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Review Article

Main Reasons Why the U.S. Health Care System So Expensive

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Abstract

Health care is among the most important issues for Americans since the U.S. health care system is the most expensive in the world. Public spending, including governmental spending, social health insurance, and compulsory private insurance constitutes the largest source of health care spending. The U.S. spends on health care nearly twice as much as the average country of the Organization for Economic Co-operation and Development (OECD).

Politicians like to talk about health care of equal quality for all population. Unfortunately, this had never been in the past, and it is unrealistically to expect in the future. Now rich persons, members of the U.S. Congress, and federal government employees have better health insurance than many retirees. Not all doctors accept patients with Medicare or Medicate, since these insurances are not good sources of revenue. For the same reason, old Americans should wait at least a week for office-based medical appointments. That is why the described above possible way to improve the existing health care system can be efficient. Many people, especially young, do not need the highest quality physicians to treat them, and they can wait a week to get appointment. If the country has 8.8 percent of people without health insurance coverage and the insurance prices are high, the compromised approach is more realistic that empty proposals of politicians.

The country with the 27 trillion national debt, which exceeds it's GDP, and with spending on health care almost 18 percent of its GDP cannot spend on health care more. The United States economic health does not allow doing that.

Keywords: Health care; Health insurance; U.S. Government

Introduction

Health care is among the most important issues for Americans since the U.S. health care systemis the most expensive in the world.Public spending, including governmental spending, social health insurance, and compulsory private insurance constitutes the largest source of health care spending. The U.S. spends on health care nearly twice as much as the average country of theOrganization for Economic Co-operation and Development (OECD) [1]. Per capita health spending in the U.S. exceeded $10,000, more than two times higher than in Australia, France, Canada, New Zealand, and the U.K. In 2019, the U.S. spent 16.8 percent of its gross domestic product (GDP) on health care, nearly twice as much as the average OECD country. The second-highest ranking country, Switzerland, spent 12.2 percent. However, New Zealand and Australia spent only 9.3 percent, approximately half as much as the U.S. did.

In the U.S., per-capita spending from private sources, for instance, voluntary spending on private health insurance premiums, including employer-sponsored health insurance coverage, is higher than in most of the OECD countries. At $4,092 per capita, U.S. private spending is more than five times higher than Canada, the second-highest spender. In Sweden and Norway, private spending made up less than $100 per capita. As a share of total spending, private spending is much larger in the U.S. (40%) than in any other country (0.3%–15%). The average U.S. resident paid $1,122 out-of-pocket for health care, which includes expenses like copayments for doctor's visits and prescription drugs or health insurance deductibles. Only the Swiss pay more; residents of France and New Zealand pay less than half of what Americans spend [1].

High medical costs may explain why Americans had fewer physician visits than peers in most countries. According to the 2019 OECD Health Statistics, at four visits per capita per year, Americans visit the doctor at half the rate as do Germans and the Dutch. Maybe that is why, compared to peer nations, the U.S. has the highest rate of avoidable deaths.

Despite high per-capita spending the U.S. has fewer practicing physicians per 1,000 people than almost all comparable large and wealthy countries. For Greece this index equals6.1, Austria 5.2, Switzerland, Germany 4.3, Sweden 4.1, Italy 4.0, Spain 3.9, Australia 3.7, Netherlands 3.6, France 3.2, United Kingdom 2.8, Canada 2.7, but for U.S. only 2.6 (Source: https://www.oecd.org/health/health-systems/Health-at-a-Glance-2019-Chartset.pdf).

Despite the highest spending, Americans experience worse health outcomes than their international peers. For example, life expectancy at birth in the U.S. was 78.6 years in 2017-more than two years lower than the OECD average and five years lower than Switzerland, which has the longest lifespan. The U.S. has the highest rate of avoidable deaths, preventable with timely access to effective and quality health care (from diabetes, hypertensive diseases, and certain cancers). The U.S. rate was two times higher than in Switzerland, France, Norway, and Australia. This poor performance suggests the U.S. has worse access to primary care, prevention, and chronic disease management compared to peer nations [2]. The U.S. has the highest chronic disease burden and an obesity rate that is two times higher than the OECD average [3,4].

The above material raises doubt about the statements of many politicians that the U.S. health care system is the best in the world.

Specifics of Health Care Market

The healthcare market differs significantly form from traditional markers of goods and services. Health providers, practicing physicians, are direct suppliers of health related services. However, very high health care prices in the U.S. are the result of market and non-market factors. Formally, they can be explained by high salaries of practicing physicians trying to maximize their profit. The U.S. private healthcare system allows physicians to do that. According to 2018 Zip Recruiter reports, most physicians earn an annual income between $150,000 and

$312,000, with the highest salaries in the $397,000 range. The average U.S. primary care physician earns $223,000 annually. The average yearly salary of a doctor in the United States is $294,000/year according to a Medscape Report. It is far more than in other industrial countries: in Germany and the United Kingdom it is around $150, 000 and $175,000, respectively. The average yearly salary of family physicians in the U.S. is $209,000; in Germany and the United Kingdom it is around $120, 000 and $85,000, respectively.

Nevertheless, the existing inability of the United States to meet the needs of the population with primary care physicians contributes to excessive and rising health care costs. This fact and the low 2.6 practicing physicians per 1,000 people can be explained by the cost of medical education. The average tuition cost to attend medical school per year in the United States is approximately $55,629, which amounts to $222,516 in tuition debt for four years of school (see https://www.aamc.org/data-reports/reporting-tools/report/tuition-and-student-fees-reports). From 1998 to 2008, the average level of debt for medical students increased by more than 50 percent [5]. Depending on the specialty, it takes 11 to 15 years to train a physician (time in college, medical school, residency, and fellowship). At each step, there are direct and indirect costs; some of them it is it is difficult to anticipate (e.g., for national licensing exams). Students' loans continue to accumulate interest during the following years of training, so that in the end, some physicians may pay two to three times their original amount with interest over multiple decades [6]. As a result, students with increased debt are more likely to give more value to future salary when picking a specialty and that is why specialists outnumber primary care physicians. A decrease in the cost of medical education would increase the primary care workforce and diversity of physicians.

Medical specialty boards, the agencies that license medical doctors, investigate complaints,and discipline physicians who violate the medical practice act, contribute to the rise in health care costs inthe U.S.Theyarebuilding up substantial assets by charging physicians hefty fees for board certification.The difference in high exam costs varies by the state. In the U.S., doctors are required to pass three sets of national board examinations, before they are licensed to practice. In 2017, the average fee for an initial written examination was $1,846 and $5,600 for initial certification (see https://www.abpsus.org/initial-medical-board-certification-fees).

In contrast to prices on many goods and services, health care prices do not depend only on the type ofmedical services and their quality. Health care prices are hugely different not only between states but also within the same area. According to the 2016 research data, states such as Minnesota and Wisconsin had higher than average prices while others, such as Florida and Maryland, were cheaper overall; Arizona's health care prices were generally cheaper, about 82 percent of the national average, while next door in New Mexico health care was more expensive, about 25 percent above the national average. Some researchers believe the reason of an expensive health care in the U.S. is that almost all health care prices are hidden; this hinders market competition and does not allow patients and their health care providers to make fully informed decisions. Of course, the lack of meaningful readily available price information raises costs.However, because of specifics of health care insurance, the efforts to produce such data are complicated, and the obtained results are not very helpful.

Health insurance companies are active participants of the health care market.They influence health care prices by selling insurances to both health care providers and their patients. Health insurance companies are suppliers of health related services through health providers who, in turn, buy liability insurances, that is, influence the demand of insurance services.On the one hand, higher costs of liability insurance command higher prices for health provider services. On the other hand, to increase the profit many health providers use unnecessary procedures decreasing the profit of insurance companies. Both sides understand these strategies. The existing healthcare prices are the result of a compromise. Moreover, since the healthcare market doesn't function like the markets for other consumer goods, its quality and prices aren't necessarily correlated.

Doctors and others working in the healthcare industry are not free from possible mistakes. Lawsuits are often costly for doctors and other medical practitioners so thatmedical professionals protect their businesses through Medical Professional Liability Insurance. The **average cost** of Medical Professional Liability Insurance is **$7,500 annually.** However, there are many types of doctors and countless insurance variables. Surgeons pay between **$30,000** and **$50,000** a year.Other medical personnel can to pay between **$4,000** and **12,000** a year.The premium differences between liability insurances in different states are significant. For example, according to the American Medical Association report, in some areas of New York, liabilitypremiums for obstetricians/gynecologists reached $214,999 in 2017- while liabilitypremiums for obstetricians/gynecologists in some areas of California were $49,804.The federal government may try to remove such disparity that would reduce medical liability costs. However, it is unlikely to expect that it would influence significantly healthcare costs.

Health liability insurers have a decisive influence on the health market price.Large healthcare liability insurance companies (e.g., The Doctors Company, Medical Liability Mutual Insurance, Princeton Insurance, Nurses Service, **Dentist's Advantage**) have a knowledgeable staff of adjusters. Smaller insurers advertise themselves as creators of specific protector plans, innovative liability insurance programs meeting the insurance needs of dentists, optometrists, and other groups in protecting their practices (e.g., seeThe Dental Professional Liability 2016 Claim Report, Insurancenewsnet.com,and February 22, 2017). Usually, they are used as subcontractors of other insurances.

The healthcare market attracts insurers with a wide line of business (fire, water damage, animals, property damage liability, workers' compensation, etc.).To avoid hiring various adjusters such insurance companies use subcontractors, small insurers offering services in several specific areas.Such a pyramidal insurance structure isa reason of rising liability costs. It may look strange that someinsurance companies without any experience in the healthcare field try to penetrate in the healthcare liability market which is risky for unexperienced participants because the **costs** of adjudicating medical malpractice claims can be very high. The average settlement value for a medical malpractice lawsuit in the U.S. is somewhere between $300,000 to $380,000. The median value of a medical malpractice settlement is $250,000. The average jury verdict in a malpractice case is just over $1 million. But the average payment in a dental malpractice suit is $65,000 (according to Medical Protective, the leading provider of malpractice insurance in the United States), which made the dental liability insurance attractive for insurance companies non specialized in the healthcare field.

The Aspen American Insurance Company (AAIC),a tiny company (15 total employees across all of its locations)that makes a huge profit (annual revenue above $10 million) is an example of such companies.It insures almost all -from dental to fire, water damage, animalsand other indemnities. This is done without having experts in the related fields. As to the dental malpractice insurance, it uses, as a subcontractor, B&B Protector Plans, Inc.

Insurance companies frequently request medical records when evaluating claims. The dental field has its specifics. As a rule, dentists examine a patient and present a treatment plan; theydon't ask previous dental records. This is one of the simplest medical professions, and usually dentists do not require a patient's medical records; some of them have a form with questions a patient should answer. However, it is difficult to believe that companies that deal withanimals, fire and water damages, aerospace, dental and wedding insurances have real experts in all these fields. Blindly copying the procedures of healthcare liability insurance companies, Aspen/B&B require claimants to provide their dental records. Moreover, they require "complete dental records," which nobody has and this requirement isn't in the mentioned above 2016 Claim Report. It looks

like a trick to deny a claim orthe incompetence ofthese insurers.Maybe this is also the negligence of the state insurance administrationsthat allow such companies to operate with such requirements. The law that requires "to treat policyholders and claimants fairly*"* is universal for all states. For example, in Maryland it prohibits actions which are "arbitrary and capricious, lacking in good faith." The AAIC operates in many states and its demand for claimants to present "complete dental records" is illegal since dentists don't require previous dental records and, moreover, states allow dentists to destroy their records after a certain period of time.Since nobody can satisfy this requirement, this allows the AAIC to deny claims. There is a small probability to reach a settlement without an experienced lawyer, so that in most cases the amount of money obtained by a claimant (especially, elderly claimants)isn't enough to pay for the required future dental treatment.

The National Association of Insurance Commissioners (NAIC), the National Council of Insurance Legislators (NCOIL), and the National Association of Insurance and Financial Advisors (NAIFA) are the most influential organizations supervising the functioning of the insurance industry. NAIC forms the national system of state-based insurance regulation in the U.S. to protect American consumers supported by the laws obliging insurers to treat policyholders and claimants fairly. NCOIL is the legislative organization, comprised principally of legislators serving on state insurance that educates state legislators on current and perennial insurance issues. NAIFApromotes professional and ethical conduct among all insurance representatives and financial advisors. The top officials of the mentioned organizations were asked whether the demand of some insurance companies of "complete dental records" is an illegitimate requirement. Unfortunately, all of them refused to answer this question. This has a simple explanation: health insurances are influential companies spending millions in politics and lobbing activity to have favorable conditions for their business.

The above example attracts attention to a serious problem of the insurance industry – the absence of rigorous requirements allowing insurance companies to operate.Traditional specialized insurances (e.g., auto and home insurances, medical liability insurances) demonstrate how insurance company should operate. Only specialized insurances should be allowed to do business in the health care area. It is inadmissible to permit insurance companies to operate in the area where they have no experts - technological, medical and legal. The absence of rigorous requirements brings harm to the healthcare industry. Subcontractors increase liability costs, since both companies try to maximize their profit, and the related healthcare prices. The above example of the AIAA demonstrates the need of new laws and regulations related to the health insurance industry.

Public vs Private

Private medicine in the U.S. is too expensive. Existing channels to maximize physicians' profitare a lure for a possible fraud, which insurance companies would not fight since their profit is the result of a "productive cooperation" with private medicine. Presently it is unrealistic to expect from government any substantial decrease of private health care costs. Health insurance companies give healthy donations to political parties.

Parallel with private medicine there exist also two government-sponsored health insurance programs established in 1965: Medicare that provides health coverage for people who are 65 or older and also for certain younger people with disabilities; Medicaid that provides health coverage for people with a very low income. Funding for Medicare is done through payroll taxes and premiums paid by recipients. Medicaid is funded by the federal government and each state. These programs belong to the so-called entitlement programs that started devouring more and more money from government. According to Gray et al. [7], Medicare will go bankrupt in **2026** and the Social Security Trust Funds for old-aged benefits and disability benefits will become exhausted by **2035.** The U.S. entitlement programs represent about 18.5 percent of GDP. Medicare has had a cash shortfall every year since its creation, except two: 1966 and 1974. Medicare's annual cash shortfall in 2012 was $472 billion. In 2015, it reached $ 546 billion. Medicare now covers nearly 51 million people at a cost of $586 billion. The program is responsible for more than 25 percent of all federal debt since 2000. Medicaid provides health care for 62 million poorer Americans. Its cost was $308 billion in 2012. In 2015, it jumped to $ 446 billion. Medicare and Medicaid already cost now about one trillion per year. For ten years Medicare costs increased by about 80 percent. As to Medicaid, its costs-as a result of a huge influx of new beneficiaries due to the Affordable Care Act (ACA)-reached about 500 billion.

Medicare and Medicaid fraud is the result of inefficient implementation of these programs. It is difficult to evaluate precisely the level of medical fraud. Only in 2011, the government recovered $4.1 billion from health care providers billing for services that never being done: suppliers billing for equipment that never being sent, as well as for services, supplies and equipment obtained by stolen Medicare and Medicaid cards; for misleading diagnostics and unnecessary treatment, etc. With a help of current sophisticated technology, the efficiently managed anti-fraud system can save yearly on average $15–30 billion [8].

In the period of the 2008 financial crisis, instead of focusing on the country's economy the U.S. president spent time fighting for the promised so-called Obamacare to provide with health insurance more than 10 millions of Americans. Health care is the main fiscal problem. Its cost is main reason for our fiscal malaise. As indicated above, the U.S. spends today on health care more than any other developed country in the world (measured as a percentage of GDP or per capita). The U.S. failed affordable health care system is the result of the absence of a rigorous approach to this complex economic problem. President Obama and his surrounding, having no solid knowledge in basic science, made decision based on their ideology without understanding that the establishing an expensive health system in the period of a severe economic crisis is equivalent to suicide.

However, politicians involved in the 2010 Affordable Care Actfound economists who justified the efficiency of the future affordable health care system. They stated that the Act was designed to reduce government spending on health care. Moreover, according to the Congress Budget Office (CBO) analysis, the Affordable Care Act would reduce the debt by $143 billion over first ten years (2010-2019) and by more than $1 trillion in the second decade. But reality proved the opposite. The program costs and will cost (if it is not abolished) the government more $100 billion yearly and was one of the reasons of a slow economic recovery.

Professor Gruber, an MIT economist, the director of the Health care Program at the National Bureau of Economic Research, and an architect of the Affordable Care Act, cynically admitted that the "stupidity of the American voter" and a "lack of transparency" were key to passing the Affordable Care Act. After eleven years of malfunctioning of the current health system, Republicans, who voted unanimously against the ACA, witnessing its deficiencies, could not agree to offer something better since many of them are slaves of their ideology and selves—interests; others are simply unable to think properly.

The Affordable Care Act contributed to dropping uninsured rates by expanding Medicaid coverage and subsidizing health insurance for low and moderate-income individuals. However, access to health insurance is not sufficient if patients cannot afford all needed services because of high premiums and high out-of-pocket costs of many the ACA plans requiring also to pay a lot in premiums for coverage persons don't use.

How to Lower Health Care Costs

The former Soviet Union had universal health care free of charge for all services including dental and vision care. However, to get a service, as a rule, people waited several days, hospitals were overloaded, the quality of service was poor.

The term universal health care applied to the former Soviet Union health care system has a little bit different meaning than the definition provided by the World Health Organization, which means that everyone has equal access to quality health care that improves the health of patients and that seeking such care would not cause financial harm to those receiving it, since a real quality health care had been provided only to a limited group of persons rather than to the whole population.

Most European countries have three types (with some variations) of universal health caresystems: single-payer; socialized; privatized but regulated. In a single-payer system, the government is a health insurance provider, although, in reality, most health care is provided by private entities. In a socialized system, the government usually has control of both health insurance and the providers within the industry. It is essentially the only health insurance provider, and it also runs (and owns) hospitals and employs medical staff. Britain, France, Italy, Norway, Spain, and Sweden use variations of this system. Every citizen is enrolled in the national health care system, and a significant portion of medical services are provided free of charge by doctors who are employed by the government. Those who can afford to pay doctors not employed by the government are allowed to purchase supplemental policies. For example, France has a private system mixed in with the so-called statutory health insurance system. Private health insurance can be purchased as a supplement to the national health care system. In a privatized but regulated system (used in Germany), employed citizens with an income below a certain level are required to be enrolled in the public health insurance option (in Germany, as in France, called statutory health insurance). Those making more than that amount are allowed to bypass the public system to purchase private health insurance (although the vast majority of Germans choose to keep the public option; over 90 percent of the population currently receives health care through this program). In Netherlands and Switzerland, health insurance is not provided by the government. Citizens are required to purchase insurance. But they are free to do that through whatever company they choose. Insurance premiums are partially funded through subsidies provided by the government so that policies are affordable for everyone.

The existing health care systems are funded by tax dollars collected from employers and the public, as well as special funds coming from income taxes and some other sources. The American health care system functions differently than health care in Europe and most health care systems in other world countries. But some of its features have analogs in the existing health care programs. As indicated above, in the U.S. there existtwo government-sponsored programs (Medicare and Medicaid) and supplemental policies can be purchased through private insurers. The 2010 Affordable Care Act was a step to creating universal health system in the United States. Government subsidies enabled to reduce the number of uninsured Americans by 20 million. However, health insurance premiums of many Americans increased.

Without any doubt, all citizens of such a powerful and prosperous country as the United States should have affordable health care (right up to a universal health care system). But it is also obvious that the modification of the U.S. current health system would require a significant amount of money the government lacks. Having a huge debt the country cannot allow itself such a luxury. It was clear not only to economists (excluding those who decide to make money for fuzzy calculations) but any educated person based on common sense.

Any health care program and related health care system depends upon the available funds to support it. It is easy to declare "Medicare-for-all." But is it possible to realize? Unfortunately, politicians ignore such questions. They do not understand or do not want to understand that health care costs are a substantial part of government expenditures. As indicated earlier, total health expenditure per capita in the U.S. is the highest in the world. Any repair costs money. It would be unwise for the country with a high debt to make drastic changes in its health care system.

Trying to copy the government-run health systems existing in many industrialized countries that cost government less money than the public health system in the United StatesSenators Sanders and Warren decided to propose similar systems in the United States under the name a Medicare-for-all. Although according to several studies Senator Sanders' health care plan would increase the federal government health care spending about $33 trillion over 10 years, he stated that his "Medicare for All" proposal would save Americans $2 trillion. Elizabeth Warren declared that her plan would cost more than $20 trillion over the next decade and would not require raising middle class taxes.However, these plans are not supported by rigorous economic estimates.President Biden had openly accused Warren of "fuzzy math" and offered a public option plan—a form of health insurance provided by government that citizens can purchase to pay for their health care; this plan does not prohibit people to buy private insurance. A public option health insurance program would be run by the government but could be implemented just like private health insurance. One option is to require a public insurance to be self-sustaining, that is, the system is funded only by the premiums paid in by those who use that program. Formally, the realization of such a program can be done on the federal or state levels. However, a realistic option is with the premiums subsidized by the government. The most difficult problem is how to subsidize the program to make the health care affordable. Of course, if such government health system would operate as a non-profit organization then private insurance prices would come down. However, the only realistic way of self-sustaining is higher taxes or/and the increased debt, similar to the above indicated proposals of the universal health care.

The Republican Party believes in a patient-centered health care system based on the principles of the free market that would foster competition driving health care costs down. A consumer-driven model for health care works well on paper than in practice, although its practical realization can be a little bit better than under the existing system. All U.S. insurance companies are regulated on a state-by-state basis, so the companies have to be licensed in each state they sell policies in. Insurance markets in the U.S. are different in various states, and health insurance prices depend on state-specific health care laws.The Affordable Care Act created the related health care market to obtain coverage from competing private health care providers. A set of insurance exchanges was created where Americans could enroll in private health plans with varying degrees of subsidy. Despite this market is more transparent than it was earlier, the fact thatduring 5 years the number of participating insurance companies have decreased significantly(if in 2013 there were 395 insurers participating in exchanges, that number was down to 181 for 2018)shows that decisions made basedonly on the market approach cannot bring real positive results.

The main characteristics of health systems of the leading industrial countries should not be ignored by the U.S. policymakers since this information shows how America's existing health care system compares to others.

Since the health system contributes significantly to the country's debt, the solution of the health care problem should start with the admissible amount of money that can be now allocated for health care. This should be the starting point. Policies and alternative variants of their realization should be discussed and developed after this amount is established. Unfortunately, politicians start with policies and then ask an appropriate organization to estimate costs in 10-20 years. Such future estimates are unreliable and misleading; in addition, they ignore the fact that under a proper economic policy in the future more money can be allocated and the health system can be improved.

Formally, the two obvious ways to decrease health care prices (this would increase the number of insured persons) are: reduce liability costs and reduce doctors' salaries. Lower liability insurance costs can reduce health care prices. However, they depend on medical malpractice awards, which are different in various states. A proper legislation concerning malpractice claims could be the first important step to decrease health care prices.

Now only some states have passed laws that place limitations on the amount of money that can be awarded in a successful medical malpractice lawsuit. As indicated earlier, in their attempts to increase profits some insurances,having no health care experts, use subcontractors. Usually, any more complicated insurance structure increases liability costs. That is why liability coverage for health care professionals, insurance that financially protects doctors and other medical workers when courts award patients' financial damages in a medical malpractice lawsuit, should be in hands of insurances specialized in the health care field.

As indicated earlier, the Republican Party believes the patient-centered health care system, which is based on the principles of the free market, will drive health care costs down. Republicans believe that a health care system that is run by the government less efficient; it increases the waiting period within the health care system, which is a component of the health care quality. As we indicated earlier, the traditional free market approach to health care does not work in reality. For example, the average yearly salary of a dentist in the U.S., Germany and the United Kingdom is around $155,000, $108,000, and $75,500, respectively. These prices jumped drastically in the U.S. during last ten years. The members of the state's dental boards and insurance companies, rather than market forces, moved them up. The higher prices motivated students of social sciences departments to specialize in dentistry, and the number of dentists increased. However,the prices dictated by insurances didn't decrease. Instead of decreasing prices some dentists prefer to work less (e.g., four days a week). And the government does not interfere; this would contradict to our capitalist system.

The most efficient societal structures should contain feedforward (regulations, governmental ownership and control) and feedback (market economy) channels [9]. The United States health care system is a complex mix of public (government controlled) and private programs (market economy). Most Americans with health care insurance have an employer-sponsored plan. But the federal government insures the poor (Medicaid) and elderly (Medicare) as well as veterans, federal employees and Congressmen. State-run programs insure other public employees. Both types of public and private health care systems have positive and negative features. The reduction of healthcare prices should be a part of the government economic policy. Such policy should include measures to limit profits of health care insurance companies. The obvious solution is to use government as a competitive insurer with zero profit or less than of the existing insurance companies. The earlier mentioned option health insurance programs, to be self-sustaining, cannot be implemented without doctors who are ready to accept lower salaries. Under the current situation, when the government is unable to invest additional money in the health care system and doctors would not agree to work for less money than they can get under the current system, such programs are not realizable. However, as a step to decreasing health care prices, the states with a help of the federal government can create integrated managed care consortiums, similar to Kaiser Permanente, where doctors' salaries are lower than private practice doctors, with a low profit to compensate in the future an initial investment. Not every doctor wishes to run own business understanding the related additional load and liability; many doctors prefer to work for a smaller amount of money. A state can use its public universities to create programs for future physicians without tuition fees with their obligation to work in its managed care consortiums (one or several depending on the available investment) for a certain period of time. Such market approach should decrease health care prices in the private sector, and this can be a road to extend it in the future.

Politicians like to talk about health care of equal quality for all population. Unfortunately, this had never been in the past, and it is unrealistically to expect in the future. Now rich persons, members of the U.S. Congress, and federal government employees have better health insurance than many retirees. Not all doctors accept patients with Medicare or Medicate, since these insurances are not good sources of revenue. For the same reason, old Americans should wait at least a week for office-based medical appointments. That is why the described above possible way to improve the existing health care system can be efficient. Many people, especially young, do not need the highest quality physicians to treat them, and they can wait a week to get appointment. If the country has 8.8 percent of people without health insurance coverage and the insurance prices are high, the compromised approach is more realistic that empty proposals of politicians.

The country with the 27 trillion national debt, which exceeds its GDP, and with spending on health care almost 18 percent of its GDP cannot spend on health care more. The United States economic health does not allow doing that.

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