Socratic Seminar: Capitalism v. Democratic Socialism

Preparing for the Discussion

1. Show up prepared: Before you come to the Socratic Seminar, read and annotate the assigned articles, and type up responses to both of the discussion questions with 3 pieces of textual evidence (facts from the appropriate articles) for each response. You will turn in this writing as part of your grade.
2. Know that you may be called on to enter the fishbowl for either of the questions, so be ready to discuss both of them, have textual evidence highlighted and ready, and bring your articles on the day of the discussion.

In the Fishbowl

1. Half of you will be selected to discuss each question at the center table, which is called *the fishbowl*. Don't raise hands; take turns speaking.
2. Listen carefully and speak up so that all can hear you; talk to each other, not to the teacher.
3. Discuss *ideas* and observations. Support your ideas with evidence from the articles.
4. Remember this is a *dialogue*, not a *debate*. In dialogue, one listens to understand, to make meaning, and to find common ground. In debate, one listens to find flaws, to spot differences, and to counter arguments.
5. Once you have each had the chance to join the discussion, you will have a minute or two to consult with your Think Tank teammates to get ideas for additional comments and questions that you can offer to further the discussion for your question.
6. Your grade is based on three criteria: the number of original comments you make, how well you support your ideas with evidence from the articles, and how well your comments and questions respond to or add on to comments made by your peers.

In the Think Tank

1. When you are not in the fishbowl, you will be at one of the outer tables, known as a Think Tank. Your job here is to support each classmate from your group when he or she enters the fishbowl by offering ideas for comments and questions toward the end of the discussion for each question.

On the day of the seminar, you will bring to class your annotated articles and your typed up responses to the following two questions:

Should a nation's central/national government run its higher education system (minimum two-thirds page typed with 3 pieces of evidence from the articles?

Should a nation's central/national government run its health care system (minimum two-thirds page typed with 3 pieces of evidence from the articles?

Should a Nation's Central/National Government Run Its Higher Education System?

Higher education: Not what it used to be

American universities represent declining value for money to their students**,** *The Economist*, December 1, 2012

ON THE face of it, American higher education is still in rude [British for "vigorous"] health. In worldwide rankings more than half of the top 100 universities, and eight of the top ten, are American. The scientific output of American institutions is unparalleled. They produce most of the world's Nobel laureates and scientific papers. Moreover college graduates, on average, still earn far more and receive better benefits than those who do not have a degree.

Nonetheless, there is growing anxiety in America about higher education. A degree has always been considered the key to a good job. But rising fees and increasing student debt, combined with shrinking financial and educational returns, are undermining at least the perception that university is a good investment.

Concern springs from a number of things: steep rises in fees, increases in the levels of debt of both students and universities, and the declining quality of graduates. Start with the fees. The cost of university per student has risen by almost five times the rate of inflation since 1983, making it less affordable and increasing the amount of debt a student must take on. Between 2001 and 2010 the cost of a university education soared from 23% of median annual earnings to 38%; in consequence, debt per student has doubled in the past 15 years. Two-thirds of graduates now take out loans. Those who earned bachelor's degrees in 2011 graduated with an average of $26,000 in debt, according to the Project on Student Debt, a non-profit group. [According to the U.S. National Debt Clock, in 2017 student debt in the U.S. totals nearly $1.5 trillion.]

More debt means more risk, and graduation is far from certain; the chances of an American student completing a four-year degree within six years stand at only around 57%. This is poor by international standards: Australia and Britain, for instance, both do much better. . . .

Despite so many fat years, universities have done little until recently to improve the courses they offer. University spending is driven by the need to compete in university league tables that tend to rank almost everything about a university except the (hard-to-measure) quality of the graduates it produces. Roger Geiger of Pennsylvania State University and Donald Heller of Michigan State University say that since 1990, in both public and private colleges, expenditures on instruction have risen more slowly than in any other category of spending, even as student numbers have risen. Universities are, however, spending plenty more on administration and support services.

Universities cannot look to government to come to the rescue. States have already cut back dramatically on the amount of financial aid they give universities. Barack Obama has made it clear that he is unhappy about rising tuition fees, and threatens universities with aid cuts if they rise any further. Roger Brinner from the Parthenon Group, a consultancy, predicts that enrolment rates will stay flat for the next five to seven years even as the economy picks up. The party may be well and truly over.

In 1962 one cent of every dollar spent in America went on higher education; today this figure has tripled. Yet despite spending a greater proportion of its GDP on universities than any other country, America has only the 15th-largest proportion of young people with a university education. Wherever the money is coming from, and however it is being spent, the root of the crisis in higher education (and the evidence that investment in universities may amount to a bubble) comes down to the fact that additional value has not been created to match this extra spending. Indeed, evidence from declines in the quality of students and graduates suggests that a degree may now mean less than it once did.

For example, a federal survey showed that the literacy of college-educated citizens declined between 1992 and 2003. Only a quarter were deemed proficient, defined as "using printed and written information to function in society, to achieve one's goals and to develop one's knowledge and potential". Almost a third of students these days do not take any courses that involve more than 40 pages of reading over an entire term. Moreover, students are spending measurably less time studying and more on recreation. "Workload management", however, is studied with enthusiasm—students share online tips about "blow off" classes (those which can be avoided with no damage to grades) and which teachers are the easiest-going.

Yet neither the lack of investment in teaching nor the deficit of attention appears to have had a negative impact on grades. A remarkable 43% of all grades at four-year universities are "A"s, an increase of 28 percentage points since 1960. Grade point averages rose from about 2.52 in the 1950s to 3.11 in 2006.

At this point a sceptic could argue that none of this matters much, since students are paid a handsome premium for their degree and on the whole earn back their investment over a lifetime. While this is still broadly true, there are a number of important caveats. One is that it is easily possible to overspend on one's education: just ask the hundreds of thousands of law graduates who have not found work as lawyers. And this premium is of little comfort to the 9.1% of borrowers who in 2011 had defaulted on their federal student loans within two years of graduating. There are 200 colleges and universities where the three-year default rate is 30% or more.

Another issue is that the decreasing salary gap between those with only a high-school diploma and those with a university degree is created by the plummeting value of the diploma, rather than by soaring graduate salaries. After adjusting for inflation, graduates earned no more in 2007 than they did in 1979. Young graduates facing a decline in earnings over the past decade (16% for women, 19% for men), and a lot more debt, are unlikely to feel particularly cheered by the argument that, over a lifetime, they would be even worse off without a degree than with one.

Moreover, the promise that an expensive degree at a traditional university will pay off rests on some questionable assumptions; for example, that no cheaper way of attaining this educational premium will emerge. Yet there is a tornado of change

in education that might challenge this, either through technology or through attempts to improve the two-year community college degree and render it more economically valuable. Another assumption, which is proved wrong in the case of 40% of students, is that they will graduate at all. Indeed, nearly 30% of college students who took out loans eventually dropped out (up from 25% a decade ago). These students are saddled with a debt they have no realistic means of paying off.

Where Student Loan Debt Is an Alien Concept

Navigating France's higher-ed system requires lots of planning and test-taking, but not a whole lot of money.

By Claire Lundberg, February 6, 2014, Slate Magazine

In this series, an American in Paris pits the French welfare state against the U.S. market economy…

Are you a planner or a dreamer? Professionally speaking, which would you value more: job security or the freedom to change careers? And which of these would you find more stressful: taking a test or being in debt? If you're a planner, if you're comfortable with compromise, and if you're uncomfortable with debt, then the French system of higher education may be for you. But if you believe it's never too late to start over, stick with American universities.

If you can afford them, that is. Rising tuition rates in the U.S. have outpaced inflation for the past 30 years. The average annual tuition cost at a private university in 2013 was $30,094, and $8,893 at public four-year institutions. Inflation-adjusted rates from 1971 are about a third of those costs: $10,515 and $2,456, respectively. As a result, seven in 10 college seniors in America now graduate with student loan debt, at an average that's close to $30,000.

To Americans, these kinds of stats are depressingly familiar. In France, though, student loan debt is an alien concept. Fewer than 2 percent of students in France take out loans to pay for their education. The idea that you might *have* to take out loans is met with disbelief. The vast majority of universities here are publicly funded, with tuition rates set by the government. These public universities, among them the Sorbonne in Paris, cost an average of 183 euros per year for a *licence*, the three-year French equivalent of an undergraduate degree.

The problem here isn't with the cost of the education, but with the huge amount of tracking, testing, and winnowing that is used to help keep the system free. In America, virtually anyone can get a college education so long as they have the money to pay for it. In France, you can get an excellent, free or nearly-free education but often only if you follow a prescribed set of rules and pass a series of grueling tests that often start early in high school.

French teenagers go through their first major career sorting at around age 15, when they decide on an academic or vocational course of study. This choice determines what kind of high-school graduation exam, or *baccalauréat*, the student will sit for, and to some extent what kind of higher education is open to them. The choice of track is also not entirely up to the students; the head of their *lycée*, or high school, has the final say. There's some ability to change tracks, but it's not particularly easy.

The *baccalauréat* exam is very different from American standardized tests like the SAT. Instead of a single afternoon, the *bac* is a weeklong process that includes written and oral tests in everything from French literature to math to philosophy. And unlike the SAT, the *bac* is the sole factor that determines whether a French student will graduate from *lycée*; grades and extracurricular activities are not considered. The French system works beautifully if you're extremely focused from a very early age, work well under pressure, and are great at taking tests.

Though the *bac* is stressful for French 18-year-olds, passage guarantees them entry to any of France's free public universities. However, there's a second, more elite tier of schools in France: the *grandes écoles*, France's version of the Ivy League. They're extremely difficult to get into—most have acceptance rates under 10 percent—and offer incredible rewards to those who graduate: a recent study by French sociologists François-Xavier Dudouet and Hervé Joly found that a stunning 84 percent of executives at France's top 40 companies were graduates of a *grande école*. Contrast this with the U.S., where only about 10 percent of top executives at 100 top companies graduated from Ivy League schools, and you have a sense of the hierarchy that exists in France—a country that supposedly executed its ruling class more than 200 years ago.

Ironically, the first *grandes écoles* were established after the French Revolution as an egalitarian means of training the talented sons and daughters of the middle class. They've evolved into a powerful proving ground. Among the major *grandes écoles* are Ecole normale supérieure (abbreviated to ENS, and the only one of France's university's to make it into the top 100 internationally), which trains scientists and academics; Polytechnique, which trains largely scientists and engineers; and the business schools HEC and ESSEC. Above these sits ENA, the École nationale d'administration, which takes top graduates of *grandes écoles* and trains them for high-level government positions. The school only graduates 100 students per year, yet it's so dominant that it counts two former French presidents and the [former] president, François Hollande, among its alumni. By U.S. standards, the *grandes écoles* are a bargain—ENS and Polytechnique even pay their students a monthly stipend to attend. In return, students are expected to work for the state for several years after graduation (though ENS is trying to eliminate this requirement).

After passing the *bac*, most aspirants to a *grande école* attend a *cours préparatoire*; commonly known as a *prépas*: two years of intense study in their chosen field. At the end of the *prépas* they sit for the *concours*, another entrance test that is nationally ranked and will determine which *grande école*, if any, they will attend. Though the public *prépas* are designed to be affordable for all, they are also extremely competitive, and there's very little in the way of college counseling in France. Here and elsewhere, the process can be opaque, and it privileges those who come from families who know the process.

The privileging of the *grandes écoles* over the public university system is also reflected in education spending, with the state spending just 6,700 euros per public university student per year but up to 13,000 euros per student at a *grande école*, even though elite schools train only 5 percent of students.

Meanwhile, at France's open-enrollment public universities, the dropout and failure rate after the first year is close to 50 percent. [For context, according to U.S. News and World Report, 30 percent of U.S. students drop out after the first year of college, and 50 percent never graduate.] The most competitive majors, such as law and medicine, cull their student lists with more brutal testing.

Financing universities: Who pays to study?

When universities depend on taxpayers, their independence and standards suffer
The Economist, January 22, 2004

IT IS depressing to visit Oxford or Cambridge these days. The old buildings are so wonderfully grand that they highlight the cheap, ugly and badly kept new ones. The intellectual history is stunning, too: this is where Newton pondered gravity, and Occam honed his razor. But these days academics at Britain's two finest universities are a harried, ill-paid lot; salaries start at a mere £14,139 ($25,733).

Few disagree that both universities are living off the past, in everything from cash to reputation. The colleges' wine cellars are better than the kitchens, quips one don. The port and claret were laid down in happier times, when cash was flush and planning for the future mattered. But the food that goes with them is often dismal: that must be bought out of current income, which is usually earmarked already for everything from maintaining ancient buildings to supplementing salaries.

Yet Oxford and Cambridge are still in relatively good shape, thanks largely to their structure of self-governing, self-financing colleges. This limits the power of bureaucrats, provides independently managed money and ensures some protection for the original and the excellent. Other British universities have much worse problems.

To begin with, they have little or no endowment income to fall back on. The combined investments of Oxford and Cambridge are £4 billion; the rest of the British university system has £1.7 billion to play with. In America, Harvard alone has twice Britain's total. The "funding gap"—the hole in the universities' collective accounts created by the unfunded expansion of the past 20 years—is around £10 billion.

It is not just that money is short. The price and quantity of courses are state-controlled, in a system more suited to Soviet central planning than to a modern democracy. And as with other planned economies, the result of government intervention is increasingly unsatisfactory. In Britain, over 30 years, universities have gone from being almost wholly autonomous, with state-financed block grants handed out at arm's length, to becoming branch offices of a government ministry.

Admissions, too, bring a whiff of the old Soviet system. The government is convinced that more working-class students, including many with few formal qualifications, should go to university. Its ultimate target is 50% of 18-30-year-olds by 2010, and it is getting there fast. Figures released this week show that the number of students in higher education has risen in just one year from 43% to nearly 45% of the relevant age cohort. In 1979, the percentage of school-leavers going on to higher education was just 12.4%.

But more does not always mean better. One of Britain's best-known academic institutions, the School of Oriental and African Studies in London, found itself penalised for taking too few students from "non-traditional" (meaning poor) backgrounds. So it reduced entry requirements for such applicants, to take account of their often modest school results. But then it turned out that those students found learning Arabic or Chinese from scratch so hard that they were dropping out, incurring a further fine from the government.

The story of British higher education is less about expansion than inflation of qualifications. University degrees mean less and less and there are more and more of them…This trend towards uniformity has disastrously weakened higher education in Britain. Hence the importance of the government's proposed reform of university finance, which will allow a modest liberalisation of tuition fees. Instead of the current flat rate of £1,125, universities will be allowed to charge up to £3,000. The scheme is festooned with carrots, chiefly easy terms for poor students, in order to forestall a revolt by the government's nominal supporters in Parliament.

Critics say the new fees will create an unmanageable debt burden. Yet a broadly similar system in Australia has not had this effect: graduates pay back the loans when they are earning enough….

The present picture in Britain may be dismal, but misery is relative. Strolling happily through the Oxbridge quadrangles, and in the bustling corridors of less beautiful British universities, are 12,000 undergraduates from other European Union (EU) countries. Their home universities are in a still worse state: not only more overcrowded, but with barely a vestige of direct teaching. Oxford and Cambridge, more than other British universities, still offer undergraduate students close attention from a designated don. The system is threadbare and arguably wasteful, especially as many students do little to prepare for their supervisions. But at least it happens. At France's best-known university, the Sorbonne, a translation seminar at the start of last term had 80 registered students. "Too many," said the teacher superciliously. "Half of you have to leave. When we are down to 40 I'll start teaching. Foreigners will go first."

In Germany, too, where professors enjoy the status of tenured civil servants, conditions are frequently dreadful. A current scandal is the *Blockseminar*—an ingenious system whereby an academic turns up briefly at the university and delivers an entire term's teaching in the space of a weekend, before returning to the unhurried pursuit of private knowledge. . . Similar stories come from Spain and Italy, where universities are plagued by rigidity and corruption. In effect, universities in these countries have become government-owned degree mills. Their aim is to get the greatest number of young people in and out for the least money and trouble. Really determined students may fight their way through to gain a professor's attention, win a research scholarship and start doing some real work, probably in postgraduate study. The others will arrive in the labour market, qualification in hand, feeling that their mostly middle-class parents have something to show for their taxes.

It is not all gloom and doom. Most countries have islands of excellence: German postgraduate engineering faculties, for example, or the French *grandes écoles*, fiercely competitive and independent. Finland and Holland have largely managed to keep quality up and bureaucracy down. But for the most part, universities in the larger countries of continental Europe are a dreadful warning of the consequences of nationalisation. . .

Should a Nation's Central/National Government Run Its Health Care System?

Pros & Cons of Free Universal Health Care

by KAY IRELAND, Livestrong Foundation Last Updated: Aug 14, 2017

Americans are becoming increasingly confused about universal health care and if it is even a plausible solution to a broken health care system. The number of Americans without insurance is over 45 million, according to the National Coalition on Health Care. There are benefits and drawbacks to the type of universal heath care system practiced in other countries.

Pro: Extending Care
With 45 million Americans uninsured, and CNN reporting that 45,000 Americans are dying per year because they don't have access to health care because costs, a universal health care system would remedy the problem of affordability. Universal health care extends care to anyone, regardless of social status or bank account. Countries that have a universal health care system in place have a longer lifespan. Canadians have a three-percent higher lifespan than Americans, according to United North America.

Con: Raised Taxes
Although universal health care is often touted as "free," it is typically government-run. Taxes would need to be raised to accommodate for universal health care, and many Americans could be adverse to their taxed earnings paying for the health care of someone who doesn't work at all.

Pro: Reducing Medical Costs
Currently, privatized health care costs are incredibly inflated. Without the government regulating health care costs, hospital fees and insurance premiums, those who set costs in the health care sector basically have free run over the system. A universal health care system would be regulated by the government, so costs overall would be reduced with a more monitored system to reduce inflated costs for tests, hospital stays and procedures.

Con: No Competition
In Canada and England, health care workers are considered employees of the government rather than private health care workers. This means that each surgeon, family practitioner and nurse is paid through the government, and their salaries are regulated by the government. This means that the competition for patients that spurs health care workers to become better at their occupations and specialties is gone. This could mean a reduction of those willing to go into the medical profession overall. You also won't be able to choose the best doctor simply by looking at her successes and patient base.

Pro: Existing Working Models
One of the biggest pros for a universal health care system is that working models exist. Germany, Switzerland, Canada and Taiwan all have successful government-run insurance or health care for all lawful residents. While none of those places are as populated as the United States, they serve as effective models for a universal health care system and how it can work for an entire nation.

Con: Longer Wait Times
When health care is extended to everyone, it can be used too often. And with "free" access, a patient may go to the emergency room with the sniffles, causing longer wait times for those who have real emergencies. Access to family doctors and specialists may also be limited due to too many patients and not enough doctors.

$200 Minus $200

By Claire Lundberg, *Slate Magazine*, January 27, 2014

When I got pregnant with my daughter, I had been living in France for only about six months, and hadn't yet received my Carte Vitale, France's universal health care card. The day I went for my first sonogram, my midwife warned me that I should brace myself for a big bill. "Since you don't have your Carte Vitale yet," she said, "it's going to be costly."

I'm an American, and accustomed to American medical costs—I'd always worked for small businesses, where company insurance usually came with high co-pays and out-of-network deductibles. So of course I tensed up. "How much will it be?" I asked the midwife fearfully. "Will it be—more than 1,000 euros?" (That's about $1,300 at today's exchange rate.)

She looked at me like I was crazy. "No, it won't be that much!" she exclaimed. The final bill for the appointment was 150 euros, or about $200, which I paid in full, and for which I was later reimbursed in full. In other words, "$200 minus $200" counts as a "costly" medical bill in France.

France is a proud welfare state, where public spending accounts for 53 percent of GDP—the second-highest percentage in the developed world (only Sweden's is higher). The U.S. is the third-lowest, at 36 percent (ahead of Ireland and South Korea).

Having a baby so soon after moving to France gave my husband and me a crash course in one of the largest components of the French welfare state: its medical system, which has often been called the best in the world.

France's health care system is a public/private hybrid: Everyone is covered to a certain extent by the government's Assurance Maladie, but most people also have private insurance, called a *mutuelle*, that is either offered through their employer or bought on the private market. There's a thriving private insurance market in France—one that the Affordable Care Act can only dream of. Private medical insurance is advertised on the sides of buses and alongside movie previews in theaters, and there are plans geared toward numerous niches: college students, freelance professionals, and people who work in restaurants, to name a few.

Because my husband worked at a French company, he immediately began paying into the system, which covered me as well while I wasn't working. In addition, my husband's employers provided a choice of *mutuelle*; the top-of-the-line plan, which we signed up for, cost about 50 euros ($68) a month. By contrast, in the U.S., I'd been paying about $350 a month with an additional $50 co-pay for each doctor's appointment. I was adjusting to the outlandish notion that I would know the exact cost of my health care services before buying them.

Our first task was to find a place to have the baby. I'd suspected I was pregnant for two weeks before I took a pregnancy test, not wanting to be overly anxious. This was my first mistake. "You must call the *maternités* now—*vite! Vite!*" my friend Anais practically yelled at me when she heard. And she was right: Six weeks pregnant, I was already too late to get a spot in many of Paris' public maternity wards. Only then did I learn that most Parisian women call the hospital the day they miss their period. I have a friend who walked to her local hospital with her pregnancy test in hand the minute she found out.

This kind of crowding, especially in bigger cities, is one of the downsides of a government-run health care system. On the upside, had I managed to book a bed in one of the public wards, my birth would have been *completely free*, paid for entirely by the government's Assurance Maladie. Everyone pays into Assurance Maladie through charges that are taken directly from their paycheck. (Unlike Americans, French employers and workers quote salaries as net, not gross—so your salary is what you receive after deductions for health care and other social services.) From the sixth month of pregnancy to 11 days after a child's birth, the government covers a woman's medical expenses in full.

In full—except for the costs of a private clinic if you've missed out on a public ward. There are plenty of private *maternités* in Paris, and I found a great one, with an English-speaking midwife who agreed to follow my pregnancy from the outset, as I still had no regular doctor. But how expensive would it be?

Luckily, transparency in the price of medical care is a legal requirement in France. The government sets what they consider fair prices for all appointments and procedures, and then reimburses these for everyone at 70 percent. This is not unlike Medicare and Medicaid in the U.S., but because the French government system covers the entire population, it has more bargaining power to keep prices low. For example, a private appointment with a midwife is calculated at a base cost of 28 euros—the same price it would be at a public clinic or hospital. The government will reimburse the patient 18.50 euros of this, even if the midwife charges more; the rest the patient pays out of pocket and/or has covered by a *mutuelle*. . .

In the U.S., meanwhile, it's often impossible to get a price for a delivery out of a hospital. Estimates vary by orders of magnitude: This California study of 100,000 complication-free deliveries showed that new mothers were charged anywhere from $3,296 to $37,227, with no clear medical reason for the massive discrepancy. By contrast, for my complication-free delivery and five-day stay in a private clinic, my total out-of-pocket cost was 400 euros, or about $542.

The Ugly Realities Of Socialized Medicine Are Not Going Away

Forbes Magazine, December 19, 2011
Sally Pipes , *President of the Pacific Research Institute*

The worldwide recession has forced countries around the world to curb public spending -- or risk defaulting on their debt.

The United Kingdom is the latest to tighten its belt. The National Health Service (NHS) -- the centralized public agency that runs Britain's government healthcare system -- is being forced to shave $31 billion from its budget by 2015. These cuts are leading to a precipitous drop in the quality of care patients receive. The NHS has been living well beyond its means for quite awhile. And now brutal government-enforced cost controls are exacting a heavy human toll.

Thanks to Obamacare, America will soon face the same sort of reckoning. Other nations with government-dominated healthcare systems offer a preview of the fiscal woes and substandard care that lie ahead thanks to the president's spendthrift reform plan.

In order to realize some savings, the NHS is raising the threshold at which patients qualify for treatment and lengthening wait times for surgeries determined "non-lifesaving." The Service is also cutting more than 20,000 NHS jobs over the next two years and shuttering a number of hospitals.

Patients are feeling the pain. For decades, they've turned over substantial portions of their hard-earned paychecks as taxes -- and accepted "free" health care from the government in return. Only about 11 percent of Britons pay for their care privately. They've foregone cutting-edge medical treatments available in the United States, told by their leaders that these new therapies were no better than the old ones -- just more expensive. At least in Britain, they thought, everyone has access to basic health care. That has to be better than the situation in America, where tens of millions of people lack health insurance, right?

Hardly. The British healthcare system may "guarantee" access to care -- but that doesn't mean patients actually receive it…

A report released in October by Britain's health regulator found that a stunning 20 percent of hospitals were failing to provide the minimum standard of care legally required for elderly patients.

As part of the study, inspectors dropped by dozens of hospitals unannounced. They found patients shouting or banging on bedrails desperately trying to get the attention of a nurse. At one hospital, inspectors identified bed-ridden patients that hadn't been given water for over 10 hours…

The NHS is broken -- and not in some superficial way that a simple tweak would fix. The incentives are wrong. The government's main priority is keeping costs low -- not providing quality care. Patients can't choose how they receive their care -- it's one-size-fits-all medicine. And the entrenched NHS bureaucracy has no reason to improve efficiency.

The problems with "universal" health care aren't confined to Britain. Canada's single-payer, government-run system -- where any private health care is outlawed under the Canada Health Act -- is similarly failing its patients.

The Health Council of Canada recently surveyed over three thousand patients and found that those with chronic illnesses like high blood pressure or heart disease were largely dissatisfied with the medical care they received. Less than half of respondents with such conditions reported that the care they received was excellent or very good.

What 'Medicare for All' means, politically and practically

By Dr. Sanjay Gupta, Chief Medical Correspondent, Updated 12:10 PM ET, Tue July 2, 2019

(CNN) If you've been watching the Democratic presidential hopefuls gear up, you have probably heard the phrase "Medicare for All." What exactly does that mean?

Medicare, which has been around since 1965, is the government-run health insurance program that covers all Americans 65 and older and is funded by taxpayers. A portion taken out of our paychecks for Social Security goes toward Medicare to cover most services like hospital stays and doctors' visits. People on Medicare can also choose to get additional coverage from Medicare-approved private insurers to cover other services such as dental, vision and prescription drugs.

Proponents of Medicare for All want to expand this program to cover more than just Americans 65 and older. Some, such as Vermont Sen. Bernie Sanders, are pushing for Medicare to cover all citizens and lawful permanent residents, while others such as Michigan Sen. Debbie Stabenow are pushing to lower the age requirement. In 2017 she introduced a bill to allow people between 55 and 65 years old to buy into the program. Earlier this year Stabenow introduced another bill further lowering the age requirement to 50.

Many of those pushing for Medicare for All believe that health care is a human right, and many supporters believe that getting more people into the Medicare system can help rein in growing costs in the US health care system.

It's worth noting that Medicare is quite popular as it stands now. In a Gallup poll from December, of those Americans publicly insured through Medicare or Medicaid (the government's health program that covers those with limited income), 79% say they are happy with the quality of their health care and believe that they have good to excellent health coverage….

In September 2017, Sanders and 16 Democratic co-sponsors introduced a Medicare for All expansion bill to cover all Americans. The co-sponsors included California Sen. Kamala Harris and New Jersey Sen. Cory Booker, who are running for president in the 2020 election. In April this year, Sanders reintroduced the bill alongside 14 cosponsors, including Sens. Elizabeth Warren and Kirsten Gillibrand, who are also seeking the Democratic nomination for president, as well as Harris and Booker. Theirs wasn't the only bill to try to expand Medicare. In the last congressional session, there were at least eight other proposals introduced in the House and the Senate aiming to expand the program. Some would have expanded the program by lowering the Medicare age eligibility to 50; other bills added a Medicare option while maintaining private insurance choices. Last summer, Democratic Rep. Pramila Jayapal of Washington helped found the Medicare for All Caucus, which now has 78 Democratic representatives as members.

What would the program do?

Our health care system could best be described as a hybrid. About half the money comes from the private sector: people who have private insurance through their employers or who are self-insured. The other half is from the public sector: federal, state and local governments paying into Medicare and Medicaid.

If the country adopted Sanders' proposal, people who currently get their insurance from their employers would move to the government system. Sanders' plan would provide fairly comprehensive coverage, as Medicare does now, all with no copays, premiums or deductibles. It would include inpatient and outpatient hospital care, emergency services, preventative services, most prescription drugs, as well as dental and vision coverage. His 2019 plan also covers long-term or nursing home care. The only potential for out-of-pocket fees would be for some prescription drugs and certain elective procedures.

If states wanted to fund additional benefits for their residents, under the Sanders proposal, they could, but they would have to do so without federal assistance.

Aside from getting more people access to health care, supporters of Medicare for All say that moving to this system would create efficiencies to help bring down costs of health care. The US health care system now costs nearly double what other high-income countries pay, per capita….

[However], keep in mind that Medicare pays doctors and hospitals less than private insurers for services, and not all hospital systems or doctors accept Medicare. The American Hospital Association found that private health plans pay hospitals about

45% more than treatment costs, while Medicare and Medicaid pay about 12% less than costs, a difference of 57 percentage points If we moved to a Medicare for All system, would all hospitals and doctors agree to this pay cut? Would they organize to demand more? These are the kind of questions that architects of an expanded system have to wrestle with.

If Sanders' Medicare for All were to become law, it wouldn't happen overnight. It would roll out over four years. In the first year, Medicare would grow, with the eligibility age dropping to 55 and with all children 18 and younger added to the rolls. Over the next two years, the age would drop to 45 and then 35. By the fourth year, it would truly become "Medicare for all." How would this be paid for? …

To pay for the newest version of his plan, Sanders has suggested several potential options, which his office listed as:

• Creating a 4% income-based premium paid by employees, exempting the first $29,000 in income for a family of four
• Imposing a 7.5% income-based premium paid by employers, exempting the first $2 million in payroll to protect small businesses
• Making the federal income tax more progressive, including a marginal tax rate of up to 70% on those making above $10 million, taxing earned and unearned income at the same rates, and limiting tax deductions for filers in the top tax bracket
• Making the estate tax more progressive, including a 77% top rate on an inheritance above $1 billion
• Establishing a tax on extreme wealth
• Imposing a fee on large financial institutions
• Repealing "corporate accounting gimmicks…"

Are there other [countries] that do this?

Canada and Taiwan are often cited as examples of other places that have single-payer health care systems under which all residents are insured. Those governments pay for health care through taxes on their citizens. In Canada, the federal government provides only health care, and dental, vision and prescription drugs may be covered by the province or through private insurers. Britain's National Health Service is also often used as an example of a single-payer system. But in the English system, the government not only pays for services, it contracts with and employs doctors and hospitals directly. This is considered socialized or nationalized health care.

In Canada and Taiwan, and under Medicare in the United States, the government doesn't own or contract the providers. The British system is more akin to the US Veterans Administration.

Another country that frequently comes up as a model in the health care debate is France, which has a mix of public and private insurance. Although most of France is covered by one of the three not-for-profit health insurance funds financed by the government and covers between 70% and 80% of costs, there are private supplemental insurers, as well.

All of these countries provide almost universal health care, through which insurance is either provided or mandated by the federal government.

Why is health care so expensive in the first place?

In the United States, for every one doctor, there are about 16 staff members -- but only six of those staff members actually have clinical roles, like nurses' aides or medical assistants. That's more than $800,000 in labor costs per doctor. Unlike in countries that have a nationalized or single-payer system, the United States has hundreds of health insurance providers, with different codes and different rates all for the same procedures. It's administratively inefficient if the same knee replacement can be processed and charged in dozens of ways.

The cost of lifestyle diseases, such as obesity, is staggering in the United States. There are estimates that 80% of diabetes, heart disease and stroke and 40% of cancer cases are preventable. By 2050, as many as 1 in 3 US adults is expected to be diabetic.

We also spend way more on technology and drugs. Pharmaceutical drugs are particularly costly in the United States, partly because the largest user of prescription drugs -- Medicare -- can't negotiate prices down with drug manufacturers. Under Sanders' plan, the government would come to the table to broker pricing.

Patients in the US health care system tend to have a lot more unnecessary tests and procedures than patients in other countries, and that all adds up to a high price tag. It's in part due to profit motivation, as well as a phenomenon known as "defensive medicine." That's when doctors and hospitals are overly cautious and perform tests and scans out of fear of ending up out of the operating room and in the courtroom. In 2008, defensive medicine cost the United States $55.6 billion in health care costs. According to the nonprofit National Academy of Medicine, in 2009, one-third of all health care costs was a complete waste and did nothing to make Americans actually feel better.