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Will the Affordable Care Act turn the United States into Switzerland –

And how good is the Swiss model of health care anyway?

Claudia Chaufan

Claudia Chaufan, MD, PhD*
Associate Professor
University of California, San Francisco
3333 California St. Suite 340
San Francisco, CA 94118
Email address claudia.chaufan@ucsf.edu
Phone number: (415) 889-3226

*The author has no financial conflicts of interest to declare.

Biographic sketch

Claudia Chaufan received her medical degree from the University of Buenos Aires and her doctorate in Sociology from the University of California in Santa Cruz. She is Associate Professor of Health Policy and Sociology at the Institute for Health & Aging in the School of Nursing at the University of California in San Francisco. She teaches, conducts research on, and writes about the political and social determinants of health and health care, the sociology of genomic research, and global / comparative healthcare systems. She is past vice-president of the California chapter of Physicians for a National Health Program.

Abstract

Both supporters and critics of the Patient Protection and Affordable Care Act (ACA) have argued that it is similar to Switzerland's Federal Law on Health Insurance (LAMal), which currently governs Swiss health care, and have either praised or condemned the ACA on the basis of this alleged similarity. I challenge these observers on the grounds that they overlook critical problems with the Swiss model, such as its inequities in access, and critical differences between it and the ACA, such as the roots in, and continuing commitment to, social insurance of the Swiss model. Indeed, the daunting challenge of attempting to impose the tightly regulated model of operation of the Swiss model on mega-corporations like UnitedHealth, WellPoint or Aetna is likely to trigger no less ferocious resistance than a fully public, single-payer system would. I also conclude that the ACA might unravel in ways unintended or even opposed by its designers and supporters, as employers, confronted with ever-rising costs, retreat from sponsoring insurance, and workers react in outrage as they confront the unaffordable underinsurance mandated by the ACA. A new political and ideological landscape may then ensue that finally ushers in a truly National Health Program.

Introduction: The debate

Both supporters and critics of the Patient Protection and Affordable Care Act (ACA), the new federal law regulating health insurance in the United States since March of 2010, have argued that it is similar to Switzerland's Federal Law on Health Insurance (LAMal), the legislation that in 1996 created the current Swiss health care system. Supporters -- generally on the liberal/progressive side of the US political spectrum -- have relied on the apparent similarity between the LAMal and the ACA to condemn its critics -- generally, albeit not always, on the conservative side -- contending that the ACA proposes nothing but a version of Swiss health care, which, they claim, has a demonstrated ability to distribute high-quality health care equitably [1].ⁱ Critics have used the same alleged similarity between the Swiss model and the model proposed by the ACA to argue that the key strength of the latter, i.e., its ability to expand insurance coverage, is in fact a major weakness: by preventing users from having enough "skin in the game," by which they mean a personal stake in minimizing costs as they comparison-shop for health plans, the ACA encourages individuals to abuse the system, thus will lead to increasing already skyrocketing health care costs even further [2].

But while supporters of the ACA view the Swiss model in a positive light and critics regard the Swiss model negatively, both assume a meaningful similarity between the LAMal and the ACA. Indeed, many commentators have portrayed the Swiss system as a route to universal coverage that retains private

insurance – thus is more palatable to Americans who are presumed to shun “government-run health insurance” – and restrains cost increases more effectively than the U.S. approach to financing care [3]. Yet this view overlooks critical problems in the Swiss system and critical dissimilarities between it and the ACA, including : 1) the substantial failings of the Swiss model, especially with regards to access to care; 2) the origins of that system, especially its historical links to the sickness funds in Germany, which excluded for-profit insurers; 3) the daunting challenge of attempting to impose the tightly regulated, essentially nonprofit Swiss insurers’ model of operation on the dominant profit-seeking insurers in the United States – corporations such as UnitedHealth, Aetna, WellPoint and Cigna.

In this article, I elaborate on these three points, as I argue that attempts to constrain, much less eliminate, U.S. health insurers’ profits for medically necessary care, as the Swiss have done, are likely to trigger no less ferocious resistance than a fully public, single-payer system would. The clock cannot be turned back.

Swiss health care: An overview

The Swiss pride themselves of having created a health care system built on the principle of solidarity and equity in access to care that offers high-quality coverage to the entire population – 7.7 million individuals. Switzerland, a federal state made up of 26 cantons, is the fourth richest country within the Organization

for Economic Cooperation and Development [4], following Luxembourg, Norway, and the United States. However, until the mid 1990s, Swiss health care was a mosaic of 26 distinct cantonal health systems [3], and an increasing number of persons were struggling to pay their medical bills – especially women, and individuals of both sexes with pre-existing conditions, whose policies were priced much higher than the average. At the time, 98 percent of the population already had some type of coverage, yet policies included a very unequal range of services, and were purchased from either nonprofit or commercial companies on a voluntary basis [4].

In 1994, the LAMal, which provides the basis for the current national, mandatory health insurance system, was passed. It was fully implemented in 1996. Today, everybody living and working in Switzerland must purchase health insurance -- i.e., comply with an individual mandate -- for a uniform and very comprehensive package of medically necessary services. Individuals from low or middle-income groups by Swiss standards – almost 50 percent of the population – get full or partial subsidies to pay for their health care policies. Insurers are legally obligated to sell policies to everybody at the same price, irrespective of current health status, medical history, gender, or age -- a 25-year-old and an 80-year-old pay insurers the same premium for the same type of policy – with the exception of children up to the age of 18 and young adults between 18 and 24, who pay lower premiums. Further, insurers are forbidden from making profit

from the sale of this basic and mandatory package of services, although they can profit from the sale of supplementary policies that cover services not included in the basic package [4, 5].

It is worth noting that the “basic” package in Switzerland is very comprehensive and includes outpatient care – essentially whatever a doctor prescribes – hospital care, mental health, all pharmaceuticals in the government established “positive list,” some rehabilitation services, some dental care, acupuncture, and some herbal medicine. Insurance in Switzerland is also portable, i.e., not tied to employment status or to a particular job, and all insurers must offer at least one plan that contracts with all physicians, other health practitioners, and medical establishments participating in the system (virtually all health practitioners and medical establishments in the country). When individuals change insurers -- which they don't do very often -- or jobs -- more frequently in current times of economic uncertainty -- they rarely, if ever, need to change their providers [4, 5].

Payments to providers are negotiated between cantonal -- provider and insurer -- associations, and as a result providers within a canton are paid equal amounts for equal services, regardless of which plan the patient has. A system of risk equalization compensates companies that enroll individuals with greater or more expensive medical needs with funds collected by the government from companies that enroll healthier users. All policies sold in Switzerland have a

deductible of Fr.300 (roughly equivalent to \$300) and a maximum out-of-pocket cost (for covered services) of Fr.700. Users can choose to purchase cheaper policies in exchange for higher deductibles (up to Fr 2,500 for adults and Fr 600 for children), also known as “excesses” – a sort of trade-off between cost sharing for the mandated benefits package and the price of that package -- and they can also choose policies that limit access to restricted provider networks, although very few choose the latter [4, 5].

How did the LAMal come into being? A history

Switzerland has a long history of social insurance, i.e., government-sponsored, tax- or payroll-funded compulsory health insurance programs with benefits, eligibility and other aspects defined by statute and explicit provisions that account for participants’ income. Already in 1890 the federal government was given a constitutional mandate to legislate on sickness and accident insurance, and as early as 1899 it attempted to introduce reforms modeled after the German system of statutory health insurance. While this first proposal was rejected by referendum, a final, slightly modified legislation was passed, also by referendum, in 1911. This law required that health insurance funds wishing to take advantage of federal subsidies register with the Federal Office for Social Insurance and abide by its rules, which included the obligation to provide a defined package of benefits and to allow people the freedom to change funds – for

instance, if they changed residence or jobs. The law also limited the difference in rates between men and women to 10 percent. Finally, it prohibited funds from making a profit. The federal government subsidized the funds according to the number of enrollees and left it to the cantons to decide whether insurance was compulsory [4, 5].

However, the financial situation of the funds deteriorated over time, due to a mix of adverse selection -- as the sick flocked towards the funds while the healthier refrained from purchasing coverage until they became sick -- and miscalculations regarding projected demand for services. Throughout the 20th century, several attempts at fundamental system-reform were made yet failed. Ultimately, concerns about rising costs, equity of coverage, and threats to quality of care led to a new Federal Law on Health Insurance (LAMal), which implemented an individual mandate and was adopted after a narrowly passed referendum [4, 5].

Is Swiss health care working for the Swiss? A reality check

While the Swiss express high satisfaction with their system, and most indicators and observers suggest that it provides quality and relatively equitable care, it is not without problems that spring precisely from it being a multi-payer system relying heavily on private financing of health care. Several consequences thus ensue. First, Swiss healthcare is among the most expensive in the world - at

5,270 USD (adjusted for purchasing power parity), Switzerland has the highest level of per capita health care spending after the United States (8233 USD) and Norway (5388 USD) [4]. Further, the multiplicity of insurers generates high administrative costs (as high as 22 percent of each health care dollar) [6].

Second, there is increasing evidence that many individuals living in Switzerland, largely but not exclusively from low-income groups, forgo health care -- up to 14.5 percent in one population-based cross-sectional survey in 2011 - - because they cannot afford either coverage or the growing out-of-pocket costs [4, 7].

Importantly, corporate players, notably health insurers, have lobbied to control increasing health care costs by essentially externalizing these costs onto the shoulders of patients – whether by reducing or eliminating their free choice of doctors and medical establishments by replacing them with restricted provider networks – the so-called “preferred provider” networks of U.S. health insurance plans – or by reducing the generous benefit package that the Swiss expect. These groups, who rely on powerful lobbyists and whose businesses constitute a significant sector of the Swiss economy [8], have sought to deflect attention from the waste that comes from the financial fragmentation of the system and its concomitant administrative overhead, and to confuse the public. Thus when a referendum for a publicly funded single-payer system was introduced by the political center-left back in 2007, Santesuisse, the umbrella organization of Swiss

insurers (functionally equivalent to America's Health Insurance Plans), convinced voters that the new system would be mostly paid for by the middle classes, who, Santeusuisse argued -- based on dubious assumptions -- would experience a substantial rise in premiums. Santeusuisse set up a website which was ostensibly designed to facilitate the public's computation of these speculative increases. Even as proponents of single-payer attempted to neutralize the disinformation campaign with their own numbers, at the time of the vote the damage was already done, and over 70 percent of voters rejected the initiative [9]. U.S. observers may draw a lesson here as to the resistance that will be met by *any* attempt to constrain the profit-seeking behavior of private insurers.

As the single-payer referendum was defeated, prices of premiums and out-of-pocket costs continued to rise, and access to care to deteriorate. Further, despite the relatively sophisticated risk equalization techniques developed by the Swiss, it remains virtually impossible to prevent insurers from cherry-picking "good customers" and to ensure that sicker patients do not end up concentrated within insurers that charge higher premiums. It is noteworthy that although Swiss insurers are prohibited from making profits on the statutory basic coverage, they still strive to enroll healthier customers for that coverage, as these customers will generate profits through the sale of supplementary insurance [4].

In 2012, another referendum attempted yet again to control escalating health care costs via a system of managed care. Had the referendum passed – it

was rejected by over 70 percent of the electorate – the Swiss would have confronted a U.S.-like scenario of “preferred provider” networks constraining their current freedom to seek services from any participating physician or medical establishment in the country [10]. At the time of this writing, a proposal for a publicly funded single-payer health care system is being crafted, and will be put to vote sometime between 2014 and 2015. While it is too early for projections – only about 31 percent of the people surveyed have said they would actually participate in the vote – a poll commissioned by the pharmaceutical lobby group Interpharma found that about 65 percent of the population would approve the single-payer proposal if the vote were taken today [11].

Is the ACA a version of Swiss health care anyway? The bottom line

Yet the question remains, is the ACA a version of Swiss health care - in the words of one liberal observer and supporter, would the ACA, “roughly speaking, turn the United States into Switzerland”? [1]. The short answer is no. But why? Well, for one, the fact that in both systems insurance is chiefly provided by private entities and individuals are mandated to carry a policy does not in and of itself make of the ACA a version of the LAMal. The similarities between the ACA’s regulatory framework and system of private insurance and that of the LAMal, as I will lay out shortly, are very superficial, whereas the

differences in substance are significant enough to invalidate the proposed analogy. (Table 1).

First, Swiss private insurers cannot make a profit from the sale of insurance for medically necessary services. This constraint on the insurance sector in Switzerland sets it apart from the for-profit dominated U.S. system.

Second, all Swiss insurers must offer at least one policy that contracts with all participating providers in the country, even if over time insurers have managed to lure a plurality of the population (36.9 percent) towards restricted provider networks [4], with lower premiums and promises of cost controls, restrictions that likely account for the increasing popular dissatisfaction with private insurers and the outright rejection of the managed care referendum. This obligation to contract with all participating providers stands in contrast with the increasingly constrained list of “preferred providers” prevalent in U.S. commercial policies and even some public programs, as the latter are outsourced to the private sector (e.g. managed care plans currently covering close to two thirds of Medicaid enrollees [12]).

Third, individuals can choose any insurer in their canton, and are not restricted, as they are in the U.S., to those offered by an employer. Nor are they restricted to policies offered in any specific submarket (such as those that will be operational in the so-called health insurance exchanges). In fact, in Switzerland, employers are out of the health insurance equation altogether, and individuals,

regardless of occupation, job or employment status, shop unconstrained in the health insurance market.

Fourth, the Swiss benefit package is uniform and comprehensive throughout the country, i.e., there is a national standard. Thus every policy sold in Switzerland covers the same services, including all medically necessary services, so nobody needs to second-guess which plan will suit their presumed preferences or needs. In contrast, the guidelines set by the U.S. Department of Health and Human Services (HHS) for the range of benefits that health plans must cover, called Essential Benefit Package, are very loose and accommodating (i.e. accommodating *to private insurers*). For instance, the law requires that policies include 10 categories of health benefits, but allows insurers to determine which services they will cover within each category, which is presented to the public as the need for insurers to retain “flexibility” in the type and amount of services covered. Thus under the ACA, unlike under LAMal, there is no national standard, and it is anybody’s guess what services, and in what quantity, the Essential Benefits will include [13].ⁱⁱ

Fifth, the Swiss Federal and Canton governments set the fees received by physicians and the budgets and payments made to hospitals through a process of negotiation and administered prices. Thus providers get paid exactly the same fee for providing the same service, no matter who the patient is or what coverage he or she has, and insurers do not “comparative shop” for prices of hospital services.

This is in stark contrast to the total absence of anything other than private determination of payments in the US private system (other than Medicare, Medicaid and the VA). Private determination of prices leads to price differences that can be described as a perfect instance of the “law of the jungle” – for instance, one standard dose of the cancer drug RITUXIMAB ranging between \$3,000 if the buyer is a major hospital to over \$13,000 if the buyer is an uninsured patient – and that tend to be explained (or rather explained away) as the result of lack of “price transparency” [14]. It also leads to situations where providers are paid differently depending on which coverage their patients have.

It is easy to see how price transparency, however nice-sounding the word “transparency”, is absolutely irrelevant to the dramatically lower prices paid by Europeans and many Asians (e.g. Taiwan) living under various forms of social insurance where powerful purchasers, i.e., national governments, negotiate prices with the healthcare sector on their behalf. It is also easy to see how a system that pays providers different amounts for delivering the same services according to the type of coverage their patients have will provide disincentives to treat certain patients, usually those with lower incomes and greater medical needs [15].

Sixth, the Swiss provide undocumented immigrants with the same right to coverage as anybody else, in stark contrast to the ACA, which leaves at least 12 million immigrants with no coverage, not even allowing them to use their own funds to purchase coverage in the exchanges [16].

Seventh, and as mentioned earlier, LAMal does not discriminate on the basis of age. Thus Swiss insurers are legally obligated to sell policies to individuals of all ages at the same price -- a 25-year-old and an 80-year-old pay insurers the same premium for the same type of policy -- with the exception of children up to the age of 18 and young adults between 18 and 24, who pay lower premiums. In stark contrast, under the ACA premiums charged to older adults can be up to three times those charged to younger adults. In fact, the cut-off points for “younger” or “older” categories are yet to be defined.

Eighth, rather than implementing separate programs for “special populations” (the poor, the elderly, the disabled), the Swiss government includes these groups in the mainstream program and subsidizes them (via a risk-equalization system). Hence in Switzerland the healthy subsidize the sick, the young subsidize the elderly, and the rich subsidize the poor -- which will not be the case with the financially fragmented system upheld by the ACA.

Ninth, nobody goes bankrupt due to medical bills in Switzerland, at least not so far -- even if, as Swiss insurers push towards US style reforms, financial barriers to care are increasing substantially and leading to the current discontent with the system. In contrast, there is good reason to believe that the ACA will only exacerbate the problem of medical bankruptcies -- unsurprisingly given all of the above. In Massachusetts, where a plan similar to the ACA was implemented in 2006, the number of medical bankruptcies has actually increased [17]. Further,

prior to the ACA three quarters of medical debtors – mostly well-educated, middle class and home owners -- had health insurance at the time of filing [18] – likely the sort of coverage that the ACA, promoting high deductible plans with actuarial values as low as 60%, will turn into the new normal.

These stark differences make it clear that the ACA is not remotely a “version” of Swiss health care. With the LAMal, the Swiss have attempted to create a system that uses their own decades-long tradition of multiple, private insurers as “vehicles for social insurance” [19]. Instead, with the ACA, U.S. legislators have created a system that consolidates the central role of for-profit insurers and that leaves close to half a trillion dollars in wasteful administrative overhead virtually unchanged [20]. This overhead poses substantial demands on the time of providers [21], not to mention that of users, demands that will not be resolved through turning masses of paper transactions into electronic ones [22].

The ACA also forgoes critical system-wide cost savings – even as it may produce substantial savings for private insurers -- that could be accrued through economies of scale. This lack of purchasing power as is typically exercised by a government authority is the reason why Americans pay exorbitant, hard to predict prices for the same goods and services that cost a fraction elsewhere – even compared to the high prices in Switzerland. As health economist Gerard Anderson aptly put it a decade ago, “It’s the prices, stupid” [23]. As recently as July 2013, economist Gerald Friedman estimated that a publicly financed, single payer

system could save Americans *collectively* \$592 billion annually, by slashing the administrative waste of the commercial insurance industry and reducing pharmaceutical prices to European levels. Friedman also estimated that in 2014, these savings would cover all the uninsured in the country and upgrade the benefits for everybody else [24].

Disturbingly, as the price of premiums continues to rise, more employers may reduce the choice of policies they offer their employees, choose cheaper policies with greater out-of-pocket costs – already as many as 44 percent of employers are considering offering high-deductible health plans as the only option to their employees in 2014 [25] – or no longer provide insurance and instead pay a fine [26].ⁱⁱⁱ

President Obama has argued that the ACA will allow Americans to build on “what works” [27] – a decades-long, increasingly strained and corporate-dominated system whose pillar, employer-sponsored commercial health insurance, is truly exceptional among industrialized nations -- exceptional in its underperformance [28]. Maybe paradoxically, however, the ACA will unravel and lead to the type of “socialized” system that most Democrats and Republicans have repeatedly asserted is “politically unfeasible.” As employers confront ever-rising costs and pass them on to workers, or retreat from sponsoring insurance altogether, and workers enter the new health care markets and find coverage unaffordable and inadequate, popular outrage with the commercial-insurance

model of financing care may give rise to a change in the political and ideological landscapes – an “Europeanization” of US politics -- that might finally provide the basis for the establishment of a true, publicly financed National Health Program [29].

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Footnotes

ⁱ Regina Herzinger is among the conservative sympathizers of the ACA and of the Swiss model. She believes that while the latter is substantially better than the ACA, it does not go “far enough” in “freeing” demand of health services (because, for instance, means-tested subsidies make premiums “artificially” low) or supply (because, for instance, hospitals and physicians are limited in their “pricing freedom”) [26].

ⁱⁱ These guidelines were endorsed by no other than the prestigious Institute of Medicine, on the grounds that the comprehensiveness of coverage needs to be balanced against affordability to users [30] -- apparently the IOM could not imagine any “non-market” constraints on the price of policies or medical care.

ⁱⁱⁱ Pressure placed by employers has already resulted in the White House announcing that the employer mandate will be postponed until 2015 [31].

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