration of medical working conditions will negatively affect patients—as it always does. In their universal system of government-controlled care, Canadian physicians are not able to treat all of the Canadian patients that need treatment. Not surprisingly, as of 2016, more than 63,000 Canadians left Canada to get the surgeries they needed. In the United Kingdom, as Dr. Kevin Pham reports in Chapter 18, British doctors and nurses are doing heroic work in trying to cope with periodic funding problems, shortages of medical equipment, and surges of patients in often-overcrowded and understaffed hospitals, which remain the delayed destination of literally millions of British citizens awaiting care.

Improvement in the American medical practice environment will only be possible if both federal and state policymakers enact competently crafted legislative and regulatory changes that would not only reduce the bureaucratic hassles that are demoralizing American doctors and other medical professionals, but would also restore, as much as possible, the traditional doctor–patient relationship.

Conclusion

Self-styled "progressives" in Congress and elsewhere are proposing a government takeover of American health care. Such a takeover would destroy Americans' existing coverage and their right to alternatives outside the government program; and it would erect a system of total political control over

virtually every aspect of the financing and delivery of medical care. Nor would it ensure delivery of its central premise and promise: care for every American.

Beyond closing off individuals' alternatives to coverage outside the government program and restricting their medical care through independent physicians, such a government takeover would also introduce an unprecedented politicization of American health care. Congress, beset by frenzied lobbying by powerful special interest groups, would ultimately determine health care budgets and spending, as well as the rules and regulations that would govern care delivery by doctors, hospitals, and other medical professionals. Patients' personal choices, as well as the professional independence of their doctors and other medical professionals, would be subordinated to the turmoil of congressional politics and the bureaucratic machinations of distant administrators. The machinery of federal control would dwarf the existing federal bureaucratic apparatus that runs today's Medicare, Medicaid, and Obamacare programs.

The scholars who contributed to this volume have outlined the substance of "single payer" legislation, the many promises made on its behalf, and the many costs and consequences entailed in adopting such a large and disruptive program of centralized government control. They have indicated, in impressive detail, the patient experiences in Britain and Canada, the unprecedented tax impact of single-payer legislation on the economic well-being individuals and families, and the threat that such an impersonal system poses to physician autonomy and patient freedom, including personal access to high-quality and specialized medical care.

Progressive politicians are promising high-quality health care for every American at lower personal and national cost. They are promising far more than they can ever deliver. It is what they do.

No Choice, No Exit: The Left's Plans for Your Health Care