

Health Care for All Reality Check

Universal protection without unlimited promises or a monopoly on care



Health care, public responsibility and evidence. Conceptual editorial illustration.

Universal health coverage aims to make necessary care affordable and available. Patients also want a meaningful choice of providers. This investigation examines how five countries pursue those goals, what their systems cost and what the United States could learn from them. The evidence supports considering a universal core of financial protection with public, nonprofit and independent providers. Its success depends on sustainable financing, sufficient capacity and clear accountability for patient outcomes.

THE ARGUMENT

What universal coverage promises and what it costs

Imagine the offer. No insurance premium. No frightening bill after surgery. No loss of coverage when a job disappears. The doctor you need, when you need one, paid by a government whose resources never run out.

That is an appealing prospect.

The unlimited-budget assumption is the problem. Public financing can reduce or eliminate a patient's bill at the point of care, but staff, facilities and training still have to be paid for. The practical question is how to finance those costs while ensuring that patients can obtain treatment.

Advocates of universal coverage generally recognize those costs. The public discussion should give the financing, service limits and trade-offs as much attention as the proposed benefits.

The need for financial protection is clear. A child may need treatment for a congenital illness, and a working family can face medical expenses beyond its resources. Insurance spreads those risks rather than leaving each household to meet them alone.

Financial protection also requires reliable funding and effective administration. Waste reduces the resources available for care, while commitments that exceed capacity can leave patients waiting. Access and fiscal accountability need to be evaluated together.

The experience of countries with universal coverage provides a useful starting point.

FOLLOWING THE FUNDING

Following the money across five countries

The OECD's comparable 2024 figures put annual health spending per person at \$6,747 in the United Kingdom, \$7,301 in Canada, \$9,365 in Germany, \$8,436 in the Netherlands and \$7,469 in Australia. Their respective shares of GDP were 11.1%, 11.3%, 12.3%, 10.0% and 10.3%. The corresponding US figures were \$14,885 and 17.2%. These are total current health expenditures in purchasing-power-adjusted dollars, using provisional or estimated 2024 data. They are not government-only budgets or personal tax bills. [1]

The money takes different routes. General taxation finances some systems; compulsory insurance contributions and household premiums finance others. Employers also pay, although a payment appearing on an employer's ledger remains part of the economic cost of employing people. Its burden can affect wages, prices and profits. Patients may pay for exclusions, deductibles or charges above the covered amount. Providers encounter the budget through fees, contracts and limits on revenue.

This is why a country's overall tax rate tells us little by itself about the price of its health guarantee. The proper account includes taxes, premiums and out-of-pocket spending, together with what the patient actually receives. If a tax replaces a premium, we should compare the two rather than count both as new costs. The relevant comparison is the household's combined burden before and after the change.

A historical financing exercise shows the scale of the shift. In October 2019, the Committee for a Responsible Federal Budget modeled roughly \$30 trillion in additional federal costs over ten years for Medicare for All. Its preliminary alternatives included a new 32% payroll tax or a 25% surtax on adjusted gross income above the standard deduction. These were separate illustrative options, not taxes to be added together, enacted policy or a current forecast. The archived analysis is explicitly outdated. Its continuing relevance is the need to specify broad financing when private health spending moves onto the federal budget. [21]

That comparison must also account for premiums and out-of-pocket payments that the new system would replace. A large tax increase does not necessarily mean an equally large increase in total household health costs. The proposal must show who pays more, who pays less and whether its revenue remains adequate as enrollment and treatment costs change.

COUNTRY INVESTIGATIONS

Three ways to make a guarantee

United Kingdom

The UK's four devolved health systems rely chiefly on general taxation. The NHS provides broad coverage and substantial protection against major medical bills. England also allows eligible patients to choose qualifying providers for certain referrals, including independent hospitals contracted by the NHS. Public financing already purchases care beyond public ownership. Charges remain for some prescriptions, dentistry and other services, with exemptions; the rules differ across the UK's nations. [2]

The pressure point is capacity. The European Observatory describes growing planned-care waits, difficulties obtaining primary care and infrastructure constraints after funding restraint. Available staff and facilities determine how much care can be delivered. Contracting additional providers may help, but workforce expansion takes time. Britain combines strong financial protection with persistent problems obtaining timely care. [2]

Canada

Canada's provinces and territories administer tax-financed insurance with federal support. Medically necessary hospital and physician services form the core guarantee, without patient charges. Outpatient prescriptions, routine dentistry and vision care are not automatically covered in full by that core; additional programs and private insurance cover parts of the remainder. Many doctors operate as independent contractors. Public administration of insurance does not require public ownership of the doctor's practice. [3]

Covered hospital care offers an important defense against financial catastrophe. Availability is less reassuring. Statistics Canada reported that 82.8% of adults had access to a regular health-care provider in 2023, down from 85.8% in 2022. Canada provides broad insurance protection, but eligibility for coverage does not ensure that a provider is available. [3]

Germany

Germany requires health insurance, generally through statutory sickness funds, with substitutive private insurance available to eligible groups. Income-related contributions, normally shared by employees and employers, finance statutory coverage alongside federal support. The standard contribution is 14.6%; the official 2026 average supplementary-rate benchmark is another 2.9 percentage points, although actual fund rates vary. Income ceilings apply, and qualifying dependents can receive coverage without a separate contribution. [4]

Patients generally enjoy broad physician choice. Outpatient doctors are predominantly private practitioners, and hospitals have public, nonprofit and for-profit owners. Universal coverage and independent medical practice already operate together in this system. It is also expensive: Germany spent 12.3% of GDP on health in the comparable 2024 figures. Copayments remain, and fragmented responsibilities complicate coordination between hospital and outpatient care. Broad protection and provider choice coexist with significant cost and coordination problems. [1,4]

COUNTRY INVESTIGATIONS

What choice can and cannot buy

Netherlands

The Dutch require residents to obtain a standard package from regulated private insurers. Those insurers must accept applicants and cannot price the same policy differently because of age or health. Premiums, income-related contributions and public support finance the guarantee, with assistance for lower incomes. General practitioners usually coordinate specialist access. [5]

Adults generally face a €385 mandatory annual deductible, with GP visits exempt; other copayments can apply. Provider networks can limit reimbursement outside participating providers. Supplementary coverage buys services outside the basic package. Competition operates within rules that protect the common guarantee. [5]

The results merit attention. OECD-reported 2024 surveys found 0.6% reporting unmet medical-care needs because of cost, distance or waiting times, and 83% satisfied with the availability of quality care. These are separate measures of reported experience, not proof that every need is met. Mental-health access and workforce shortages remain concerns. The Dutch system demonstrates that universal coverage can operate through regulated private insurers and providers. [5]

Australia

Australia combines Medicare with optional private insurance. Public patients receive free public-hospital care, while outpatient bills can leave a gap unless the provider bulk-bills. Most taxpayers pay a 2% Medicare levy, but general taxation supplies additional money. The levy is one funding stream, not the full cost of the system. Private hospital cover can offer doctor choice while still leaving patients with charges. [6]

Waiting times remain a concern. Among patients admitted from public elective-surgery waiting lists in 2024-25, the median wait was 45 days and 6% waited more than a year. Those clocks start with placement on the ready-for-surgery list, not the first GP referral. Research in Victoria found that additional private coverage had only a small practical effect on public waiting times. The useful distinction is between adding financing and adding capacity. [6,14]

FINANCING AND REFORM

America already pays an extraordinary bill

The United States begins from a position of high spending. On the OECD comparison, the United States spends far more per person than any of these five countries. Yet the Census Bureau reported 26.7 million people, or 7.9%, uninsured throughout 2025. High national expenditure has not produced universal insurance coverage. [1,15]

Government is already deeply involved. America operates Medicare, jointly funds Medicaid with the states, subsidizes private insurance and supports employer coverage through tax policy. CMS recorded \$5.3 trillion in national health spending in 2024, or 18.0% of GDP, with federal, state and local governments together sponsoring 47%. CMS uses a different domestic accounting measure from the OECD comparison; the two percentages should not be treated as competing estimates of an identical total. [7]

Any American reform must work through institutions that already employ people, treat patients and depend on existing revenues. A federal coverage promise would meet state Medicaid programs, employer plans and providers with different obligations and financial positions. Canada, Germany and Australia also divide responsibilities across levels of government. The task is to settle who pays, who decides and who answers for failure.

Provider payments are central. Lower fees can save money, but reductions that drive doctors away or destabilize essential hospitals defeat the purpose. Extending a guarantee while paying every existing market price could overwhelm its budget. A credible proposal therefore needs actual payment rules, rural safeguards and a transition, not a savings estimate with the difficult decisions omitted. [8]

The distinction between public spending and total spending is equally important. In five illustrative single-payer designs published in 2020, CBO estimated that federal health subsidies in 2030 would rise by \$1.5 trillion to \$3.0 trillion against its then-current-law baseline. Total national health spending ranged from \$0.7 trillion lower to \$0.3 trillion higher. Lower provider prices and administration could save money; greater use of care could increase it. These historical scenarios are not a current score of a particular bill. [8]

A larger federal budget can therefore coexist with a smaller national health bill when taxes replace premiums and other payments. Whether that is a good bargain depends on the total, the distribution and the care delivered. Families deserve to see what disappears from their existing bills as clearly as what appears on their tax returns.

THE FISCAL STARTING POINT

The budget is already spoken for

Any federal health reform must account for existing commitments to retirement benefits, medical care, national defense and debt service. These obligations limit the budget available for additional programs and make the financing of a permanent expansion especially important.

CBO's fiscal 2025 actual-spending breakdown provides a consistent accounting year. Of \$7.010 trillion in federal outlays, mandatory programs accounted for 59.4%, discretionary appropriations for 26.7%, and net interest for 13.8%. These categories describe how spending is authorized: permanent benefit laws, annual appropriations and debt service. Mandatory does not mean Congress is powerless to change the law. It means the spending does not ordinarily wait for a fresh annual appropriation. [16]

Social Security pays retirement, survivor and disability benefits. Medicare primarily serves older Americans and certain younger people with disabilities; Medicaid covers eligible low-income and other qualifying groups through joint federal-state financing.

The largest program was Social Security at \$1,575 billion, or 22.5% of outlays. Net Medicare cost \$988 billion, or 14.1%; federal Medicaid, \$668 billion, or 9.5%; and other mandatory programs, \$936 billion, or 13.4%. Defense discretionary spending was \$893 billion, or 12.7%, and nondefense discretionary spending \$980 billion, or 14.0%. Net interest claimed \$970 billion, or 13.8%. Amounts are rounded and shares use the same federal total; state Medicaid spending is excluded. [16]

Social Security, Medicare and Medicaid together consumed 46.1%, not a majority by themselves. Medicare and Medicaid accounted for 23.6%. Within other mandatory spending, \$397 billion supported income security, including food assistance, unemployment benefits and refundable tax credits. Adding that distinct category brings the combined share to 51.8%. Housing assistance also receives discretionary funding, so the safety net cannot simply be placed in one mandatory-spending box. [16]

Dedicated payroll taxes finance substantial Social Security and Medicare spending. These outlay shares therefore are not a measure of unfunded promises. Nor does the Medicare figure mean its payroll-tax receipts have been subtracted; its net presentation deducts premiums and other offsetting receipts. Using consistent definitions makes the financing choices easier to assess. [16]

The budget constraint is substantial. Mandatory spending and net interest together absorbed about 73.3% of outlays before the annual contest over most defense and domestic appropriations. A permanent health expansion needs a durable funding source rather than an unspecified reduction in future discretionary spending. Reform must specify its revenue, the spending it replaces and the efficiencies it can actually deliver. The financing plan should be explicit before new commitments are made.

FISCAL INVESTIGATION

The debt behind the promise

Existing debt increases the financing challenge. CBO's February 2026 baseline projected debt held by the public at 101% of GDP in fiscal 2026 and 120% in 2036. Its October estimate put the completed fiscal 2026 deficit at about \$2.0 trillion, with annual net interest exceeding \$1 trillion. The debt ratios are projections, and public-held debt differs from gross federal debt, which includes intragovernmental holdings. [9]

Interest pays for past borrowing and competes with current spending priorities. Financing a permanent health expansion through continuing deficits would add to future debt-service costs.

The existing health system also faces rising costs. CMS's June 2026 outlook projected national health spending at 20.6% of GDP by 2034. Maintaining current policy would not hold spending constant. The responsible comparison is the net cost of a specified reform, including new revenue, displaced spending, credible savings and the transition. [7]

Medicare provides a concrete warning. Its 2026 trustees projected depletion of Part A hospital-insurance reserves in the second quarter of 2033, after which continuing income would cover 89% of scheduled benefits. Parts B and D adjust premiums and federal contributions through their financing mechanisms. A reserve shortfall does not mean all Medicare disappears; it means taxpayers, beneficiaries and policymakers face an obligation they have not fully financed. [10]

Financial pressure can appear as longer waits, lower provider payments, higher contributions or narrower benefits. These are important measures of sustainability. Debt constrains the available options, but it does not by itself establish whether a particular universal-coverage design is feasible.

FRAUD AND PAYMENT CONTROLS

Fraud, improper payments and verified losses

Fraud diverts resources from legitimate care and can disrupt patients' treatment. Effective oversight should protect both public funds and access to services.

CMS estimated \$28.83 billion in Medicare fee-for-service improper payments and \$37.39 billion in Medicaid improper payments in fiscal 2025 reporting. These are not fraud estimates. They include documentation failures, administrative errors and underpayments as well as overpayments. CMS attributed 77.17% of Medicaid improper payments to insufficient documentation, generally not indicative of fraud or abuse; Medicaid's estimates draw on rolling state-review cycles. [11]

Criminal cases provide a separate measure of documented misconduct. In June 2026, the Justice Department reported a conviction in the HealthSplash and DMERx case involving more than \$1 billion in false billings. Medicare had paid more than \$450 million. Both figures matter, but they measure different things. A bill submitted is not necessarily a dollar stolen, just as a charge is not a conviction and a recovery is not an annual loss estimate. [12]

The answer is disciplined administration: verify providers, examine suspicious claims, audit intelligently and impose credible penalties, while preserving appeals for legitimate care. Public and private payment systems both need these defenses. Fraud prevention belongs inside the design of reform, rather than appearing afterward as a promise to find the missing money. Savings estimates should be supported by evidence and should avoid double counting.

ACTIONS AND OUTCOMES

The administration's work to lower health care costs and improve quality

The current administration is pursuing fraud enforcement, payment reforms and greater price transparency to reduce unnecessary spending and improve access to care. The following measures show what has been implemented, what money has been collected or protected, and where benefits remain projected. Their effect on quality must be assessed through patient outcomes, not assumed from lower spending.

The administration's enforcement record includes nationwide investigations and payment reviews. The June 2026 national health-care fraud takedown charged 455 defendants in schemes involving more than \$6.5 billion in alleged false claims; authorities reported seizing more than \$182 million in assets. Allegations and seizures are distinct from convictions and final recoveries. A more useful collection measure appears in CMS's January–June 2026 program-integrity dashboard: \$1.8 billion in overpayments identified through medical review and \$378 million collected through post-payment review. Overpayments themselves need not involve criminal fraud. The figures measure different activities and should not be added together. [17]

Coordination between Medicare programs is another area of enforcement. In September 2026 CMS barred 11 medical-equipment suppliers from future Medicare Advantage and Part D payments, citing \$3.4 billion in suspected billing. Four had already lost Original Medicare billing privileges before turning to Medicare Advantage. CMS separately described nearly \$24 million in claims stopped before payment. The stopped claims represent prevention; the \$3.4 billion figure is suspected billing, not cash recovered. Stronger screening and cross-program information can protect money without first taking a benefit away from an eligible patient. [17]

Enforcement has also involved large health-care organizations. Kaiser affiliates agreed in January 2026 to pay \$556 million to resolve allegations concerning unsupported Medicare Advantage diagnosis codes, without a determination of liability. The federal complaint had been filed in 2021 over earlier conduct. The settlement was reached under the current administration following a case initiated before it took office. [17]

CHOICE AND COST CONTROL

From enforcement to patient choice

On patient choice, new tax rules effective January 1, 2026 made qualifying bronze and catastrophic plans compatible with health savings accounts and expanded access to qualifying direct-primary-care arrangements. Congress supplied the legal changes; implementation makes them usable. These options may help people purchase care from independent practices, but a tax-advantaged account does little for someone who cannot afford to fund it, and direct primary care does not cover the full risk of serious illness. [18,19]

The administration has also changed payment and disclosure rules. CMS's 2026 outpatient rule extended site-neutral drug-administration payment in specified off-campus hospital departments, projecting \$290 million in annual savings: \$220 million for Medicare and \$70 million in beneficiary coinsurance. Those are projected savings, not an audited result. Hospital price-transparency changes effective in 2026, with enforcement beginning April 1, added disclosures including median and percentile allowed amounts. Publishing better prices may aid purchasing; it does not ensure that a patient has a competing provider nearby or that the bill will fall. [18]

These measures address deceptive billing, uneven payment rules, price information and patient options. Their effects should be tracked through sustained collections, treatment quality, patient costs and access. Demonstrated fraud savings can support existing services, but they do not establish a sufficient funding source for universal coverage.

THE CONGRESSIONAL RECORD

Congressional legislation and oversight

Congress determines statutory benefits, financing and many of the rules governing federal health programs. Hearings provide a public record of implementation problems and proposed changes. Legislative status and testimony should be distinguished from enacted policy and measured results.

Public Law 119-21, enacted July 4, 2025, illustrates both opportunity and tradeoff. Its direct-primary-care provision allows qualifying arrangements to coexist with health savings account eligibility from January 1, 2026, and permits HSA payment of qualifying fees. The statutory monthly limits are \$150 for an individual and \$300 for arrangements covering more than one person, with later inflation adjustments. That gives some patients another route to an independent primary-care practice. It does not turn a primary-care subscription into hospital insurance. [19]

The same law also illustrates why lower federal spending must not automatically be called efficiency. CRS reports CBO's estimate that its health provisions would reduce federal outlays by \$1.1 trillion over fiscal 2025–2034 while increasing the uninsured population by 10 million in 2034 against the January 2025 baseline. Medicaid provisions account for an estimated \$989.7 billion reduction and 7.5 million additional uninsured people. These are projected effects, not measured fraud recoveries. The fiscal assessment must distinguish reduced waste from reduced eligibility or coverage. [19]

Other proposals remain proposals. H.R. 9393, the Lower Costs, More Transparency Act of 2026, was introduced June 23, 2026, and advanced as amended from committee on July 21 by a 45–0 vote. Its introduced text addresses hospital prices, consumer information, accuracy and enforcement. Those objectives deserve examination, but a committee action is not an enacted national guarantee, and the introduced text should not be confused with every subsequent amendment. [19]

Congressional hearings have examined alternative purchasing and delivery arrangements. At the Senate Aging Committee's October 22, 2025 hearing on shoppable services, Oklahoma surgeon G. Keith Smith described bundled cash prices at an independent surgery center. CalPERS health director Don Moulds discussed reference pricing by a public purchaser. Jeanne Lambrew cautioned that people still need insurance against illness and injury. These were witnesses describing approaches and risks, not a controlled demonstration that one model solves the national problem. Their testimony identifies options for public purchasers and independent providers that warrant further evaluation. [20]

Other hearings have examined program-integrity weaknesses. GAO's December 10, 2025 House testimony reported subsidized Marketplace coverage for 18 of 20 fictitious applicants in a preliminary covert test. That exposes control weaknesses; the non-generalizable test does not establish a fraud rate for actual enrollees. At the April 21, 2026 Ways and Means Medicare-fraud hearing, hospice association leader Sheila Clark described bogus hospice elections that could obstruct legitimate treatment, urging stronger verification and prompt restoration of benefits. These accounts support evaluating fraud controls alongside their effects on legitimate coverage and treatment. [20]

FEDERAL AND STATE RESPONSIBILITIES

State budgets and the costs that remain

Federal health policy also changes state financing decisions. California offers examples of both higher-than-expected expansion costs and the choices that follow a withdrawal of federal support. These are separate issues, affecting different groups, and should not be combined into a single estimate of immigration costs.

In its October 24, 2025 analysis, California's Legislative Analyst's Office estimated that Medi-Cal's comprehensive-coverage expansions for undocumented residents cost about \$10 billion annually from the state General Fund, more than twice the initial estimates. Higher enrollment and greater service use contributed to the difference. This is a dated estimate of gross program spending, not a calculation of immigration's net fiscal or economic effects. It demonstrates why expansion budgets need realistic enrollment and utilization assumptions, with reserves or contingency plans when those assumptions prove too low. [22]

A different population appears in the LAO's October 19, 2026 spending-plan analysis. Federal changes eliminated comprehensive Medicaid funding for certain qualified noncitizens, including refugees and asylees. California provided an estimated \$365 million in General Fund support in fiscal 2026–27 to maintain comprehensive coverage through June 2027 for roughly 150,000 affected people. These groups should not be described as unauthorized immigrants. From July 2027, the planned transition to emergency and pregnancy-related coverage avoids an estimated \$980 million in ongoing annual General Fund costs that continued comprehensive coverage would require. Federal savings therefore can leave states choosing between replacement funding and narrower benefits. [23]

Emergency treatment remains a separate obligation. Under EMTALA, Medicare-participating hospital emergency departments must provide an appropriate screening examination and, when an emergency condition is found, stabilizing treatment or an appropriate transfer, regardless of ability to pay or citizenship status. This does not guarantee free treatment or comprehensive ongoing insurance. Reducing coverage eligibility does not eliminate the need to finance emergency services; it changes which coverage, patient payments or other resources are available to meet those costs. [24]

For Congress and the administration, the relevant test extends beyond federal savings. The assessment should also track state spending, remaining hospital obligations, patient access and the total cost of care. Otherwise, a reduction on one budget can be mistaken for a reduction in the resources the health system needs.

THE CASE FOR REFORM

The patient's guarantee should travel with the patient

A practical mixed model would combine a defined coverage guarantee with a choice among qualified providers.

Every patient should have a defined, affordable entitlement to necessary care. Qualified public, nonprofit and independent providers should be able to compete to deliver it under enforceable standards. The patient's choice of an independent doctor need not require a second insurance policy or an ability to pay extra. Several of the countries examined here already demonstrate that separation between who finances care and who provides it.

There is evidence that purchasing additional capacity can help. An Institute for Fiscal Studies study of independent hospital entry into England's publicly financed hip-replacement market found expanded publicly funded admissions and shorter waits. It did not find a reduction in admissions at incumbent public hospitals or evidence of a readmission benefit. Its main lesson was expanded provision, including earlier treatment of less-severe patients, rather than a wholesale competitive transformation. [13]

For the patient, real choice can mean continuity with a trusted doctor or somewhere else to turn when a service fails. For the economy, effective treatment can reduce avoidable disruption to work, while portable coverage can make changing jobs less hazardous. The gain comes from better access to useful care. Those benefits depend on effective care, not provider ownership alone.

The safeguards are practical. Payment must recognize the cost of complex patients, or providers will be rewarded for avoiding them. Essential rural and emergency services need protection. Patients need intelligible information about waits and outcomes, help exercising their choices and protection from unaffordable charges for the guaranteed package. Competition policy must address local monopolies, and contracts must enforce quality rather than reward volume alone.

We must also ask whether a new provider adds staff and treatment capacity or merely hires the same scarce nurses away from the public hospital. Shorter private waits should be evaluated alongside any changes in public access. Supplementary insurance may purchase additional services, but it cannot become an excuse for neglecting the universal core.

THE TESTS THAT MATTER

What the investigation must test next

Any proposal should answer a clear set of questions. What exactly is guaranteed? Which taxes, premiums and out-of-pocket payments will change for different households? What will participating providers be paid, and will essential services remain viable? How much capacity will be added, and what remedy will a patient have when treatment is delayed?

The evidence to watch is equally concrete: waiting times across the whole care pathway, access for poorer and rural patients, outcomes adjusted for patient complexity, household financial exposure, total spending and verified fraud losses. An improvement in an insurance enrollment figure is welcome. It is not sufficient evidence that people can obtain care.

Building a health-care system capable of expanding good coverage requires more than a larger spending commitment. A productive, growing economy strengthens the resources available to finance care, while better technology, effective prevention and more efficient delivery can help clinicians serve more patients without sacrificing quality. Those gains need a disciplined system of integrity: clear eligibility rules, accurate verification, early fraud detection and enforceable standards for providers and payers. Qualified patients must also have a practical way to correct administrative mistakes. The current administration's work at CMS and HHS addresses important parts of this foundation through payment reform, prevention, transparency and stronger oversight. The opportunity is to turn those changes into sustainable capacity for better care. Success must ultimately be demonstrated through verified savings, improved access and outcomes, and a manageable burden on households and taxpayers. [17,18,25]

The United States has options for expanding financial protection while preserving independent practice and patient choice. A workable approach would define the covered services, fund them sustainably and hold participating providers accountable for timely, effective care. The strongest case for reform will rest on better patient outcomes and a manageable total cost, with results reported openly as implementation proceeds.

Research approach

This investigation synthesizes official statistics, national system descriptions and published research. International spending uses OECD 2024 current health expenditure; US CMS totals use a different domestic accounting framework. Reporting years and projections are identified in the text and source notes. Policy conclusions are analysis, not a causal ranking of ownership models.

Project, Research, Analysis, Editorial by Patrick Russell; assisted by OpenAI, Anthropic, Gemini, Grok, Perplexity.

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Sources and reporting notes

Research cutoff October 20, 2026. Reporting years differ by source. Projections and historical modeling are identified in the article.

[1] Comparable national health spending

OECD, Health at a Glance 2025, Table 1.6 and methodological notes. 2024 current health expenditure; provisional or estimated, adjusted for purchasing power. Not directly interchangeable with CMS National Health Expenditures.

[OECD country dashboard and Table 1.6](#) · [OECD per capita expenditure methodology](#)

[2] United Kingdom financing and access

European Observatory, Health Systems in Action 2024; NHS England patient choice guidance; NHS guidance on patient charges. England-specific choice and charging rules are identified in the text.

[United Kingdom health system review](#) · [NHS England patient choice guidance](#) · [NHS charges and exemptions](#)

[3] Canada coverage and access

Health Canada explains the public insurance guarantee and private delivery. Statistics Canada's 2024 report provides the 2022 and 2023 regular-provider measures.

[How publicly funded coverage works](#) · [Canada health care system](#) · [Statistics Canada access to care](#)

[4] Germany insurance and provider structure

German Federal Ministry of Health contribution rules; European Observatory, Germany Health System Summary 2024. Fund-specific supplementary contributions vary; the 14.6% base is not the complete contribution.

[Statutory health insurance contributions](#) · [Germany health system summary](#)

[5] Netherlands regulated insurance

Dutch government standard-package and cost-sharing guidance; European Observatory, Netherlands Health System Summary 2024. OECD 2025 Table 1.4 reports 2024 Gallup satisfaction and EU-SILC unmet-need indicators.

[Standard health insurance](#) · [Dutch health insurance questions and answers](#) · [Netherlands health system summary](#) · [OECD Netherlands country note 2025](#) · [OECD Table 1.4 survey indicators and years](#)

[6] Australia financing and waiting times

Australian government Medicare and private-insurance guidance; AIHW public elective-surgery statistics for 2024-25. Waiting-time statistics describe admitted patients from ready-for-surgery lists.

[Medicare costs and funding](#) · [Medicare coverage](#) · [Private insurance out of pocket costs](#) · [AIHW elective surgery waiting times](#)

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Sources and reporting notes continued

[7] US health spending and projected growth

CMS actual National Health Expenditures for calendar 2024 and June 2026 projections through 2034. Sponsorship and insurance payment categories are distinct.

[CMS National Health Expenditure fact sheet](#) · [CMS 2025-2034 projections summary](#)

[8] US reform costs and transition

CBO, December 2020 illustrative single-payer scenarios for 2030, compared with then-current law; CBO, May 2019 design and transition considerations. Historical modeling, not a 2026 score of proposed legislation.

[CBO illustrative single payer systems](#) · [CBO key design components and considerations](#)

[9] Federal debt and deficit

CBO February 2026 baseline public-debt projections and October 2026 Monthly Budget Review estimate of the completed fiscal-year deficit. Forecasts are distinguished from preliminary fiscal-year results.

[CBO budget and economic outlook](#) · [CBO October 2026 Monthly Budget Review](#)

[10] Medicare financing outlook

2026 Medicare Trustees Report, released June 9, 2026. Part A reserve depletion differs from exhaustion of continuing revenue or termination of Medicare.

[2026 Medicare Trustees Report](#)

[11] Improper payments are not a fraud estimate

CMS Fiscal Year 2025 Improper Payments Fact Sheet, January 15, 2026. Medicaid measures incorporate rolling state-review cycles and documentation deficiencies.

[CMS fiscal 2025 improper payment estimates](#)

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Sources and reporting notes continued

[12] A proven fraud case and actual payments

US Department of Justice, June 4, 2026. The HealthSplash and DMERx case distinguishes more than \$1 billion in false billings from more than \$450 million paid by Medicare.

Justice Department trial convictions report

[13] Independent capacity within public financing

Elaine Kelly and George Stoye, The Impacts of Private Hospital Entry on the Public Market for Elective Care in England, IFS Working Paper W20/01, 2020. Evidence concerns hip replacements, not all care or all ownership models.

IFS study of private hospital entry

[14] Private insurance and Australian public queues

Ou Yang, Jongsay Yong and Yuting Zhang, Health Economics 33(6), 1192-1210, 2024. Study of Victoria, 2014-2018; additional private coverage produced a small estimated effect on public waiting times.

Peer reviewed study and abstract

[15] US uninsured population

US Census Bureau, Health Insurance Coverage in the United States 2025, published September 15, 2026. The uninsured estimate means no coverage throughout the calendar year.

Census report on 2025 health coverage

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Sources and reporting notes continued

[16] The federal budget in fiscal 2025

CBO, March 2026 infographics reporting fiscal 2025 actual outlays. Shares calculated from \$7,010 billion; amounts rounded. Mandatory income security is a subset of other mandatory spending. Federal Medicaid excludes state outlays; Medicare is net of premiums and other offsetting receipts.

[Total federal budget](#) · [Mandatory spending](#) · [Discretionary spending](#)

[17] Trump administration enforcement and collections

DOJ and CMS records distinguish allegations, seizures, identified overpayments, collections and stopped claims. Kaiser settlement resolved allegations without a determination of liability; the federal complaint preceded the current administration. These amounts are not summed.

[June 2026 national takedown](#) · [CMS January–June 2026 dashboard](#) · [September 2026 supplier action](#) · [Kaiser January 2026 settlement](#)

[18] HSA choice, site-neutral payments and price disclosure

IRS guidance implements 2025 legislation. CMS 2026 outpatient payment and hospital price-transparency rules: savings are projected, not measured results, and disclosure does not guarantee lower prices.

[IRS HSA guidance](#) · [2026 outpatient payment final rule](#) · [Hospital price-transparency changes](#)

REFERENCE LEDGER

Sources and reporting notes continued

[19] Congressional legislation and coverage tradeoffs

Public Law 119-21 enacted July 4, 2025. CRS explains direct-primary-care provisions and CBO's projected fiscal and coverage effects. H.R.9393 introduced June 23, 2026 and advanced as amended from committee July 21, 2026; it is not described here as enacted law.

[CRS: health provisions in Public Law 119-21](#) · [CBO health-insurance estimates](#) · [H.R.9393 introduced text](#) · [Committee advancement July 21, 2026](#)

[20] Congressional hearings and oversight testimony

Senate Aging, October 22, 2025, shoppable-services hearing; GAO House testimony, December 10, 2025, preliminary non-generalizable Marketplace covert test; House Ways and Means, April 21, 2026, Medicare fraud hearing. Witness accounts and recommendations are identified as testimony, not independent national outcome estimates.

[Senate hearing transcript](#) · [GAO Marketplace testimony](#) · [Ways and Means hearing record](#) · [Sheila Clark written testimony](#)

REFERENCE LEDGER

Sources and reporting notes continued

[21] Historical Medicare for All financing alternatives

CRFB preliminary analysis, October 28, 2019, now archived and marked outdated. Separate illustrative alternatives for roughly \$30 trillion in additional federal costs over ten years, not enacted tax rates or a current forecast; replacement of private payments matters.

Archived financing analysis

[22] California expansion cost estimates

California Legislative Analyst's Office, October 24, 2025. Estimated annual General Fund spending on comprehensive Medi-Cal eligibility expansions for undocumented people; gross program cost, not net fiscal effects of immigration.

LAO: changing Medi-Cal fiscal and policy landscape

[23] California's response to federal eligibility changes

LAO, October 19, 2026 enacted spending-plan analysis. Temporary state-funded comprehensive coverage for affected qualified noncitizens, including refugees and asylees; planned July 2027 transition and estimated avoided ongoing costs.

LAO: 2026–27 health spending plan

[24] Emergency screening and stabilization obligations

CMS explanation of EMTALA rights in Medicare-participating hospital emergency departments. Emergency screening, stabilization or appropriate transfer is distinct from free comprehensive insurance coverage.

CMS: emergency-room rights under EMTALA

[25] CMS strategy and eligibility oversight

CMS Innovation Center strategic direction and Medicaid eligibility-verification initiative. Stated policy directions are distinguished from demonstrated savings or outcomes; accurate verification and correction of administrative mistakes remain important.

CMS Innovation Center strategic direction · CMS Medicaid eligibility-verification initiative