Insight

Shutdowns Show Why Government-run Health Care Is Risky

MICHAEL BAKER | OCTOBER 8, 2025

Executive Summary

- Since October 1, 2025, when federal discretionary appropriations lapsed and the government entered a shutdown, the federal health care system began operating on autopilot: While Medicare and Medicaid programs are financially operating, necessary health care administration processes such as rate-setting rulemaking, new drug application review, and program reimbursement/participation support are all on hold.
- One appeal of a single-payer health system is that it theoretically offers a unified financing and governance framework, but in practice, political structures and considerations frequently intrude and worsen access and quality.
- The current government shutdown offers a glimpse of what a single-payer system might look like at its worst: a central government whose broad responsibilities and political exposure open it to blunt, destabilizing decisions that threaten the delivery of medical services.

Introduction

Since October 1, 2025, when federal discretionary appropriations lapsed and the government entered a shutdown, the federal health care system began operating on autopilot. While certain programs are operating financially, such as Medicare and Medicaid, the back-office administration, such as rate-setting rulemaking, new drug application reviews, and program reimbursement/participation support for non-CMS programs (such as 340B, federal grants, etc.) are all on hold. As noted in recent American Action Forum research, this shutdown has been driven by a disagreement over a health care policy item: the enhanced premium tax credits in the American Rescue Plan Act, which were extended in the Inflation Reduction Act. The shutdown and the attendant dysfunction inflicted on the

public aspects of the U.S. health care system highlight an important point: If medical care in the United States had been governed by a single-payer regime, the results would have been far worse.

The shutdown creates a cascade of operational disruptions offers a stark illustration of how central governments – which must balance myriad policy domains – are structurally vulnerable to inefficiencies that spill into health care. A government shutdown forces the central apparatus to suspend or curtail many discretionary programs, furlough staff, and prioritize "essential" functions – a blunt and politically mediated mechanism that reveals hidden brittleness in health system governance.

One of the appeals of a single-payer health system is that it offers a unified financing and governance framework; ideally, health leadership can act coherently on behalf of population health, equity, cost control, and quality. Yet in practice, political structures and considerations frequently intrude. It is often very difficult for a central government – enmeshed in gridlock through fiscal or political crises – to oversee the provision of basic health services.

In many settings, health system leaders are not autonomous technocrats but function within matrices of power, accountability, and constraints. This means that non-health imperatives – e.g., fiscal priorities, ideology, electoral calculus, bureaucratic turf, intergovernmental bargaining – may dominate or distort health leadership decisions. Thus, the shutdown scenario would translate into real stress on the health care delivery network (fund flows, program continuity, oversight) in ways that system managers (especially in a more centralized or single-payer design) would struggle to insulate against.

A Central Government's Scope Breeds Inefficiency in Health Care

Several features of central governments that manage single-payer systems amplify the risk that shutdowns will disproportionately harm health outcomes and system efficiency.

Scale and breadth force rigid trade-offs

Because a central government is responsible across various domains (defense, infrastructure, education, social welfare, health, etc.), budget and staffing decisions are made holistically (or politically) rather than by program merits alone. In a shutdown, these broad judgments inevitably lead to coarse "essential vs. nonessential" breakpoints. Health programs, especially preventive, regulatory, or ancillary ones, are vulnerable because they look less urgent in the moment, despite their long-term importance.

Shutdowns cannot be fine-tuned

A shutdown is an all-or-nothing tool, not a fine-tuned adjustment. Central governments often lack mechanisms to "scale down" noncritical functions gradually or buffer critical systems (such as health) from wider fiscal freezes. In contrast, in more decentralized or ring-fenced systems, health sectors might preserve continuity even when other sectors suffer.

Institutional inflexibility and bottlenecking

The central government also has many bottlenecks: approving rules, waivers, allocating funds, and regulatory oversight. When central institutions are incapacitated – even temporarily – downstream actors cannot substitute or self-govern around the gap. For example, hospitals under a single-payer regime that depend on national accreditation or central regulatory clearances would be forced to pause or delay innovations.

Weak local discretion in extraordinary circumstance

If the central authority is paralyzed, local health agencies may lack the formal authority or resources to act independently. In a pure, centralized single-payer model, local clinics or hospitals may not have the necessary autonomy to reallocate funds, borrow, or adjust services to absorb shocks. Thus, when central processes stall, no local buffer exists.

Delayed feedback and accountability loops

Health leadership expecting that central decision-makers will unfreeze constraints after political resolution must plan around worst-case scenarios. The uncertainty and delays discourage long-term investments, especially in areas that depend on continuous regulatory oversight (e.g., medical device approvals, drug trials, surveillance systems). This breeds underinvestment in robustness and redundancy.

Fiscal Politics and Budget Constraints

Even under a single-payer model, health is only one line item in the public budget. Health leadership must contend with the political reality of limited fiscal space, competing demands (education, infrastructure, security, welfare, etc.), and pressures to restrain spending. These constraints can push health leaders to adopt policies that are suboptimal from a public health standpoint. Because health is financed from general taxation (or payroll taxes) in a single-payer system, health advocates must compete with non-health ministries for the same revenue pool. Political leaders might redirect health spending toward other priorities during economic downturns, leaving health leadership vulnerable to reallocation.

If the legislature imposes strict caps on health expenditures (e.g., growth ceilings, "efficiency savings" targets), health ministries may be forced to prioritize cost control (e.g.,

cutting services, delaying investments) over long-term strategic health goals (e.g., prevention, infrastructure). In some single-payer proposals, efforts to contain costs run into strong political headwinds. Electoral politics may force health authorities to demonstrate immediate returns (e.g,. increased access today) at the cost of neglecting investments whose benefits accrue over longer time horizons (e.g., preventive infrastructure, capacity building).

Thus, although a single-payer system consolidates financing, it does not immunize health leadership from fiscal politics. Indeed, pressure to "bend the cost curve" often becomes a central political demand, rather than letting health strategy drive cost structure.

Intergovernmental and Constitutional Constraints

In many jurisdictions, health is not purely national; it interlocks with provincial, state, or local governments. Political structures therefore impose constraints. In federated polities, such as the United States and Canada, subnational governments may retain control over hospitals, clinics, licensing, and local public health. A national single-payer arrangement may still have to negotiate or defer to regional authorities, which weakens the ability of top leadership to effect uniform reforms. In the United States, for example, the Employee Retirement Income Security Act limits states from regulating self-insured employer plans, complicating state-level single-payer proposals. Even in national systems, courts may impose judicial constraints on how health leaders allocate resources or define entitlements.

Some single-payer proposals require flexibility from higher-level governments (e.g., national governments allowing states to assume control of Medicare/Medicaid funds via waivers). Health leadership must manage these negotiations, often ceding space in exchange for fiscal leeway. Health leadership might also be deprioritized compared to other national priorities, including defense, taxation/finance, or trade policy. In many systems, finance ministries have the upper hand over technical health agencies, imposing ceilings, approval requirements, or performance metrics not aligned with health priorities. The structural position of health leadership within the governmental architecture thus significantly conditions its autonomy and room to maneuver.

Downstream Consequences: Worse Health Outcomes and Inefficiency

These structural vulnerabilities during a shutdown translate into several adverse outcomes. Patients in novel care models (such as hospital-at-home) may be uprooted. Telehealth and outpatient supports may be lost. Preventive programs and surveillance may pause, increasing the risk of undetected outbreaks or chronic disease deterioration.

Regulatory inactivity (including from a shutdown) drastically slows implementation of

innovative policy and payment programs. Decisions about safety or market entry for drugs/devices may stall, meaning patients will wait longer for new therapies. This also could mean delayed reimbursements, which harm cash flow, particularly for safety-net providers. This can force service reductions or staffing cuts even when patient demand persists. Vulnerable populations (rural, low income, mobility-limited) often rely most heavily on the "soft" supports that are jeopardized by a shutdown (for example, telehealth, outreach, and public health programs). Thus, a political failure at the center disproportionately harms those with greatest need. Repeated disruptions erode faith in the ability of central leadership to protect health, making patients and providers more reluctant to engage with centralized authority or adhere to reforms.

Conclusion

The government shutdown offers a harsh vignette of patient care under a single-payer health care system. A central government's broad responsibilities and political exposure open it to blunt, destabilizing decisions that threaten the continuity, responsiveness, and fairness of health care delivery. In a single-payer health care system, the same systemic fragility exposed by shutdowns could degrade care and generate worse health outcomes over time.