# Universal Health Care:

# A Luck Egalitarian Approach

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# A Luck Egalitarian Approach

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# Chapter 1

## Introduction

Regarding health systems, their main objective is to improve health. To do just that requires not only goodness, but also fairness. Goodness can be thought of as “a health system responding well to what people expect of it; [while] fairness means it responds equally well to everyone, without discrimination” (WHR 2000, xi). Obviously, many Americans would disagree that the current U.S. health care system is capable of accomplishing such a feat, which is why health care reform has taken center stage in American politics. Concerning access to health care, while well-placed Americans have primary physicians who are in a position to help ensure that they receive timely, appropriate comprehensive, and continual care, for the disadvantaged “access to health care may mean a hasty trip to the nearest hospital ER, where a similarly high quality of care cannot be guaranteed and [is] unlikely to be secured” (Dougherty 1988, 182).

In comparison with other developed countries such as Canada, Germany, and the U.K., the U.S. system of health care provides not only the most expensive care in the world, but also excludes the largest number of people from health care. Contrary to what other countries have done, the United States stands alone as it is the only country among the world’s industrialized nations to adopt a policy position that approaches health care in a market-oriented way. The United States treats health care “as essentially a private consumer good of which the poor might be guaranteed a basic package , but which is to be distributed more and more on the basis of ability to pay” (Barr 2007, 2). Unlike the United States, all other developed countries have national health plans that assure citizens access to basic medical care. In these countries, medical care is approached as a social good that is to be made available to everyone.

With respect to the current United States health care system, health care needs to be distributed along the same lines as it is in most other industrialized countries, including the ones I did my case studies on, not as a market commodity on the basis of ability to pay, but as a social good that everyone has a right to in order to neutralize the number of inequalities attributable to bad brute luck. Luck egalitarianism, the theory I base my argument on, finds that "it is unjust for individuals to be worse off than others due to outcomes that it would have been unreasonable to expect them to avoid" (Segall 2010, 13). Thus when bad health is the outcome of an unchosen natural and social circumstance, justice requires compensating people for the disadvantages that they are not responsible for. Regarding those who need medical assistance through some fault of their own, luck egalitarianism advocates treating health care as a normatively non excludable good as it is "in the class of benefits that society provides universally and unconditionally" (Segall 2010, 79). Although health care is to provided universally, for those who avoidably incur medical expenses, "the unconditional entitlement to such provisions gives society the license to impose some of the costs of treatment" ex ante rather than ex-post, due to the possibility that reckless patients may try and refuse treatment on financial grounds (Segall 2010, 77).

## **Egalitarianism**

From an egalitarian point of view human beings are considered fundamentally equal, others have a duty to treat them as such, and human beings have a right to be so treated. It is morally offensive when people are treated as though they are only of extrinsic and relative value. Rather, human beings have an incalculable and intrinsic dignity which by acknowledging may be termed respect for persons. The value of a human being is not relative to external factors, which is to say that it does not depend on others' ascription of beauty, usefulness or price.

Egalitarianism’s main goal is respect for all persons. Respect for persons demands rudimentary rights such as the primary right to be respected as an equal and incalculable value, the right to equal opportunity, and “respect for the necessary empirical conditions of persons, the body and mind- an equal right to be free as far as possible from pain, suffering, disability, and premature death” (Dougherty 1988, 55). According to these rights, it is therefore unjust for those who lack access to health care to be left without insurance. Equal access to health service, regardless of income or class, is of central importance according to the egalitarian view of justice.

A variant of egalitarianism, luck egalitarianism, believes it imperative that inequalities related to access to health care be neutralized. According to luck egalitarians leveling the disadvantages inequalities that are due to brute luck is the only point of distributive justice. Unlike Rawlsians, who see resources as the sole appropriate currency of distribution, luck egalitarians are famously divided between ‘resource’ and ‘welfare’ egalitarians” (Segall 2010, 13). I argue in favor of that with which luck egalitarians are mostly identified with today, the Welfarist strand- all resources are to distributed so as to approximate, as nearly as possible, a condition in which everyone’s net welfare over a lifetime is equal” (Buchanan 2009, 66).

The luck egalitarian perspective, which arises as a response to the “criticism that unmodified equality is unfair because it provides the same benefits for the idle grasshopper as it does to the industrious ant,” represents a shift to an egalitarianism that is sensitive to issues of responsibility, which is demanded by a proper understanding of the ideal of equality itself, as “it is not a development that represents a compromise with the ideal of equality” (Cohen 2010, 120). Luck egalitarians are revolted by the injustice of actual social inequality that comes from the sheer luck of inheritance and circumstance rather than from the choices people make. Traditional egalitarianism in relation to health care argues that, in the name of fairness, there should be plain, ordinary equality. The traditional egalitarian standpoint however ignores the responsibility objection, which asks "why should those, like the grasshopper and the ant, with exactly the same initial advantages, and who merely chose differently, be forced back to equality if an inequality ensues?" (Cohen 2011, 121). In response to this objection, in the name of fairness, luck egalitarianism objects to inequalities, if and only if they are a matter of luck. Luck egalitarians find the differences between people's advantages just, if and only if they are "in accord with a certain pattern in the relevant people's choices" (Cohen 2011, 117), Therefore, not only are inherited differences of advantage considered unjust, so are those that are at all due to luck. Differences of advantage are considered just if either a choice fully explains the difference, or if the difference in question were to "nobody's advantage, compared to anybody else" (Cohen 2011, 117).

Luck egalitarianism, which provides a coherent account of universal yet-luck sensitive health care, does so by conceiving of health care as a normatively non excludable good, on account of humanity's inalienable duty to meet basic needs, including basic medical needs. This way, luck egalitarianism justifies the first aspect of universality of public goods, the non-excludability aspect, as societies have an obligation to treat reckless patients, who are liable to pay the cost of their reckless conduct.

## **Why Equality?**

Among political ideals, equality has become an endangered species, and therefore the question is raised, can we turn on backs on it? As a political ideal, equality is rejected by self-described left-of-center politicians, "who represent a 'new' liberalism or a 'third way' of government, and though they emphatically reject the ‘old right’s’ creed of callousness, which leaves people’s fates entirely to the verdict of an often crude market, they also reject what they call the ‘old left’s’ stubborn assumption that citizens should share equally in their nation’s wealth” (Dworkin 2000, 1). Considering how unequally wealth is distributed, even in very prosperous nations, the equal concern governments have for the fate of all those citizens over whom they claim dominion, and from whom they claim allegiance, is made suspect. If equal concern is “the sovereign virtue of political community,” then without it “government is only tyranny” (Dworkin 2000, 1).

So as not to get confused, political equality, unlike social equality, is one of the core values of democratic theory and the source of democracy’s radicalism. It is the “idea that all people are equally qualified to rule” (Hudson 2010, 254). Although the central value of political equality is agreed upon by democrats in relation to social equality, its relationship with political equality in a democratic society remains controversial as “vast inequalities among citizens in social status, wealth, and life styles [are]... found in all countries claiming to be democratic” (Hudson 2010, 257). Hudson (2010, 258) wonders if these types of inequalities can coexist with political democracy, and whether or not they affect, or interfere with “the ability of people to govern themselves as equals?” The question of whether political equality requires some measure of social and economic equality, and to what degree, leads to the debate between equality of opportunity and equality of condition.

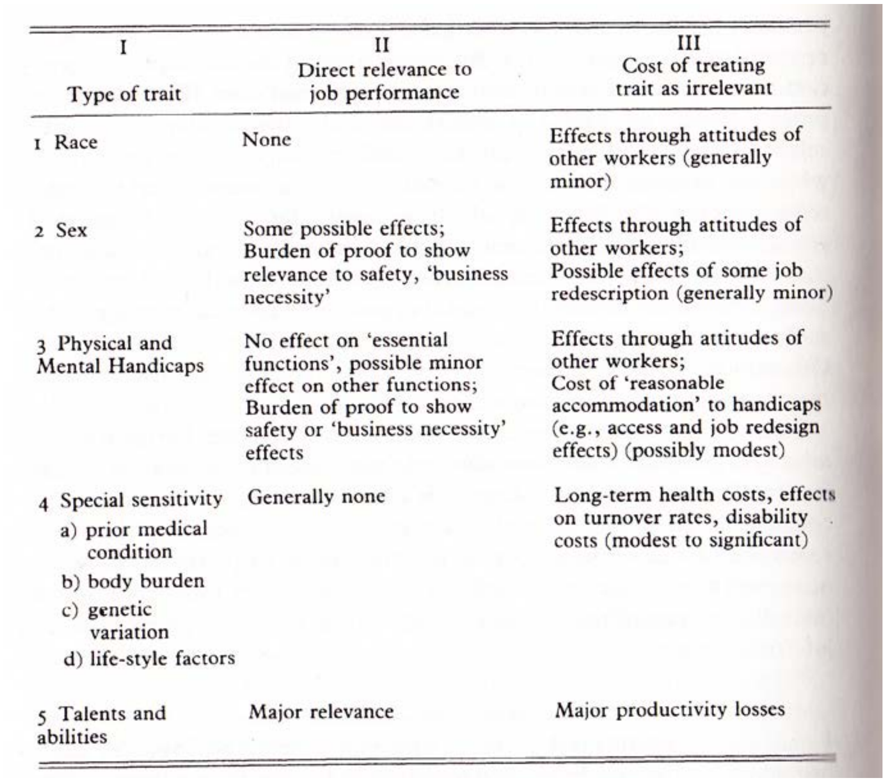
## **Equality of Opportunity**

Equality of opportunity argues that “as long as the political rules of the game are the same for everyone, there is no cause for concern when some are able to succeed better than others, and inequality results" (Hudson 2010, 258). According to egalitarianism, equality of opportunity is a basic human right that "respect for persons" demands. People have the right "to personal liberty, to the ability to construct and execute a reasonable life plan and to share in the control of the institutions and policies that shape society and one's own life" (Dougherty 1988, 55). In determining real opportunity, however, one's health status is an important variable to consider, as poor health can easily compromise one's ability to function normally and/or pursue offices and jobs that are available in principle to all in a just society. According to fair equal opportunity, the goal of guaranteeing a right of access to health care would be to maintain, restore, or replace normal functioning. A right of access to health care, based on fair equal opportunity, would have the same status as a right to public education, meaning it "would be publicly distributed to guarantee the attainment of a minimum degree of functional normalcy so that the conditions of competition for offices and jobs would be broadly fair" (Dougherty 1988, 107).

Norman Daniels (1985), who developed his own fair opportunity account, argues that, due to the strategic importance of health in our lives, as it greatly affects "the range of opportunities one can normally expect to have in one's particular society, given one's particular talents... society ought to provide health care in an egalitarian way" to restore one's health to the greatest extent possible (Segall 2010, 30). According to Daniels (1985), "people have equality of opportunity only if irrelevant features of persons do not interfere with ability-based placement" (204). Traits like race and sex have little or no direct bearing on one's ability to perform a job, and therefore are considered morally irrelevant for purposes of job placement. By ignoring such traits in job placement decisions, no harm is done to the individual, only good. In contrast, skills, abilities, and talents are considered relevant, as "there is a gain in productivity from matching within certain limits the abilities of persons to the requirements of jobs” (Daniels 1985, 204). Although there is disagreement about whether people with the highest qualifications should always get the job or whether over-all productivity should be taken into more serious account, due to a “deep social concern to enhance productivity through social cooperation, skills, and talents,” most agree that skills and talents are a relevant basis for assigning persons to jobs (Daniels 1985, 204). Handicaps, which fall between relevant and irrelevant traits, are relevant only if they directly “prevent the competent performance of the central tasks of a job…we then say the individual is not a qualified individual” (Daniels 1985, 205).

Other traits, categorized as special sensitivities, include prior medical conditions, body burdens, genetic variations, and life-style factors. These special sensitivities to workplace risks, like handicaps, fall between relevant and irrelevant traits. Ignoring special sensitivities to workplace risks, by treating them as irrelevant, in the name of equal opportunity, might actually cause harm to the individual, which is a good reason for not putting them in the same category as race and sex. In order to protect equal opportunity in the workplace, special policy options might need to be applied in order to expand the range of opportunities people with special sensitivities have “in order to compensate them for the loss of opportunity involved when we exclude them from risky work settings” (Daniels 1985, 208). Basically, special sensitivities have generally no direct relevance to job performance, while the cost of treating them as such, can lead to long term health costs, effects on turnover rates, as well as disability costs.

**Chart 1.1**



| I<br>Type of trait | II<br>Direct relevance to job performance | III<br>Cost of treating trait as irrelevant |
|---|---|---|
| 1 Race | None | Effects through attitudes of other workers (generally minor) |
| 2 Sex | Some possible effects;<br>Burden of proof to show relevance to safety, 'business necessity' | Effects through attitudes of other workers;<br>Possible effects of some job redescription (generally minor) |
| 3 Physical and Mental Handicaps | No effect on 'essential functions', possible minor effect on other functions;<br>Burden of proof to show safety or 'business necessity' effects | Effects through attitudes of other workers;<br>Cost of 'reasonable accommodation' to handicaps (e.g., access and job redesign effects) (possibly modest) |
| 4 Special sensitivity<br>a) prior medical condition<br>b) body burden<br>c) genetic variation<br>d) life-style factors | Generally none | Long-term health costs, effects on turnover rates, disability costs (modest to significant) |
| 5 Talents and abilities | Major relevance | Major productivity losses |

Source: Daniels 1985, 206

## Objections to Daniels's Fair Opportunity Account

Two main objections are raised concerning Daniels's fair opportunity account. The first objection argues that Daniels's fair opportunity account justifies selective care, instead of universal care, making it discriminatory, and therefore it "might be harmful to individuals' sense of self respect, which is according to Rawls, "perhaps the most important primary good" (Segall 2011, 32). Although Medicaid, a selective service for the poor, is seldom seen as disrespectful of the rich, the exact opposite is sometimes suggested, namely that selective services stigmatize the poor. In contrast, new universalistic family security policies that have non stigmatizing incentives could give to the most disadvantaged among the American poor the opportunity to be morally reintegrated into the mainstream of national life. When it comes to funding family security programs, or even universal health insurance, based on the history of the modern Social Security system, “Americans will accept taxes that they perceive as contributions toward public programs in which there is a direct stake for themselves, their families, and their friends, not just for ‘the poor’” (Skocpol 1995, 270).

The other main objection to Daniels’ fair opportunity account is that it fails to justify providing any sort of health care to people over the age of 75. Most patients who are treated by health care systems are individuals in the twilight of their lives, and therefore “it seems safe to say, then, that the lion’s share of health care resources are not currently geared toward providing patients with an opportunity to pursue their life plans” (Segall 2011, 33). By the age of 75 he assumes that people have lived out their life plans. This would mean that even the provision of aspirin to people over the age of 75 would need to be “justified on grounds other than opportunity to pursue life plans, and therefore other than justice” (Segall 2011, 33). In cases of terminal illness, where there is an endless demand for the commitment of health care resources, the attainment of normal opportunity is no longer a practical possibility. Therefore by tying the right to health care to opportunity, terminally ill patients would be denied health care on the basis of having a right to it. Rather “it may be provided out of compassion or a sense of decency” (Dougherty 1988, 107).

## Equality of Condition and the Power of Politics

On the other side of the debate, those that argue for equality of condition “question whether true equality of opportunity can exist when there are large differences in wealth and social status in society” (Hudson 2010, 258). Proponents of equality of condition, consider the actual opportunities people have growing up in places like New Orleans’s impoverished Lower

Ninth Ward,  and compare them to the kinds of opportunities a child in a wealthy suburb has, as they believe the difference between the two “translates automatically into differences in opportunity” (Hudson 2010, 258). Hudson (2010, 258) argues that a society of political equals, would find ways to make up the difference in the kinds of opportunities that the rich have in comparison to the poor, and therefore “the very existence of acute social inequalities is probably an indicator of political inequality”.

Dworkin, who argues for an equal division of resources, believes that an overall theory of equality must integrate private resources, as well as political power, as he explains that “from the standpoint of any sophisticated economic theory, and individual’s command over public resources forms part of his private resources” (Dworkin 2000, 65).  Therefore “someone who has the power to influence public decisions about the quality of the air he or she breathes, for example, is richer than someone who does not” (Dworkin 2000, 65). As regards to the nonaffluent, who find political participation and representation much more costly than do the rich and highly educated, as they lack the power to influence government, social inequalities in America have begun to move beyond tolerable levels. This inequality would be tolerable, except for the fact that without any political influence, the poor now have no way of improving their condition. According to Hudson (2010, 284) income inequality in America, along with “the coincidence of differences in wealth, race and even geographical location [has] produced tremendous differences in political power and influence”.

In relation to health, according to the current understanding in epidemiology, differences in health are primarily determined by factors other than health care. Empirically speaking, as it is more or less universally accepted, socioeconomic factors are most significantly predominant in determining one’s health. Therefore, in order to reduce health inequalities, governments ought to pursue policies aimed at “equalizing individual life opportunities, such as investment in basic education, affordable housing, income security, and other forms of antipoverty policy” (Segall 2011, 91). Although an increase in public investment in education makes good sense, an overall increase in inequality in recent years has occurred despite the fact education levels and skills have risen in America. Besides more progressive taxation, universal programs, like those in Europe, which have reduced inequality below American levels, are the most effective way to boost the incomes and living standards of all Americans, including the poor. Among universal programs, universal health insurance is at the top of the list, as it “would eliminate a substantial source of insecurity in the lives of the poor and would attract widespread political support” (Hudson 2010, 289).

It was proven in a study that the affluent receive a greater amount of responsiveness from their senators, than do the poor, which may also explain why in recent years, public policy has been contributing to economic inequality rather than reducing it. Therefore, due to the poor’s lack of access to the same kinds of opportunities the rich have to influence government, political scientists have begun to fear that “political inequality in America has reached such a level that to enact policies to address rising economic inequality has become impossible” (Hudson 2010, 285). In the United States, it is unlikely that social programs, such as universal health insurance, will ever be enacted, without the mobilization of the working class and lower income citizens, who typically do not participate politically in the United States, but who have precisely the same social and economic characteristics as those who support left-wing European parties. The extent to which social and political inequalities are linked in the United States, seems to suggest that unless some form of redistribution of wealth occurs, the poor will continue to lack what it is they need to improve their condition, making equality unattainable.

## **Utilitarianism**

Opposite of egalitarian theories of justice are the utilitarian and libertarian perspectives. Utilitarianism, as a comprehensive moral theory, has two main parts: act and rule utilitarianism. Act utilitarianism argues that an act is right, if and only if, it maximizes net utility; “utility is defined as satisfaction, happiness, or as the realization of preferences, as the latter are revealed through individual choices” (Buchanan 2009, 55). Rule utilitarianism argues that actions are right if they happen to fall under rules intended to maximize net utility, meaning it would be wrong to comply with any rule that fails to maximize utility. Although there are different forms of the theory, the most prevalent form, classic utilitarianism, “defines the rightness of acts or rules as maximization of aggregate utility” (Buchanan 2009, 55). Aggregate utility is the sum of the utility produced, by either an act or general compliance with a rule, for each individual affected. Contrary to act utilitarianism, rule utilitarianism “include[s] an account of when institutions are just,” in order to justify actions or decisions that do not maximize utility, so long as they fall under some rule of an institution (Buchanan 2009, 55).

The problem with utilitarianism has to do with its implications for justice. From a theoretical standpoint, utilitarianism is incapable of judging a situation to be just or unjust, as it attends to only the aggregate outcome.  Act utilitarianism, for example, “mandates the consequentially maximum choice in a situation, even if reaching this optimum result appears to work an injustice on one individual or some of the individuals involved” (Dougherty 1988, 51). Although rule utilitarianism “tempers this tendency by the application of the mandate at the level of rules or policies... there is still a possibility that a rule that maximizes goods consequences on average and in the long run can appear unjust to one or some individuals” (Dougherty 1988, 51).

Rule utilitarianism improves on act utilitarianism's shortcoming, by allowing for the derivation of rights from rules. Derivative rights, founded ultimately on considerations of utility, are secured by a rule or policy that guarantees certain entitlements to persons, and therefore "a utilitarian moral theory can include principles of rights that prohibit or trump appeals to utility maximization, as long as the justification of the principles is that they are part of an institutional system that maximizes utility" (Buchanan 2009, 56). For example, "an employee's right to health care benefits may be based on the utility produced by the rule for the distribution of benefits, and the rule determines that today this employee is entitled to receive benefits" (Dougherty 1988, 51). Due to utilitarianism's lack of a coherent concept of a right, it has an obvious problem with justice, as what might appear unjust, although it may be a less likely result, cannot be ruled out in principle.

A serious criticism of utilitarianism, that it is incapable of providing a secure foundation for a universal right to health care, a right to at least some minimal core of health, stems from the certain classes of individuals that the theory virtually excludes from all health care. Babies born with Down syndrome who tend to require more social resources throughout the course of their lives, relative to what it costs to take care of them, individuals born with this disease may not make a large contribution to social utility, thus permitting their exclusion from the right to health care. There are two points to consider concerning the classes of individuals utilitarianism would require excluding from the right to health care. The first point to consider has to do with the fact that babies born with Down syndrome are generally capable of "enjoyment, purposeful activity, and meaningful interpersonal relationships, and can often attain something approximating a normal life span," unlike severely disabled individuals (Buchanan 2009, 57). The second point to consider regards utilitarian calculations, which might require that Down syndrome babies be denied not only expensive, exotic, medical technology, but also the most basic of care. It is Rawls (1971), who argues that utilitarianism has a deficiency, in that it lacks the ability "to accord proper recognition to the values of fairness and dessert, [which] stems ultimately from its failure to take seriously the 'separation of persons'" (Buchanan 2009, 58).

Ethical objections to utilitarianism count heavily against not only attempts to base a right to health care on utilitarian grounds, but also to rely on the principle of utility "as a guide to more allocative decisions, both within and outside health care" (Buchanan 2009, 58). This does not mean however that utilitarian considerations have no weight in allocating health-care resources, as virtually all ethical theories find maximizing utility a weighty consideration. There are principles besides those of justice, such as the concern for maximizing utility, which "is an important component of any ethical guide to health distribution," that health policies ought to take into account (Segall 2011, 118). With regard to ethics and health, a sole moral principle like distributive justice cannot account for all our intuitions, and therefore it must be supplemented and traded off with other moral requirements, like the concern for maximizing utility.

There are however limits when it comes to maximizing utility, as valid right claims 'trump' appeals to what would maximize utility, whether it be the utility of the right-holder, or social utility. For instance, if A has a right to X, then A's right cannot be infringed upon, even if overall utility is maximized by doing so, according to recent rights theorists. As an ethical principle, utility does not fare well as the appropriate standard for evaluating allocations, by assuming that society is an apparatus for maximizing overall utility. By maximizing utility, utilitarianism runs the risk of being grossly unfair or unjust, as it neglects fairness as a fundamental ethical value, which makes it a very controversial ethical theory.

## **Libertarianism**

Contrary to the egalitarian and utilitarian perspectives, Robert Nozick's paradigmatic libertarian view prohibits coercive efforts to redistribute wealth, "even for the purpose of providing the most minimal welfare rights, including all forms of a right to health care" (Buchanan 2009, 58). In reference to the state and its powers, the state is only allowed to protect individual's negative rights, such as protection from assault, theft, and fraud and for national defense. Unlike real negative rights, positive rights, like the right to education, employment, housing, and to a decent standard of living, because they can only be satisfied by the violation of someone else's right, are therefore "not rights at all for the libertarian, but are manifesto assertions of desiderata" (Dougherty 1988, 71). In most cases, positive rights require that people be provided with access to goods and services through the coercive taking of people's private resources in the form of taxes. This however violates their fundamental right of personal liberty, and therefore there can be no positive rights. Personal liberty is violated not only when people are interfered directly, but also when people's possessions are coercively taken. As people invest their rational choices in their property, their possessions become extensions of themselves, which makes the negative right of noninterference with personal property second only to the negative right of personal interference.

Thus there is no need for a theory of the just allocation of resources, including health care resources, as resources would be allocated by market processes; in so far as people exchange or give what they have rightfully acquired, whatever allocation of resources that results would be considered just. Justice then, from a libertarian point of view, is simply respecting persons and what they rightfully own.

According to the libertarian point of view, “the obligation of citizens to participate in or support the broader community or public good is minimal” (Hudson 2010, 112). The central premise of libertarianism suggests:

> that a truly democratic society is precisely one in which individuals have maximum freedom to pursue their own goals independent of others in society... fails to take into account the many ways in which individuals are inevitably connected to and dependent upon one another and on society as a whole (Hudson 2010, 113).

Based on thought experiments by social scientists, it is very important for individuals to have concern for others, for without their cooperation “totally self interested individuals cannot achieve even their individual interests” (Hudson 2010, 113). The prisoner’s dilemma, a famous “thought experiment,” illustrates how radical individualists who try to maximize their self interests fall short of achieving what they could have through cooperation. Contrary to the libertarian conception of the autonomous individual, in reality, “individuals need more than simple freedom from others and society to attain their goals; they require social support and the cooperation of others to live successful and productive lives” (Hudson 2010, 118)

## **Liberty vs. Equality**

According to a long term and familiar finding in the study of American political culture, there has been a preference for individual liberty over societal equality in America. Although the two are often discussed together, liberty and equality can often conflict given the many individual and environmental differences among people. For instance, “the more a society focuses on individual liberty, the more people will find themselves under inequality of income, education, social connections, health, and overall options in the pursuit of happiness identified as a national goal in the Declaration of Independence” (Smith 2011, 161). From a libertarian perspective, the strongest moral obligation, not to interfere with others' rational agency, acts as a constraint on all other moral values. Other moral values, like producing happiness or achieving greater equality of opportunity, can only be sought "insofar as they do not violate the fundamental right of personal liberty" (Dougherty 1988, 70).

On the other hand, "the more government promotes equality, the less liberty will be enjoyed by the population at large, who are likely to be heavily taxed to provide social services for the poor, to find their business activities heavily regulated by government, or to find that they must associate with groups they may dislike, at least in the public sphere" (Smith 2011, 161). Taking into consideration other wealthy industrialized democracies, although the U.S. government's commitment to the "general welfare of its citizens has grown dramatically over time, when compared with most developed nations, the United States has only a quite modest commitment to promoting socioeconomic equality" (Smith 2011, 161).

Alexis de Tocqueville (2003) who analyzes the reasons why democratic nations display a more passionate and lasting love for equality than for freedom, explains that the aim of democracy is an ideal at which point freedom and equality meet and blend together. At this point, "with no man different from his fellows, nobody will be able to wield tyrannical power; men will be completely free because they will be entirely equal; they will all be completely equal because they will be entirely free" (Tocqueville  2003, 584). That form of equality, while there are others like it, is the most complete form of equality on earth.

Concerning freedom and equality, in every century:

> One unusual and predominant fact appears to which all the others are connected... that special and predominant fact which particularizes these centuries is the equality of social conditions (not freedom)... Freedom has revealed itself to men at different times and different forms; it has not been exclusively bound to one social state and it makes its appearance elsewhere than in democracies. Thus it

> cannot be taken as the distinctive characteristic of democracies. (Tocqueville 2003, 584).

Besides equality being the distinctive characteristic of the era, there are other reasons as to why men of all ages prefer equality to freedom. For one, equality is harder to destroy than freedom, as men are attached to it not only because it is dear to them, but because they believe it must last. Only by long laborious efforts could a nation ever destroy equality, as “it would have to modify the state of society, abolish its laws, renew its ideas, change its customs and debase its ways” (Tocqueville 2003, 585). Freedom on the other hand is easy to destroy, “for just loosening one’s grip is enough for it to slip away” (Tocqueville 2003, 585). Although democratic nations have a natural taste for freedom, when it comes to equality, they would rather be equal in slavery than be unequal and free. With a burning, insatiable, constant, and invincible passion for equality, nations will endure poverty, subjection, and barbarism but they will not endure aristocracy; and therefore “any man and any power which would contest the irresistible force of equality will be overturned and destroyed by it” (Tocqueville 2003, 587).

Drawn from actual political controversies in Britain and in the United States, the following examples are of situations in which liberty and equality are thought to have been in conflict. The first example, campaign expenditures, refers to the 1974 statute that the U.S. Congress enacted, whose aim was egalitarian, which “limited the amount any one person could lawfully spend to advance the interests of a particular political candidate” (Dworkin 2000, 124). The idea was that rich people would have a much larger impact on the political process than poor people, if they were allowed to spend as much as they wished on politics. Although the decision was widely challenged, part of the statute was declared unconstitutional by the Supreme Court which held that the constraint violated freedom of speech, protected by the first amendment.

Another example, one lively in British politics, involves Britain's National Health Service and how those with sufficient means may pay for private medical care, which allows them "to jump queue for treatment of painful and incapacitating disease" (Dworkin 2000, 124). In the interests of equality, some sections of Britain's labor party "favor abolishing private medicine through laws that would forbid private arrangements to medical care"; however most British politicians "reject that policy on the grounds that it would violate an important part of their liberty-freedom of choice in medical care" (Dworkin 200, 124).

The last example that of minimum wage and maximum hour legislation has not only historical character, but also continuing contemporary importance. Early in this century, U.S. state legislatures, like that of New York's, began regulating "employment contracts by limiting the hours people might be employed to work during a week or day or by stipulating minimum wages an employer might offer his employees" (Dworkin 2000, 124). The state of New York, for example, "forbade bakers to work for more than sixty hours a week" (Dworkin 2000, 124). This statute was defended as a health measure, but was declared unconstitutional, as it infringed upon an important liberty of constitutional standing: freedom of choice in contract and employment. Considered to be the second worst decision in U.S. Supreme Court history, most of the critics of the decision seem to believe, that the court insisted on its own preferred ranking of liberty and equality in place of the ranking the New York state legislature had made. These examples seem to show just how unimportant equality really is for some people. What makes them controversial, is that in each case liberty is thought to conflict with equality rather than something else, meaning if liberty must at times yield to competing interests, why should equality not be among those competing interests?

## Government Involvement

Regarding the current state of the American health care system, there are three evident directions for active government involvement. These alternatives all share the same first premise: "that the health care marketplace, even when modified, fails to satisfy the important public duty of achieving some decent level of health care for all Americans as a matter of a right, and that in light of this failure, there is a public, hence ultimately governmental, responsibility to create an alternative system for financing and delivering care" (Dougherty 1988, 164). The first direction the government could take would be to somehow expand the existing Medicare and Medicaid programs. Medicare, with its limited scope, has had success "in providing enhanced security, access to care, and improved health to older Americans and to its other beneficiaries" (Dougherty 1988, 165). Medicaid, on the other hand, due to its strict eligibility requirements, is more of a mixed success, as in some states "eligibility standards fall well below federal poverty guidelines, making coverage for the poor far from adequate nationally" (Dougherty 1988, 165). The second direction the government might could take, would be to adopt some sort of universal health insurance scheme, and lastly a national health care service, like that of Great Britain's, could also be designed and implemented.

## **Medicaid and Medicare**

Medicare's lack of coverage for health care needs of the elderly is one of the reasons why the government should consider expanding the existing Medicare program. According to the Kaiser Family Foundation, a non-profit research organization that serves as a non-partisan source of facts, information, and analysis for policymakers, Medicare covers about half (48) percent of health care cost for enrollees. Meaning the other half, health care needs like "long-term custodial nursing care, dental care, drugs purchased outside a hospital or skilled-nursing facility, eyeglasses and exams, hearing aids and exams, routine podiatry, routine physical exams, most immunization and vaccinations, services by a detoxification facility, and any injections that can be self-administered, such as that of insulin" the enrollees must pay for themselves (Dougherty 1988, 166).

In 1988, Congress tried to change Medicare when it "enacted major legislation to expand Medicare coverage to include long-term nursing home care for the elderly" (Hudson 2010, 125). The Medicare Catastrophic Coverage Act of 1988 (MCAA), was to broaden Medicare's coverage in order to prevent financial ruin from "catastrophic expenses which might include diseases such as cancer or AIDS that progress over a lengthy period of time and thus are very costly" (Patel and Rushefsky 1999, 108). Medicare previously had extremely limited long-term care coverage, which can deplete the life savings of the average family in a couple of years. Following the enactment of the MCAA, the risk for illness-related catastrophic financial losses in the elderly would have been reduced; however, the act was repealed in 1989, due to opposition not only from the drug industry, but also from senior citizen groups, who were at one time proponents of the legislation, but then became outraged when Congress imposed increased premiums to pay for the expanded coverage.

The Affordable Care Act, which offers new and improved benefits for those who rely on Medicare, promises not only free preventive checkups, but also more complete subsidies for prescription drug coverage. By 2011, beneficiaries of Medicare will no longer pay deductibles and other costs for recommended preventive services. Older people on Medicare will also experience a sharp reduction in the cost of their pharmaceutical medications by the end of this decade, as “the new reform will pay for 75% of prescription drug costs, and the prices charged by pharmaceutical companies will be sharply reduced for Medicare recipients” (Jacobs and Skocpol 2010, 124).

One way to improve Medicaid would be to federalize the program. Federalizing Medicaid would solve the problem created by the eligibility standards of some states, which disqualify many women of child bearing age, whose incomes are below the United States’ poverty line. Instead, by federalizing Medicaid, there would be one administration, and one standard for eligibility, which “might be set not by an income level for the nation, but by a national formula that would measure local costs of living in general and of health care in particular” (Dougherty 1988, 167).

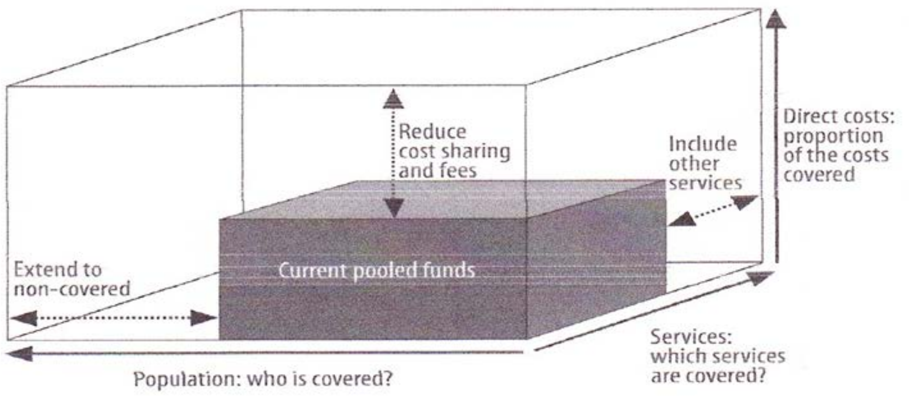
For the economically vulnerable, who currently lack insurance, the Affordable Care Act expands access to Medicaid. Now more Americans will be eligible for the program, as Medicare is being redesigned to grow to cover 16 million more enrollees. The program is being widened to include adults without children, while the income level for eligibility will also be raised “to a nationally consistent 133% of the federal poverty line” (Jacobs and Skocpol 2010, 132). Considering that Medicaid expansion will cost 45% of what the new health reform will cost overall makes it a big deal.

## Universal Health Insurance

Adopting universal health insurance is the second direction the government could take in order to provide a decent level of health care for all Americans. The challenge the United States currently faces in providing universal health care coverage is made present in Fig 1.1. The three dimensions to consider when moving towards universal health care coverage are: population, services, and direct costs. The box labeled “current pooled funds” “depicts the current situation in a hypothetical country, where about half the population is covered for about half the possible services, but where less than half the cost of these services is met from pooled funds” (WHO 2011, 13). Therefore in order to obtain universal coverage, the hypothetical country would need to go about extending coverage to more people, while also offering more services, and/or pay a greater part of the cost.

**Figure 1.**

Fig. 1. **Three dimensions to consider when moving towards universal coverage**



Source: Adapted from (*9, 10*).

In the past, the American political agenda has included plans for national health insurance. For example, many reformers considered the passage of Medicare and Medicaid in

1965 to be an incremental step in that direction. Coincidentally, the rising costs of the Medicare and Medicaid programs, along with inflation and recession, have stalled consensus on other proposed bills for national health insurance. Take for instance President Clinton's plan. Considered to be the most far-reaching program of social engineering to be attempted in the United States, since the passage of Medicare and Medicaid in 1965, Clinton's plan would have "herded almost all Americans under age sixty five into large, government-sponsored health insurance purchasing alliances" (Feldman 2000, 1).

## Clinton's Plan

The president charged a task force of experts within the executive branch, under the supervision of First Lady Hillary Clinton, with developing a comprehensive and detailed plan for national health care reform. The plan developed by Clinton's task force, had at its core Professor Enthoven's theory of managed competition. Managed competition, "a system for providing health care on regional basis, in which patients choose between competing systems of managed care" relies on managed care at the basis of organization, financing, and delivering health care (Barr 2007, 102). Managed care is paid for through a capitation arrangement, and is "managed" by a responsible group, like for instance an insurance company. The "responsible" groups are responsible for assuring that all necessary care is provided, and that the cost of that care does not exceed budgeted funds. Enthoven developed his theory in response to the problems that occur when a purely market approach is taken to providing health insurance. He predicted that by modifying market through regulation, in order to counteract the forces that create market failure, "the health care system would be transformed, gradually and voluntarily, from today's system with built-in-cost increasing incentives to a system with built-in incentives for consumer satisfaction and cost control" ( Barr 2007, 102). According to Feldman (2000), given the fact that people do not trust the government to manage their medical care, Clinton's plan failed because it was too transparent. Citizens were interested in knowing more about Clinton's health care reform at the time, but were misinformed by the President's plan, which hid the cost of public insurance.

One of the major benefits associated with national health insurance is improved access to and equity of care. By ensuring care in the future, a national health insurance plan would also create peace of mind in the present. Although national health insurance is considered to be more of a financing mechanism than a health care program, it is compatible with American ideology. By spreading risks, "sharing them at any given time between the healthy and the sick," a national health insurance program would also "tend to create an enhanced sense of community and underscore the social character of health and sickness" (Dougherty 1988, 168). An insurance scheme such as this "tends to shift more costs to the healthy and the nonpoor and more benefits to the sick and poor, thus helping those who are worst off" (Dougherty 1988, 168).

Public and self-interest theories provide competing explanations regarding not only the objectives underlying national health insurance, but also the pressures that have forced various Presidents as well as the U.S. Congress to enact health reform. Beginning with public interest theory, it states that" the motivation underlying NHI is to increase access to medical care by those with low incomes" (Feldstein 2001, 276). Contrary to this belief, the self-interest theory argues that those with low incomes already have national health insurance; it is Medicaid. Medicaid, which is generally acknowledged to be an inadequate program, could be improved, by increasing the funding and the eligibility for the program; however, the middle class is unwilling to do so, thus "it must therefore be concluded that the main objective of NHI is not to help those with low incomes by increasing taxes on those who have higher incomes" (Feldstein 2001, 277).

An alternative goal of national health insurance is one that is consistent with the self-interest theory, namely, to use the power of government to benefit politically powerful groups. Politically powerful groups like the aged, who are able to provide legislators with political support, have been provided with benefits in excess of their contributions to Social Security and Medicare. These redistributive programs are funded through the use of regressive taxes, "which were borne by the non-aged" (Feldstein 2001, 277).

Some national health insurance plans are a part of even wider social insurance plans which cover pensions, unemployment, occupational retraining, and financial support for students. Social insurance, which is compulsory, "represents a transfer of income from younger employed people to older people or to people who become prematurely disabled" (Bodenheimer and Grumbach 1998, 163). Unlike private insurance, which is insured by a private institution, social insurance is insured by a private agency and is financed by a large number of people that pay relatively small amounts. Social insurance and private insurance do share some similarities; for instance, social insurance contributions resemble those of private insurance in the sense that they are earmarked for a particular use. Other similarities the two often share include: the wide pooling of risks, specific definitions of the benefits provided, specific definitions of eligibility rules and the amount of coverage provided, specific premiums, and contribution or tax rates required to meet the expected costs of the system (Myers 1985).

## **National Health Service**

The establishment of a national health service is the third and final direction for government involvement. In establishing a national health service, generally, government would have more of a "direct hand in the provision and financing of health care, perhaps through a system of national hospitals and salaried health care professionals of through more direct public control over capitation, fee-for-service arrangements, and other aspects of the health care market" (Dougherty 1988, 175). Active governmental control is the norm in other industrialized democracies and throughout Europe where health care is either free or heavily subsidized by the government.

There are a number of clear benefits to be expected from a national health service, among them are universal access, general equality of care, cost containment, the delivery of high-quality health care, and an enhancement of social solidarity, as well as a focus for national sharing and mutual concern. First, implementing such a system in the United States could improve upon the average life span and infant mortality rates, which are "worse in the United States than in most other industrial democracies that have more active government health care policies" (Dougherty 1988, 176). Second, in terms of cost, although government spending on health care would likely increase, with a thorough monopsony ("single-payer" system) over virtually all sectors of the health market, the total cost of health care to the economy would likely decrease, as prices would be contained. Third, a national health service would also likely deliver a higher quality of care, as it would serve not only the politically powerless, but also the politically powerful. Thus the bulk of the middle class, the elderly, groups organized for the care of those suffering from specific diseases, and even portions of the most wealthy would have an interest in maintaining the highest possible national system of health care. Lastly, a national health service is also likely to enhance cooperation among citizens creating a sense of social cohesion. There is proof of this considering that Medicare, a national health care initiative, was instrumental in ending racial segregation in southern hospitals.

There are also objections however to the establishment of a national health service. First, there are concerns that such a system "would interpose government into the doctor-patient relationship in a way prejudicial to the interests of physicians and patients alike," leading to fears that "governmental control and regulations might dictate treatment options and so overrule some or many physicians' professional judgments" (Dougherty 1988, 178). Second, as the government would become explicitly involved in decisions about rationing and the justice questions raised by them,  moral issues in health care, like abortion, hydration and tube feeding of the irreversibly comatose, and genetic mutation, would become more centrally political questions, posed and resolved by government (Dougherty 1988, 178). Lastly there are concerns about how responsive a national health service would be to individual and highly specific health care needs.

Some of the objections to the establishment of a national health service can be answered. On the subject of doctor patient relationships, "there is no evidence [that supports the claim] that physicians in nations with strong governmental health policies and democratic political institutions have lost their autonomy of practice" (Dougherty 1988, 178). On the contrary, rather the "evidence suggests that physicians maintain a great degree of control over other nation's health policies, over methods of practice and reimbursement, and over the character of the doctor-patient relationship" (Dougherty 1988, 179). In Britain, where doctors have enjoyed far greater freedom from scrutiny than their American counterparts, doctors have complete autonomy to decide whom to treat and how within budgets set by the NHS.

Another serious objection to the establishment of a national health service has to do with the "general question of responsiveness of a massive government bureaucracy to individual and highly specific care needs" (Dougherty 1988, 178). According to many studies, waiting lists are one of the reasons why people opt for private health care and buy private medical insurance coverage. Contrary to what many might think, the NHS is not the only health care system that has waiting lists. All health care systems have waiting lists, the “NHS waiting lists are just more overt than those of other health care systems” (Powell and Wessen 1999, 318).  Due to a lack of responsiveness, “Britons are increasingly accepting the concept of pay-as-you go health care for services not readily available through the national health system” (Johnson and Stoskopf 2010, 108).

# Chapter 2

## Literature Review

With respect to human lives, one's health is vitally important, and in order to survive humans must be able to maintain healthy lifestyles. To ensure the likelihood of survival, in a country like the United States, all must have relatively good insurance to safeguard against from what many consider to be the extremely high cost of health care. The question becomes what's fair. It is fair that so many Americans, through no fault of their own, lack health insurance? Is it fair that many more Americans are forced to purchase their own health insurance, or should the government have a greater responsibility for providing people with access to health care? Should the United States try and pursue a universal health care system that would ensure equal access to health care? Although the government has had an impact on the lives of many Americans, who without Medicare or Medicaid would be unable to afford health insurance, more must be done to ensure that American citizens have throughout their life span basic medical care coverage. It would be a shame if, in the United States, where more money is spent on health care than in any other country in the world, everyone's basic needs were not met.

In conducting my research I was motivated to find a solution for solving the problem that so many Americans currently have in trying to gain access to health care. In part due to the United States being a democracy, which as a form of government was founded upon these very same principles, I primarily focus on theories of distributive justice which argue for fairness and equality. Fairness, a concept argued for by Daniels, Light and Caplan, is related to social justice and equal opportunity. According to Patel and Rushefsky (1999, 134) this concept "sees health care as instrumental in that it allows people to function normally". For the system to be fair, the playing field has to be leveled, by "designing a health care system that keeps all people as close as possible to normal functioning" (Patel, Rushefsky 1999, 134). In trying to decide whether a universal health care system is preferable to the current US health care system, which seems to deny too many people their basic needs, I have reviewed the following literature, which has led me to believe that from a luck egalitarian view of distributive justice, the United States should take immediate action in order to neutralize those inequalities attributable to brute bad luck.

## Rawls' Theory of Justice

American political theorist John Rawls, whose published work *A Theory of Justice* (1971), is considered not only hugely influential, but also groundbreaking by normative international relations theorists. Rawls introduced a now-famous thought experiment known as the 'original position'. In the 'original position' individuals have no knowledge of their own "skills talents, class, social status, historical position, sex, and conception of the good," and therefore it is in an individual's best interest to agree to principles of justice for society, like for instance Rawls' difference principle, "or the stipulation that social and economic inequalities be arranged so that they are 'to the greatest benefit of the least advantaged,'" in case they somehow reach an undesirable fate (Dunne, Kurki, Smith 2010, 40). For normative international relations theorists, Rawls' theory "inspired attention to questions of justice beyond the borders of the state, and a frustration with the silences on ethical issues generated by an ostensibly value-free discipline of IR" (Dunne, Kurki, Smith 2010, 41)

In relation to the right to health care, and the level of health care that might be claimed within this right, Shelton (1978) summarizes in his work Ronald Green's analysis of Rawls' *Theory of Justice* (1971), as well as Robert Veatch's beginning of a construction of theory for a just distribution of health care. Green points out that Rawls' theory does not discuss health care, though he is convinced that Rawls' views for health care policy have serious implications. His analysis of Rawls' theory argues that it "opt[s] for a principle of equal access to health care to the most extensive health services the society allows" (Shelton 1978, 168). He notes that Rawls "seems to rule out direct income-based distribution of health care" (Shelton 1978, 168). Rawls gives priority to basic preventive and therapeutic services, over "expensive, high quality care and 'costly esoteric research'" (Shelton 1978, 168). While basic services should be made available to all members of society, society's "basic structure" must determine the amount of resources spent on health care.

Like Shelton (1968), Rhodes (1992) also examines Rawls' theory of justice, as he finds Rawls' framework to be compelling. According to Rawls' maximum argument, while individuals are in the original position that is when they are "aware of neither their present nor future income, social position, or other advantages" they will choose a set of principles "whose implementation will maximize the minimum share of primary goods that one can receive as a member of society." (Rhodes 1992, 22). Rawls explains how in the original position, "individuals should make this social contract when they know the actual distribution of circumstantial and generic traits among persons in society, but none knows what person he shall become" (Roemer (1996, 175). According to the maximum argument, the three principles "insure the greatest minimal share," as Rawls argues that any individual would rather choose his principles than "risk that life's prospects might include oppression, slavery grinding poverty, or some other terrible condition" (Rhodes 1992, 22).

According to Rawls' second principle, also known as the difference principle, "social and economic goods are to be distributed equally unless an unequal distribution would improve the position of the worst off" (Zucker 2001, 77). Scholars have used Rawls' difference principle to argue for universal coverage, based on the idea that health care should be added to the list of primary goods, “on the grounds that the least advantaged will not be equally well off without health care even if they are equal in respect to other primary goods” (Rhodes 1992, 22). Rawls’ index of primary goods includes five types of social goods:  a set of basic liberties, freedom of movement and choice of occupations against a background of diverse opportunities, powers and prerogatives of office, income and wealth, and lastly the social bases of self-respect. Daniels (1985), who extends Rawls’ theory to health care, believes that Rawls’ index of primary goods is a bit of a truncated scale. By dropping Rawls idealizing assumption that all individuals are “normal, active and fully cooperating members of society over the course of a complete life,” not everyone will be equally well off, “once we allow them to differ in health-care needs” (Daniels 1985, 43) .Thus Daniels (1985) feels that health care needs cannot be treated as irrelevant when questions of justice are concerned.

## An Inegalitarian Theory?

Roemer (1996, 6) argues that Rawls’ theory has been key in egalitarian theories of distributive justice, “of what it is the just society should equalize across persons”. Contrary to this belief, Zucker (2001, 77) considers Rawls’ difference principle to be inegalitarian, as it follows “from the psychological law that people are rationally self-interested,” which allows for “extreme inequalities of income.” Feldstein (2010, 212-3) agrees with Zucker (2001) on this point, as he explains that when universal redistributive programs are instituted, although the proponents of such programs claim the poor will end up being treated as equals due to the elimination of means testing, the ones who actually net the benefits are groups other than the poor, while the burden of having to fund such programs is actually shifted “to those who are less politically powerful, generally those with low incomes". Due to the fact that median voters are those found in middle income groups, as legislators must move to a position favored by the median voter in order to get reelected, when forming the majority of any and all voting coalitions, middle income groups hold the "key to the formation of majorities, hence political power" (Feldstein 2001, 214). When forming voting coalitions, middle income groups have the option of teaming up with either the rich or the poor. Considering the fact that rich income groups have higher voting participation rates and are also more capable of providing funds to legislators than can the poor, it seems more likely that the middle and rich income groups will form a coalition teaming up against the poor. Regardless of who teams up with who matters not, for as long as the middle income groups hold the majority of power in whichever coalition they decide to form, the objective of any and all universal redistributive program will always be "to provide the middle class with the benefits in excess of their costs" (Feldstein 2001, 214).

## A Right to Health Care?

In the debate whether health care is a privilege or a right, there are those that argue that "everyone should have equitable access, to an adequate level of health care without the imposition of excessive burdens" (Bodenheimer, Grumbach 1998, 217). Bodenheimer and Grumbach (1998, 217) point out that while the principle of justice requires health resources to be fairly allocated among the entire population, as those resources grow scarce, ethical dilemmas arise. What is fair may not always be seen as what is right, when one considers the possibility that physicians, in order to meet everyone's needs, may deny certain medical services in order to refrain from harming others indirectly as services become too costly. Daniels (1983, 4) finds it problematic when those who assert a right to health care have in mind no particular theoretical account of its foundations, justification, or its limits. He argues that a pragmatic appeal to rights to reform the health care system does not "carry us past our disagreements and uncertainties about the scope and limits of such right claims" (Daniels 1984, 5). According to Daniels (1985, 4):

> The appeal to a right to health care is not an appropriate starting point for an inquiry into just health care. Rights are not moral fruits that spring up from bare earth, fully ripened, without cultivation. Rather, we are justified in claiming a right to health care only if it can be harvested from an acceptable, general theory of distributive justice, or, more particularly from a theory of justice for health care.

When claiming a right to health care, a systematic theory of distributive justice for health-related needs is needed, as it serves to answer questions regarding what amounts of resources are needed for servicing health, how shares are to be divided among the different types of health needs, and what an individual's fair share of health services ought to be. A systematic theory of distributive justice is the appropriate starting point for an inquiry into just health care. Such a theory serves to answer questions that those who assert a right to health fail to answer. Rhodes (1992, 18) argues that people do not have a right to health care, because the right cannot be enforced, due to factors that "determine good and bad health [which] are frequently out of the control of government... government... cannot guarantee health."

## Democracy and Distributive Justice

On the subject of democracy and distributive justice "the liberal theory of political justice argues that principles of distributive justice should not be included in the constitutional of a democratic republic because there is bound to be wide disagreement about whether they have been attained in particular circumstances, which might cause political instability" (Zucker 2001, 289). Principles of distributive justice, which are controversial and "frequently considered to be a set of second order moral principles," should not be excluded from the defining characteristics of democracy, simply because it is "difficult to assess the attainment of their aims" (Zucker 2001, 289). Basic liberties are just as hard to assess, meaning "it should not be more difficult, therefore, to get agreement that distributive justice has been attained than to get agreement that political rights have been attained" (Zucker 2001, 290). Principles of distributive justice, in relation to basic liberties, are equally capable of being included in the constitutional essentials of a democratic republic. It actually might be easier to assess whether principles of distributive justice have been met in relation to political liberties, which "cannot be gauged merely by the distribution of votes" (Zucker 2010, 290). Even if the conditions marking the attainment of principles of distributive justice were not easily identifiable, constitutions "almost never specify the particular facts that define the final attainment of a right or liberty" (Zucker 2010, 290). By leaving it up to the Supreme Court as well as legislative enactments, which throughout history have helped in determining the aims of the fourteenth amendment, principles of distributive justice could possibly be established over a long period of time (Zucker 2010, 290).

## **National Communities**

From the point of view of justice, "it is not only the strength of national identity but also the character of national identity that matters" (Miller 1995, 94). A shared national identity is neither necessary nor sufficient for a practice of social justice along Rawlsian or similar lines. For instance, although the U.S. has a strong national identity, it has been singularly reluctant to implement redistributive schemes of social justice. As national identities embody a shared public culture, the quality of that culture in particular, the extent to which the nation conceives itself along solidaristic or individualistic lines is of vital importance in determining which practices of justice are seen as legitimate. It is important to consider not only the strength but also the character of America’s national identity when explaining welfare policy in the U.S. which is “by common consent unusually individualistic” (Miller 1995, 95).

Countries that support redistributive policies like Canada and Switzerland, whose members have both national and communal identities and allegiances, cannot simply be labeled as multinational. In Canada for example, “there seems to have been a shift identity among the French speaking community Quebec over the last decade” (Miller 1995, 95). Originally this community identified themselves as Canadian, but more specifically with the French-speaking population scattered throughout Canada, while, more recently, “the Quebecois have tended to think of themselves as belonging to a separate Quebec nationality whose place in the Canadian state must be understood in instrumental terms.(Miller 1995, 93) Assuming this trend continues, Canada will become a multinational state, “though with the peculiarity that one constituent unit sees itself as distinct while the other does not( the English-speaking population continuing to think of the Quebecois as French-Canadians)” (Miller 1995, 95). Canada’s institutions and policies stem from a period when French and English speakers thought of themselves as different kinds of Canadians. The two held in common more than merely the fact of membership in a single state, a common Canadian identity, one indicative of democratic states that have successfully pursued policies aiming at social justice.

## **Universalism in the U.S.**

Unlike social policies aimed exclusively at helping the poor, universal policies that deliver benefits across classes and races have recurrently flourished. In the U.S., hopes of targeted policies, like the poor houses in the nineteenth century, the mothers' pensions launched in the 1910s, and the War on Poverty and associated Great Society reforms of the late 1960s and early 1970s, were all dashed when met with rock-hard political realities. In the nineteenth century, poor houses were a "part of a general proliferation of institutions to reform people thought to be defective in a period when the disciplines of the market, wage labor, and political citizenship were being established for the majority" (Skocpol 1995, 254). As poor houses failed to improve the character and behavior of the poor, they lost the support of reformers and the public, while "new movements were launched to abolish all public assistance for the able-bodied" (Skocpol 1995, 254).

Mother's pensions, a targeted policy aimed at giving benefits to impoverished widowed mothers, "despite generous intentions and broad popular support, evolved into one of the most socially demeaning and poorly funded parts of modern U.S. social provision" (Skocpol 1995, 255). Most nonwhites were unable to even apply for benefits, as the pensions were implemented predominantly in non-rural jurisdictions. The communities where these pensions were established were so reluctant to spend taxpayers' money on the poor that "many clients could not avoid working for wages or taking in male boarders," which opened them up to charges of child neglect or immorality (Skocpol 1995, 255).

During the administrations of John F. Kennedy, Lyndon Johnson, and Richard Nixon, efforts to erase poverty again to came to the fore in American politics, while reaching unprecedented visibility and scale, reformers once again "dreamed of reeducating the poor to take advantage of economic opportunities, especially by reforming juvenile delinquents, giving children a head start and better schools, and offering job training to adults" (Skocpol 1995, 256). Expenditures directly targeted at the poor almost tripled from the end of FY 1969 through FY

1974, with an increase not in cash assistance, but in programs such as Food Stamps, Medicaid, housing subsidies, and student aid. The service and transfer strategies of all three administrations "failed to reduce poverty rates much among the non-elderly, and certainly failed to reverse such specifically worrisome trends as the increase in out-of-wedlock births and families sustained only by mothers" (Skocpol 1995, 257).

Federal social policies, that exemplify targeting within universalism, like Civil War benefits of the late nineteenth and early twentieth centuries and the Sheppard-Towner program for maternity and neonatal health education of 1921-29, serve as examples of what effective and politically sustainable policies ought to look like in America in order to fight poverty. With policies like these in place, people may soon realize how "work really does lead to rewards, [while] a certain amount of the social despair that now pervades the very poor might well begin to dissipate" (Skocpol 1995, 271).

Although Civil War benefits are not considered a part of U.S. public social policy provision, they did evolve into "a massively expensive de facto system of disability, old-age, and survivors' benefits for all American men who demonstrate[d] merely minimal service time in the United States" (Skocpol 1995, 259). Civil War pensions involved ethnic and regional biases partially correlated with differences in socioeconomic status, meaning that many of the benefits went to native born northern farmers, middle-class employees, and skilled workers, but were also awarded to more than 186,000 freed black slaves, who had served in the Union army. The pensions also helped many poor whites who had lost income and family ties in old age. Civil War benefits were defined in opposition to poor relief as it was argued that they had been earned, an argument that convinced many voters. Broad political coalitions campaigned for ever-improved benefits which "bore political fruit through the Republican Party, yet they also gained the support of many northern Democratic legislators who could not afford to Republicans outdo them in bidding for votes" (Skocpol 1995, 261).

In the early twentieth century, mothers' pensions, child labor laws, and protective labor laws for women workers were established by state legislatures. Political coalitions that included educated reformers, trade unionists, and geographically widespread associations of elite and middle-class married women promoted these materialist measures, "as they were understood as extensions of mother love into the public sphere" (Skocpol 1995, 262). While mothers' pensions ended up focusing on the poor alone, policies like the Children's Bureau and Sheppard-Towner programs rapidly grew, and "reached many especially needy people through efforts that never became stigmatized (as mother's pensions unfortunately did)" (Skocpol 1995, 262). The Children's Bureau, which was created in 1912 to "investigate and report... upon all matters pertaining to the welfare of children and child life among all classes of our people," following the passage of the Sheppard-Towner Act of 1921, "was able to reach large numbers of American mothers" (Skocpol 1995, 262). After seven years of administering the act, the bureau had coordinated the distribution of 22 million pieces of literature, conducted 183,000 health conferences, established 3,000 prenatal centers, and visited more than 3 million homes. Even though the act experienced success in targeting within universalism and remained broadly popular with American women backed by elite and middle class women's associations, it was not made permanent. Private physicians who wanted to conduct prenatal and postnatal health counseling themselves, with the help of their local associations affiliated with the American Medical Association, persuaded President Hoover to kill the program. Unlike Civil War pensions and Social Security, the Sheppard-Towner programs lacked the same successful measures, those that ensured entitlements to broad categories of beneficiaries.

## Policy Making in Relation to Health Care

In relation to health policy making it is important to consider ethical behavior “for any and all participants in the political markets where policy making occurs, as ethical behavior is guided by four philosophical principles”; one of which is justice (Longest 2006, 103). Justice affects the policymaking process as well as the policies themselves. Justice can be thought of as fairness, meaning “a person receives that which he or she deserves” (Longest 2006, 103). The question of “what is fair?” is often raised while various participants in political markets and in the health policymaking process do not always agree on what is a fair distribution (Longest 2006, 104). Egalitarianism, utilitarianism, and libertarianism offer three different perspectives in relation to justice. According to the egalitarian perspective of justice, “everyone should have equal access to both the benefits and the burdens arising from the pursuit of health and that fairness requires recognition of different levels of need” (Longest, 2006, 104). Medicare for the elderly and Medicaid for the poor, are both based on the egalitarian view of fairness. Another perspective of justice, the libertarian perspective, requires “a maximum of social and economic liberty for individuals,” meaning “unfettered markets as the means of distributing the benefits associated with the pursuit of health” (Longest 2006, 104). If health care were a non-excludable public good, and if in order to finance a universal health care system, imprudent patients were asked to pay for at least some of what it would cost to treat them, according to the libertarian perspective, it would be unfair for society to ask them to pay for such costs, considering it is not their problem that society chose to generate or preserve health care, that which cannot be denied from the individual.

The last perspective, a utilitarian perspective of fairness, argues for the greatest good for the greatest number. Health policies pertaining to pollution, workplace safety, and communicable diseases have been influenced mainly by the utilitarian view of what is just in the distribution of benefits and burdens arising from America's pursuit of health. Egalitarian utilitarianism, with regard to equality of welfare, as a conception of equality, is understood "as the theory that people are treated as equals when and only when their pleasures and pains are taken into account quantitatively only, each in that sense to count as one and only one" (Dworkin 2011, 63). By only taking gains and losses in enjoyment as the measure of when people are being treated as equals, the utilitarian conception of equality is implausible, as people value welfare in these particular conceptions differently. In relation to justice, it "provides much of the underpinning for all health policies"; from allocative to regulatory policies, the nation's legal system exists partially to ensure that public policies respect principles of justice (Longest 2006, 104). With respect to all three perspectives of justice, I find that egalitarianism, more specifically luck egalitarianism provides the best solution, for solving the problems currently associated with America's health care system.

## **Institutional Structure**

American health care institutional structures are to blame for the ongoing widespread inequities, and injustice. The system itself lacks ethical principles which "would provide a foundation for distributive justice in the health care system" (p.51). A brief history of the United States' medical profession helps to explain why this is so. A national policy decision that was to have a profound effects on the way health care would evolve in the United States, one closely linked to America's approach to medical care as a market commodity rather than a right, was made in the early part of the twentieth century "to vest in the medical profession substantial authority over the organization and financing as well as the practice of medical care" (Barr 3, 2007). At the time, according to the “The Flexner Report,” state and local governments were relying heavily on the American Medical Association as well as on the AMA’s affiliated state and local medical associations in guiding the restructuring of medical practice. The policy decision to restructure the medical profession was made in response to what was perceived a national crisis. As a complex array of practitioners from different backgrounds, the U.S. medical profession had no legal or ethical standards to maintain a consistent level of quality in the way medicine way practiced.

The decision to vest considerable authority in physicians and their professional organizations over medical education and the practice of medicine was based on a somewhat idealized view of physicians. Physicians were seen as altruistic, guided by a code of ethics, and were therefore trusted to always act as disinterested agents on the patient’s behalf. Historically, the ways in which physicians’ professional organizations have exerted the authority given to them offers a very different picture, as they have often used their power to further their own ends by limiting entry into the profession and by maintaining political sovereignty over the system of medical care. Their power has also been used “to support and protect the role of the individual physician as self- interested entrepreneur… best served by establishing and maintaining the policy principle that medical care was ‘a service that is provided by doctors and others to people who wish to purchase it” (Barr 2007, 4). By approaching medical care as a market commodity, physicians have established their right to charge a separate fee for each service they provide, and base that on whatever the market bears, which is why when making medical decisions, physicians simultaneously look out, not only for the needs of their patients, but also for their own financial interests. Thus, by looking out for their own needs, financial incentives will often push physicians to provide additional care that would otherwise be medically unnecessary.

## **Decentralization**

Concerning policy makers and organizational reforms of government, an option many consider is decentralization. Decentralization “entails the downward delegation of authority and/or decision making to smaller more locally based organizational units, and it implies greater autonomy for local units with resulting diminution of uniformity within the system” (Powell and Wessen 1999, 374). One important goal of decentralization is “to attain greater responsiveness to local needs and demands, thus promoting greater efficiency” (Powell and Wessen 1999, 374). Decentralization in democratic polities, “is seen as means of enhancing or protecting the ‘voice of the people’” (Powell and Wessen 1999, 374). On the downside, decentralization is known to threaten economies of scale, “militate against an organization’s overall ability to deal with exogenous problems, and it may risk the loss of equality among organizational units” (Powell and Wessen 1999, 374).

The decentralization or the devolution of health care services, “is a shift from allocating according to need to allocating equal bundles of resources (in disregard of unequal need)” (Segall 2010, 149). Not only does decentralization upset distributive justice, it also weakens social solidarity. In a decentralized system, the need principle still reigns across communities, meaning the “previously centralized health care budget is divided up and each regional health care authority receives a budget proportional to the size of its population” (Segall 2010, 144). Even when taxation remains in the hands of the federal government, a society that aims at equalizing needs across communities is still less egalitarian than one that distributes goods and services across society according to need.

Pursuing a unified health care system is not always advisable, especially when trust between two or more communities breaks down irreparably. Take for example Israel and

Belgium. They do not count for what Don Horowitz has termed “severely divided societies,” but do have their respective intercommunal difficulties, and therefore “it does not seem a good idea to try and impose, in such societies, a unitary health care system, and it is probably better to allow different communities to separate (through devolution or even secession)” (Segall 2010, 143). Simply put, devolution acts like any other form of divorce, and like divorce, devolution is not something that should ever be encouraged or actively sought. On the other hand, devolution should be allowed, when communities, like individuals, have irreconcilable differences.

Besides the fact that a devolved system of health care upsets distributive justice, another reason “for retaining a unified system rather than opting for a devolved one” concerns the potentially harmful effect devolution has on social, intercommunal solidarity (Segall 2010, 148). Experiments in social psychology reveal that a shift from “distribution according to need to distribution equal shares weakens solidarity in the group in question” (Segall 2010, 149). Considering that social solidarity is significant in the pursuit of distributive justice, by weakening it, devolution appears detrimental to the pursuit of distributive justice across society.

There are two potential objections to the solidarity argument for resisting devolution. The first objection states that devolution does not imply switching to equal distribution between regions, and therefore the need principle “can be enshrined in the very structure of [a] devolved system” (Segall 2010, 149). The idea that even after devolution, regional health budgets could conceivably recognize and mirror a disparity of health needs creates not only a practical problem, but one of principle as well. Practically speaking a wealthy community with fewer health needs has an incentive “to slash the disparity of funding in the future, and bring the situation back to equal per capita funding” (Segall 2010, 149). Post-devolution, there is no reason to think that such a community would not act on the incentive, considering it is a well-documented phenomenon in social policy. If a devolved system of health care was to reflect unequal needs, principally it would defeat one of the purposes of devolution, “namely dealing with the resentment by members of the wealthy community of what they regard as the ‘expensive taste’ cultivated by members of the poorer one” (Segall 2010, 149).

## What Needs to Be Equalized

Equality is said to have instrumental value when it affects the wellbeing of individuals. The instrumental value of equality includes “avoiding unacceptable forms of power and control, preventing stigma through differences in status, preventing harm to individual’s self-esteem, removing impediments to community and fraternity, and facilitating and maintaining democratic institutions” (Segall 2010 113-4). It is important to note that while inequalities in income do seem to “harm a person’s sense of self respect, and consequently may also weaken society’s sense of community and solidarity,” in relation to health, “equality has only a negligible instrumental value” (Segall 2010, 114). Basically equality of health has no instrumental value, meaning it has no effect on an individual’s wellbeing, and therefore it is permissible to abandon the pursuit for equality in health. Rather Segall (2010) argues that priority should be given to the worse off.

Contrary to equality of health, equality of income does have an effect on individual’s well-being. Segall points out that by leveling down, or by equalizing, levels of income, many benefits associated with equality, are realized, as income is said to have instrumental value. Regarding factors that affect health directly, “differences in access to health care account for a rather small percentage of the difference between individual’s health outcomes” (Segall 2010, 90). Differences in health are primarily determined by socioeconomic factors and less so by health care. Medical care can prolong survival, or improve the prognosis, but more important are the social and economic conditions “that make people ill and in need of medical care in the first place” (Segall 2010, 91). Even when health care is understood in its broadest sense, by including non-clinical procedures such as “clean water and food safety, anti-pollution regulation, workplace safety, nutrition programs for infants, and health education,” health care still has a limited impact on one’s health. Considering how important socioeconomic factors like income are in determining one’s health, this discussion will now shift towards deciding whether an egalitarian regime, whose aim it is to reduce income inequalities, is a viable option for a country like the United States.

According to major axiom of modern economics income inequality is positively related to savings investment and economic growth, and therefore it would seem that an inegalitarian regime has the possibility of producing far more savings than an egalitarian regime. By producing more savings, the inegalitarian regime would surpass the egalitarian regime’s productive capacity to generate more national wealth. Thus, members of an inegalitarian regime would be better off than the members off an egalitarian system. In an egalitarian system, the lower strata of society would receive a greater proportion of the national income than they would in an inegalitarian regime; however, “their absolute income would be lower” (Zucker 2001, 142).

Contrary to this argument, a comparative analysis of the Japanese and American economies reveals that the “Japanese economy achieved considerably higher savings with less income inequality than did the U.S. during the 1960s... therefore negating the axiom that income equality and savings are negatively related” (Zucker 2001, 144). Based on Zucker’s (2001, 146) findings, an egalitarian regime is a viable option for not only developed countries, but also the developing ones, as the data suggests that “an egalitarian regime would not impair the standard of living”.

## **Luck Egalitarianism**

Distributive justice, from a luck egalitarianism perspective, requires that a person should be no worse off than anyone else, in respect of some given metric or currency of goods, as a result of brute bad luck. Among others, this view is advocated by Dworkin (2000), Arneson (2004), Cohen (2011), and Roemer (1996). Brute luck according to Segall (2010, 20), is to be understood as “the outcome of actions (including omissions) that it would have been unreasonable to expect the agent to avoid (or not to avoid, in the case of omissions)”. Contrary to Dworkin (2000), Segall replaces personal responsibility with his unreasonableness criterion. He argues that in order to specify when it is permissible to deny people compensation for the disadvantages they suffer from, an inquiry must be made into what society can reasonably expect people to do. His unreasonableness criterion causes the burden of proof to shift away from the individual and towards society, as cases of brute luck are decided upon “whether it is unreasonable for society to expect the individual to avoid a certain course of action” (Segall 2010, 20).

Luck egalitarians do not necessarily object to inequalities per se; they only object to those that are attributable to bad luck (Lang 2004). It is the “fundamental impulse behind Luck Egalitarianism... to correct, compensate for, or neutralize, involuntary disadvantages between individuals”. Luck egalitarians make the case against inequality attributable to bad luck by arguing that if agents are not genuinely responsible for their actions, it is inappropriate for others to blame or penalize them" (Lang 2, 2004). Barry (2008, 3) and Lang (2004) both agree that the luck egalitarian approach "aims to neutralize the impact of luck on the lives of individuals."

Luck egalitarianism has its origin in John Rawls' idea that distributive shares should not be influenced by arbitrary factors. According to Rawls, where one starts off in life is the outcome of a "social lottery (the political, social, and economic circumstances into which each person is born), and a natural lottery (the biological potentials each person is born with)" (Lippert-Rasmussen 2009). The outcome of one's social and natural lottery "is, like the outcomes of ordinary lotteries, a matter of good or bad 'fortune' or 'luck'" (Lippert-Rasmussen 2009). Therefore, argues Rawls, no one's starting position can be justified by claiming that they either merit or deserve an outcome of this kind.

There are two kinds of luck, brute luck and option luck. The difference between the two is a matter of degree, "and we may be uncertain how to describe a particular piece of bad luck" (Dworkin 2009, 73). Contrary to brute luck, option luck is the result of a deliberate and calculated gamble. If one bets on a winning horse at the racetrack, then the option luck is good. Betting on a horse at a racetrack is clearly a deliberate and calculated gamble, while getting hit by a meteorite while on the way to work, is clearly not. The idea is that a man on his way to work has no way of knowing whether a meteorite is going to strike him or not and therefore he is not making a deliberate calculated gamble; he is simply doing what he does every day. It just so happened that a meteorite struck the man, resulting in bad brute luck. If by watching the morning news that morning the man knew there was a chance that a meteor might hit him, then his bad luck would be option luck and not brute luck, since he could have reasonably avoided the incident. According to Segall (2011), society cannot reasonably expect the man to avoid such an incident.

## Option Luck

Cohen (2011) summarizes Dworkin’s (2000) conception of option luck, which, according to Dworkin, helps preserve justice. Based on Dworkin’s view, inequalities that result from option luck are considered just. Contrary to what Dworkin believes, Cohen argues that option luck does not always preserve justice, and therefore it never does. He presents what is called the anti-Dworkin argument, which asks whether a form of equality in distribution would remain just if those whom the distribution applied to, decided to disrupt the equality in distribution by giving half of all their assets to Sara and Jane, not because they consider what they are doing is fair, but because they feel Sarah and Jane are fair. Cohen argues “that the upshot is unfair.” The choice to give Sarah and Jane half the assets was unanimous, which makes it legitimate, but because the new distribution is unfair, which implies injustice, it is also unjust. There are two understandings of how the decision affects justice. The first, which is held by Cohen (2011, 133), argues that “the unequal outcome is not entirely just (because it is unfair) but it is legitimate.” Unanimity trumps equality, meaning it would be wrong for anyone to force the group to return to equality when all were in favor of disrupting it. The unanimously endorsed unequal result is legitimate. Unlike Cohen (2011, 133), Dworkin (2000) holds the contrasting view that “the unequal outcome is both legitimate and entirely just.” According to this view, “unanimous will confers unqualified justice on an unequal outcome that would otherwise be an unjust outcome” (Cohen 2011, 134). According to Cohen (2011), the view held by Dworkin both affirms and denies that the outcome is unfair. In contrast, Cohen (2011) argues that no one has the right to complain about the unequal outcome due to the fact that it is legitimate.

## Responsibility and Expensive Tastes

Dworkin’s work, considered a major contribution to the theory of distributive justice, brings “into much sharper focus an important issue that was germinal in the work of Rawls and Sen, personal responsibility” (Roemer 1996, 237). He argues that justice is required to compensate individuals who are not responsible for those aspects of their situation which “hamper their achievement of whatever is valuable in life” (Roemer 1996, 237). Aspects of their situation for which individuals are responsible for are of no concern for justice. For example, take someone who picks up smoking and is later diagnosed with lung cancer. If it were determined that smoking was the direct cause of the lung cancer, then that person would not be compensated for what it would cost to treat the cancer. The issue that Dworkin’s argument runs into is called the abandonment objection. Many believe that luck egalitarian accounts of justice cannot provide a theory of justice in health care, because they abandon those who need assistance through some fault of their own.

Contrary to Dworkin, Cohen argues that individuals are not to be held responsible for choices they make, when those choices are “dictated by features of his person or personality that he did not choose” (Dworkin 2010, 288). For instance, suppose an individual cannot stand the taste of ordinary water and decides instead to buy expensive bottled water, which lacks what he considers to be the unbearably sour taste of ordinary tap water. The individual did not choose for the water to taste unbearably sour. Rather his taste is a part of his physiological condition. A special sensory reaction causes the water to taste sour to him and forces him to want to purchase bottled water. Instead of being held responsible for what it costs to purchase bottled water, he should be compensated for his bad luck; the condition he has prevents him from wanting to drink ordinary tap water.

Champagne tastes, or expensive tastes that have been cultivated, are those that individuals are to be held responsible for. According to Dworkin, “society should not have to supply the champagne lover with more resources than the beer lover, for assuming the former is glad he has champagne tastes, he should take personal responsibility for acquiring the extra money required to satisfy them” (Roemer 1996, 7). When individuals’ expensive tastes are not cultivated, when they are simply landed, like the expensive tastes belonging to the individual who could not bear the taste of ordinary water due to a physiological condition, they should not have to bear the financial consequences of those conditions.

Regarding expensive tastes, equality of welfare is an improper political ideal, because it fails to distinguish between those who have “schooled themselves into” expensive tastes, and those who are simply stuck with them, like the guy who could not stand the taste of tap water. Therefore, Cohen rejects equality of welfare and equality of resources, in favor of “equality in people’s capacity or capability or opportunity to secure welfare or some other form of advantage” (Dworkin 2010, 289). However, by trying to abandon simple equality of welfare, by trying to be a distinct political ideal, equality of opportunity “collapses back into simple equality of welfare” (Dworkin 2010, 289). Equality of opportunity, considered fundamental by Cohen, is illusory according to Dworkin. Dworkin has an issue with the way Cohen treats beliefs, convictions, tastes, judgments, and ambitions as lucky or unlucky accidents. Dworkin (2010) argues that people do not arrive at moral or ethical conclusions by way of luck. Rather, as moral and ethical agents, they struggle their “way to the convictions we now find inescapable” (Dworkin 2010, 290). He finds it bizarre for society to pity someone, or to compensate people who do not “take consequential responsibility for their own personalities” (Dworkin 2010, 290). If I decide to help a friend in need, it is not a matter of luck. With respect to the man with the expensive taste for bottled water, according to Dworkin’s interpretation of equality of resources, his taste would be considered a handicap and would be treated as such. A handicap is an expensive taste or an “obsession” or “craving” that for the purposes of distributive justice is assimilated to resource deficiency. If an expensive taste is one that an individual “wishes he did not have, because it interferes with what he wants to do with his life and offers him frustration or even pain if it is not satisfied” (Cohen 2011, 23). Equality of resources redistributes for handicaps, meaning the man with the expensive taste for bottled water would receive compensation.

According to Daniels (1985), satisfying the desires that extravagant people form is not the object of justice. People with exotic and expensive tastes, who are desperately unhappy when their preferences are not satisfied, are to be responsible for choosing their ends in such a way that they have a reasonable chance of satisfying them under just arrangements. Thus “there is no injustice in not providing them with means sufficient to reach extravagant ends” (Daniels 1985, 38). Regarding expensive tastes, and in relation to health care, Segall (2010) considers the following illustration. Suppose Israeli Jews consume a greater share of the national health care budget than their proportion of the population, because unlike the Arab minority in Israel, Jewish prospective parents ask for more fetal screenings per pregnancy. Now suppose that the unequal demand is due to choice alone and has nothing to do with bad luck. According to Segall (2010), the unequal consumption represents an unfair state of affairs: an inequality brought on by one group’s expensive taste. Segall attempts to tackle the unfairness in question by applying one of two strategies. The first strategy would be to allow one group to consume a greater share of medical resources, but make its members pay the actual cost of their expensive tastes. The other strategy would be to impose uniformity in the consumption of health care resources. Segall

(2010) argues in favor of the latter, as the former strategy amounts to devolution of health care services, “which is less egalitarian in the immediate term [than a unified system of health care], and risks undermining social solidarity, which is crucial for the attainment of distributive justice in the long term” (Segall 2010, 152).

## Equality of Resources vs. Equality of Welfare

Dworkin’s work takes up the issue initially posed by Rawls and later elaborated on by Sen: “What is the right equalisandum for an egalitarian theory of justice?” (Roemer 1996, 7). Rawls’ difference principle and Sen’s equality of capabilities are both considered theories of equality of resources. Based on their two theories, equality of resources can be defined as “things that help people realize their plans of life or achieve success” (Roemer 1996, 246). Concerning the right equalisandum for an egalitarian theory of justice, Dworkin argues that equality of welfare is not the right equalisandum, as it requires more resources to be given to those with expensive tastes, which he finds ethically unacceptable. Instead, equality of resources, or the equalizing of bundles of resources available to persons, is considered the right alternative to the equalizing of welfare. In determining what allocation of resources would appropriately compensate individuals for their fixed unequal bundles of nontransferable resources, Dworkin came up with an ingenious solution “that the distribution of resources should be deemed relevantly equal if it would have resulted from a prior situation in which individuals, from behind a veil of ignorance, could have taken out insurance against being born with paltry bundles of nontransferable goods” (Roemer 7, 1996). Behind Dworkin’s veil of ignorance, individuals know what they want, but they do not know what they will receive from the “birth lottery”. Hence they are provided with the same amount of money for which such insurance can be purchased.

Roemer (1996) argues that Dworkin’s insurance scheme does not effectively create a kind of equality that resource egalitarians would prefer. Cohen also faults Dworkin’s solution, as:

> It would not permit a community, in the name of equality, to make special provision for people who need expensive medicine to relieve pain that, while serious, does not disable them from pursuing their plans, or for people who, because they are particularly susceptible to cold, need expensive sweaters, or for people who suffer from enduring and serious (but somehow not disabling) depression or gloominess that spoils their lives but that they are unable to shake off. (Dworkin 2010, 297)

Roemer (1996) explains why, in his opinion, it is difficult to create an appealing conception of resource equality. He points out that human beings are not identical. They are not produced from the same zygote, meaning they grow up in different conditions, and thus they have different preferences and ambitions. Circumstances do not entirely account for the differences in peoples’ preferences and ambitions. If that were true, then “all aspects of a person belong in the category of ‘circumstances’” (Roemer 1996, 246). Dworkin (2000), who agrees with Roemer (1996), believes in a residual category called preferences and ambitions. He argues that “an appealing conception of resource equality must implement equalization across persons of the comprehensive bundles of resources, consisting of both conventional external resources and circumstantial resources” (Roemer 1996, 246). Considering that circumstantial resources like genes, parents, handicaps, and talents are not easily transferrable, by trying to bring about equality of comprehensive resource bundles, the question for Dworkin becomes, “what distribution of external resources appropriately compensates persons for their differential bundles of circumstantial resources?” (Roemer 1996, 247).

## **The Abandonment Objection**

In order for the luck egalitarian account of health care to be universal, it must avoid the abandonment objection by not excluding imprudent patients. A luck egalitarian view that avoids the abandonment objection is known as all-luck egalitarianism. All-luck egalitarianism avoids the abandonment objection by “pooling the costs of medical treatment among those who make similar gambles with their health” (Segall 2010, 47). For example, consider smoking and smoke related diseases. The cost of smoking related diseases would be pooled from lucky and unlucky smokers, while the revenue would be used to treat the unlucky ones. Although the all-luck egalitarian proposal avoids the abandonment objection, “it runs the risk of paternalism (something many liberals find objectionable)” (Segall 2010, 47). All-luck egalitarians argue that because luck is morally arbitrary, all-luck, brute and option, ought to be neutralized. A smoker with good option luck, who does not have a smoke related disease, is forced to help someone with bad option luck, who does have a smoke related disease, by having to pay taxes on cigarettes. All-luck egalitarianism tries to eliminate the effects of luck, brute or option, as people are held responsible for the choices they make, rather than the consequences. By taxing cigarettes, all smokers are held responsible for deciding to smoke, and the revenue raised from the tax is used to fund treatment of smoking-related diseases. According to all-luck egalitarianism, “individuals suffering bad option luck need not be abandoned. Rather, they ought to be helped by those enjoying good option luck... this means unlucky smokers ought to be helped by unaffected(i.e., lucky) smokers” (Segall 2010, 48). Taxing people who choose to smoke is not meant to deter people from wanting to smoke. Rather, “in doing so the state merely pursues the requirements of justice (between lucky and unlucky smokers)” (Segall 2010, 48).

All-luck egalitarianism's innovative solution for avoiding the abandonment objection makes it an attractive proposal; however, ultimately its solution proves to be an unsuccessful one. First off, all-luck egalitarianism does not fully escape the abandonment objection by pooling risks between equally reckless patients. For instance, what if all smokers in a society turn out unlucky? If that were the case, there would not be enough lucky smokers to help out the unlucky smokers. All-luck egalitarianism's ability to avoid the abandonment objection "is contingent on a more or less equal distribution of good and bad luck among all smokers in society. But that would surely not always be the case" (Segall 2010, 49). All-luck egalitarianism's main problem in trying not to exclude or abandon impudent patients lies in its formulation of the egalitarian ideal that 'individuals who make the same choices should always have the same outcomes'" (Segall 2010, 49). Suppose individuals A and B smoke ten cigarettes a day, while individuals C and D smoke 20 cigarettes a day. The all-luck egalitarian principle requires that all four individuals end up with the same outcome, even though individuals A and B smoke less than individuals C and D. The all-luck egalitarian principle is salient on whether individuals A and B, who smoke less, should end up better off than individuals C and D who smoke more. It shocks Segall that the all-luck egalitarian principle is satisfied with the possibility that individuals C and D might end up with better health than individuals A and B. Hence, he feels that the all-luck egalitarian ideal needs to be reformulated. The all-luck egalitarian ideal should state that "is it unfair for one individual to end up worse off than another if she has made at least as prudent decisions as that other person" (Segall 2010, 49).

Although a strict application of luck egalitarian justice would leave imprudent patients untreated, when coupled with other moral considerations that make up social policy, "a full luck egalitarian guide to policy would then recommend treating imprudent patients" (Segall 2010, 72). As regards the abandonment objection, considerations of fairness/equality sometimes prove to be indeterminate, meaning they sometimes are unable to determine whether a particular resource allocation is fair or unfair. When this happens, considerations of fairness/equality must be traded off with other moral considerations, such as utility, concern for self-respect, privacy, publicity, autonomy, compassion, promise keeping, cultural diversity that will produce a determinate and desirable policy. The luck egalitarian view accepts that considerations of egalitarian distributive justice do not trump all other considerations of justice. Thus, "the combination of luck egalitarianism with other considerations may tell us to provide medical treatment for the reckless driver rather than abandon her" (Segall 2010, 65).

## **Luck Egalitarianism vs. Rawls' Theory of Justice**

Shlomi Segall (2010), who contrasts luck egalitarianism with the Rawlsian account of egalitarian distributive justice, points out that one of the major differences between the two is that Rawlsian justice is contractarian, while luck egalitarianism is typically not. A contractarian theory of justice "follows from consideration of the significance of persons' free and rational agency when these two points are stressed: autonomous persons must freely bind themselves to rational constraints, and they must do so as social beings" (Dougherty 1988, 94). Thus, according to contractarianism, a system of justice is the result of free and rational choices made by persons. Whiles as a function, justice, binds people together under rules agreed upon by all. Luck egalitarianism, on the other hand, "sees principles of justice as independent of what rational agents would choose under some circumstances that simulate impartiality" (Segall 2010, 11). Contrary to luck egalitarianism, Rawlsian justice, which is sometimes referred to as "political":

> Focuses on the relationship between individuals as members of a political community... the implication being that the principles of justice it recommends

> are shaped by an image of the just relations between citizens, and what citizens can and cannot justify to one another. (Segall 2010, 11)

On the other hand, Luck egalitarianism is characterized as “natural” or even “cosmic”. While the theory focuses primarily on luck, luck egalitarianism also “has a deep social and political basis” (Segall 2010, 11). For instance, many of the disadvantages people feel are unjust, are actually products of their social circumstances which they have little or no control of.

## Universal Health Care Coverage

In relation to universal health care coverage, luck egalitarians face the challenge of not excluding imprudent patients. A universal health care system is “universal, not only if it excludes no one, but also if it allows no one to opt out of it” (Segall 2010, 74). More specifically it is defined as a system “that, first, provides treatment to everyone who requires it without excluding anyone, and second does not allow potential patients, to exchange the free medical treatment for which they are entitled for its cash equivalent” (Segall 2010, 75). In addressing two important aspects of the universality of public services, the non-excludability aspect and the non-opting out aspect (in-kind aspect), Segall’s luck egalitarian perspective provides a coherent account of universal yet luck-sensitive health care. Although the moral requirement to meet basic medical needs is independent of luck egalitarianism, “egalitarian distributive justice is but a narrow slice of morality and thus allows for a plurality of other moral considerations to be coupled and traded off with it” (Segall 2010, 74). Luck egalitarianism coupled with a “sufficientarian concern for meeting everybody’s basic needs regardless of their antecedent health-related conduct” fits within the luck egalitarian account of health care, while the concern for meeting basic needs overrides luck egalitarian distributive justice (Segall 2010, 74).

Concerning the in-kind aspect of universality, by conceiving of health care as a normatively non-excludable good that applies to all community members, whether citizen or resident, luck egalitarians argue that society has an obligation to treat reckless patients, while also holding them liable for the cost of their reckless conduct. Theories of justice that seek equality in states of mind, such as the "welfarist" version of luck egalitarianism, argued for by Segall (2010), are "sensitive to the ambitions and preferences that individuals have with regard to their lives" (85). Take for instance, Roger, a violin player, who requires an expensive surgery in order to walk again, but would be much happier with a Stradivarius. Roger decides that he would rather be in a wheelchair playing the violin then able to walk and without a Stradivarius. It is arguable that society would be forced to grant Roger the Stradivarius, according to the "welfarist" account of luck egalitarianism, which seeks equality of opportunity. If Roger were granted the Stradivarius, luck egalitarians would be incapable of justifying in-kind health care, as it would give patients the opportunity to opt out of the system, by allowing them "to convert health care, to which they are entitled, into other benefits, such as cash" (Segall 2010, 85). The luck egalitarian account of health care avoids the Stradivarius objection, as it is premised on neutralizing brute luck inequalities, which means "someone who is ill due to bad luck is entitled to have that bad luck reversed through medical treatment" (Segall 2010, 85). Only when it is impossible to directly reverse disadvantages, does an individual gain entitlement to the cash equivalent. If there exists a medical treatment capable of restoring Roger's ability to walk, than Roger is only entitled to that treatment and not to the equally priced Stradivarius. Welfarist luck egalitarianism "is committed to restoring Roger's equal opportunity for welfare compared to others; not to restoring his level of welfare to that of others." (Segall 2010, 86)

A duty to meet the basic medical needs of prudent and imprudent patients alike, fits within a value pluralist luck egalitarian approach to providing health care, from the standpoint that imprudent patients, although they bring their medical conditions upon themselves, it is not a requirement of justice that they be left to suffer. By meeting basic medical needs, it is meant "both curing illnesses, and also correcting and compensating for needs when it is impossible to cure them" (Segall 2010, 76). Unlike Daniels (1985), who argues that meeting basic medical needs is required due to the impact that health has on the opportunities people have to pursue their life plans, Segall (2010, 77) finds that the concern for basic needs "overrides luck egalitarian distributive justice and mandates meeting the basic medical needs of the prudent and the imprudent alike". With regards to imprudent patients who require medical assistance out of their own fault, they should be required to bear at least some of the burden, in the form of ex-ante taxation. Imprudent patients should have to bear some the cost of treatment, not because they failed to take good care of themselves, but because "they have avoidably burdened the public health care system" (Segall 2010, 78). As imprudent patients arguably waste resources which could have been spent on other patients, society is justified in forcing them to bear some of the cost of their treatment as they have breached an obligation they owe to others. As a normatively non-excludable good, it is impossible to deny people medical treatment. Health care "belongs, along with national security and clean air, in the class of benefits that society provides universally and unconditionally" (Segall 2010, 79).

## **Obama Care**

For a system to be truly universal, no one must be able to opt out of it. In the United States, not only is there not a national health plan in place that assures citizens access to basic medical care, like car insurance, by 2014, "every American will be required to use a combination of subsidies, employer support, or personal income to obtain an acceptable health insurance plan, or else pay a financial penalty of up to $2,085 for a family ($695 for individuals)" (Jacobs and Skocpol 2010, 129). The Affordable Care Act of 2010, in order to get everyone into the system, gives all Americans chances to get good coverage, regardless of where they work. This seems important when considering that almost three-quarters of the nearly 38 million working-aged Americans and family members who do not enjoy insurance coverage, work, while more than half of them are full-time. The system helps families of four with annual incomes up to $88,200, by entitling them to subsidies to pay for insurance premiums. It also helps small businesses that have fewer than 25 employees with average wages less than $50,000 a year, as they receive tax credits "that rise by 2014 to cover 50% of their contributions to the premiums of their employees" (Jacobs and Skocpol 2010, 127).

Regarding the "individual mandate" provision, there is broad agreement that getting everyone into the health insurance system is necessary to control health care costs. In order to keep premiums affordable, people without insurance that free-ride, by turning up in emergency rooms needing costly urgent care, must be stopped. Basically the only way to keep premiums affordable is if everyone is willing to pitch in. Rather than being able to take a chance by not having health insurance, people will be required to be more responsible in the event they crash their car or fall off a mountain and risk serious injury.

## **Challenging Affordable Care's Constitutionality**

On the subject of Affordable Care (or Obamacare as it is known), opponents have launched challenges questioning its constitutionality, and therefore the question becomes whether or not the health reform will survive and succeed. The authors of Affordable Care legislation anticipated post enactment challenges, which is why they chose to anchor it “in the sturdiest constitutional grounds and incorporated findings that explicitly invoke the constitutional authority of Congress and previous Supreme Court rulings” (Jacobs and Skocpol 2010, 151). Some, who urge its outright nullification, argue that the act violates the Tenth Amendment to the U.S.  Constitution, which states that powers “not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States” (Constitution).  The first state to pass a law that seeks to nullify the new federal law was Idaho, as it declared that its residents are ‘“free to choose or decline to choose any mode of securing health care services without penalty or threat of penalty”’(Jacobs and Skocpol 2010, 152). Idaho’s law suit is likely to fail however, considering that federal courts routinely reject Tenth Amendment challenges to federal laws.

A lawsuit filed by Bill McCollum, Florida’s Republican Attorney General and a 2010 gubernational candidate, represents a second line of legal attack that also rests on tenuous grounds. The lawsuit “challenges Affordable Care’s requirement for the establishment of state-level health insurance exchanges and for the expansion of Medicaid as ‘an unprecedented encroachment on the sovereignty of the states’” (Jacobs and Skocpol 2010, 152).

# Chapter 3

## Case Studies

The following case studies, call them "lessons from abroad," are made possible by cross-national comparisons and the analysis of extensive comparative data and information. International comparisons are very beneficial, as "the experience of other nations sharing common problems, but not always responses or outcomes, can accelerate the speed or the adequacy of national responses to health issues" (Graig 1991, 1). What follows is a discussion that compares the health care systems of Canada, Germany, and the U.K., with that of the U.S. Compared to all other 24 industrialized nations belonging to the Organization for Economic Cooperation and Development, the United States spends the most on health care. The U.S. also trails many of the OECD nations in infant mortality and life expectancy rates, while somewhere between 31 million and 37 million Americans still lack health insurance.

The particular system of health organization, delivery, and financing in the U.S. is inextricably linked to escalating health care costs. Although some experts claim that the U.S. system of health care is the best in the world, "it would be, quite frankly, ridiculous for an American to suggest that we have achieved a satisfactory system that our European friends would be wise to emulate" (Graig 1991, 2). As the U.S. increasingly commits financial resources to health care while leaving large numbers of its population uninsured or underinsured, driven by this paradox the U.S. must look to other nations "for possible cures for what ails its system" (Graig 1991, 2).

Although it is unlikely that the U.S. would ever adopt a system quite like Canada's, the United Kingdom's, or Germany's, it is possible, considering that these nations are able to provide comprehensive coverage for their populations at a lower cost than the U.S., that one day the U.S. may try and adopt certain features of these systems for use in its own system. For example, American businesses have in the past become more efficient, “by adapting manufacturing and quality-management techniques from the Japanese” (Graig 1991, 2). Adaptation is key considering that it is impossible to import another nation’s health care system into another. Thus, as regards to the current American health care crisis, it would be wise to consider international perspectives, as the experiences of other nations in administering care, can serve as models for reform of the U.S. health care system.

The way in which health services are organized, depends a great deal on prior history, professional patterns, culture, and politics. With the development of a world culture and easily made available information on events elsewhere, health care reforms are following “in the general direction of those pioneered earlier in other countries” (Powell and Wessen 1999, 26). Developed countries and developing countries face the same challenges of aging population, reduced mortality and damaging disease patterns, and a growing burden of chronic diseases, disabilities, and behavioral disorders, as well as increasing aspirations for sophisticated medical care. With growing public expectations, existing medical systems face heavy demand, as they try and keep pace with technology and long term care needs. With the diffusion of new technologies all Western nations must find prudent ways to use and control them. The willingness of other countries “to consider elements seemingly foreign to one’s existing system, reflects the extent of the perceived crisis in many settings and the degree to which a world culture is emerging on economic and technological issues” (Powell and Wessen 1999, 27). From an international perspective Canada, Germany, as well as the United Kingdom all outperform the United States in a wide variety of categories including health care expenditures per capita (Figure 1.1), health outcomes, life expectancy, etc. Thus it would be wise for the U.S. to take note of these country's methods in administering care in order to learn ways in which it may improve its own system.

**Chart 1.1**

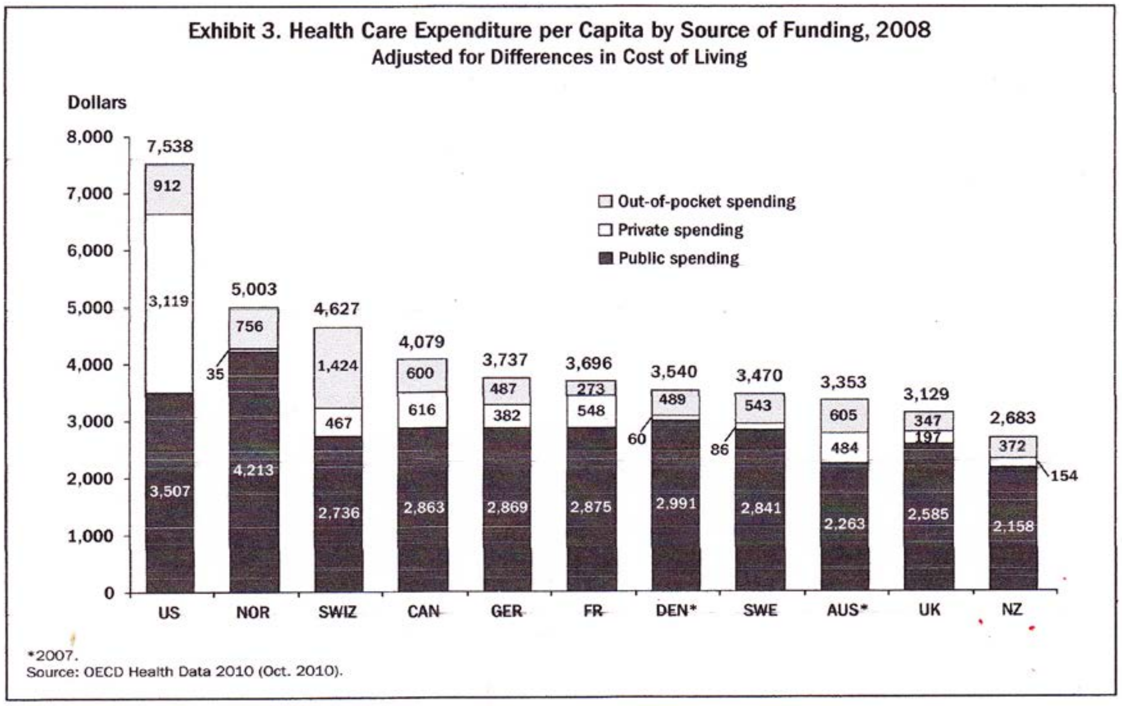


Exhibit 3. Health Care Expenditure per Capita by Source of Funding, 2008
Adjusted for Differences in Cost of Living

*2007.
Source: OECD Health Data 2010 (Oct. 2010).

## The Evolution of Canada's Universal Health Care System

According to Cust (1996), the strengths and weaknesses of the current Canadian system of health care delivery ought to be assessed before deciding whether the United States should adopt one similar to Canada's or not. There are four pieces of federal legislation to consider when analyzing Canada's health care system that have marked its evolution. It is through their tax system that Canadians share both the risk and cost of disease and injury. Beginning in 1946, in the province of Saskatchewan, the ruling Commonwealth Cooperative Federation Party "introduced a government sponsored hospital insurance program" (Cust 1996, 21). This program, "established a universal, compulsory hospital care system" (Barr 2007, 22). The plan maintained popular support, even though it increased rates of hospital use and costs in excess of initial estimates.  Later on, both Columbia and Alberta adopted similar hospital insurance programs. Then in 1957, the Canadian federal government unanimously decided to pass the Hospital Insurance and Diagnostic Act. The act created the first nationally supported health insurance program in Canada, which was based on the earlier Saskatchewan model.

The next piece important of legislation that ought to be looked at is the Medical Care Act Passed July 1, 1966, the act established universal coverage for physician services under provincially administered programs. The act made it to where if the provincial government agreed to the four principles, then the federal government would pay 50% of each province's cost, leaving the provinces responsible for paying the rest. This part of Canada's health care system was labeled "Medicare", not to be confused with U.S. program. The act took effect in July 1968.

By 1977, both the Hospital Insurance and Diagnostic Act and the Medical Care Act were repealed by the Established Programs Financing Act, in an attempt to reduce federal health care expenditures.  This act reconstituted the federal-provincial cost-sharing arrangement. The new arrangement gave "each province an annual amount linked to population, changes in GNP, and a federal tax transfer to each of the provinces and the two territories" (Cust 1996, 23). The new arrangement also meant that the federal government would have less influence on how the provinces administered their health care budgets. The provinces would now be forced to suffer the political consequences of cost-control measures. Under the new arrangement, in order to increase revenues, the provinces would charge user fees and allow for the practice of extra-billing, a practice comparable to the American practice of balance billing, which the Canadian government feared would compromise universality. Those fears led to the passage of the

Canadian Health Act of 1984 which had the purpose of establishing “criteria and conditions that must be met before full payment may be made under the act of 1977 in respect of insured health services and extended health services provided under provincial law” (Cust 1996, 24).

The Canadian Health Act of 1984 “served to integrate the three previously enacted pieces of federal legislation into one national framework for health insurance” (Johnson and Stoskopf 2010, 67). The act added a fifth criterion that the provinces would now have to meet, accessibility. This condition meant that provinces would have to do away with user fees and the practice of extra billing. All the provinces, following intense political battles, including a doctor’s strike in Ontario, decided to accept the Canada Health Act in 1987. The unified system of insurance/financing decided to adopt the common name “Medicare” previously used to denote insurance provided under the 1962 Medical Care Act. Medicare covers hospital and physician services for approximately 97% of Canadians and represents the majority of health care spending in Canada (Johnson and Stoskopf 2010, 68). The funding of Medicare, “is derived from tax revenues collected at both the federal and provincial levels” (Johnson and Stoskopf 2010, 73).

## **How the Two Systems Compare**

On the subject of health care costs, the huge and growing gaps in insurance that are associated with the U.S. might make a little more sense if the U.S. were trying to save money, except the opposite is true as the U.S. actually spends “about twice as much per person as other industrialized countries do on average and more than 50% more than the next biggest spender, eating up a huge and growing chunk of what its national economy produces” (Jacobs and Skocpol 2010, 21). According to the Organization for Economic Co-Operation and Development, which tracks trends in 31 industrialized nations, the U.S. spent 15.3% of its GDP on health care, while Canada, its neighbor to the north, spent only 10% of its own. What makes America's outsized spending on health care particularly worrisome is that all other nations, who spend less on health care than does U.S., provide their entire populations with health coverage. Limiting the availability of expensive care does not fully explain how Canada is able to spend less on health care than the U.S. Rather, fundamental differences in the way physicians in the two countries practice medicine result in differences in cost. For one, Americans spend more for care and receive less than do Canadians. For instance, in the U.S. "resources such as laboratory tests, medications, and supplies used in providing care in physician's offices cost 30 percent more in the United States than comparable resources in Canada" (Barr 2007, 47). Consider also that when Americans visit their doctors in the U.S., they have more tests, x-rays, medications, and treatments than Canadians with similar conditions do" (Barr 2007, 48).

In Canada there is no one single health care plan, rather there are 13, one for each of the 10 provinces and 3 territories. Canadian citizens are also given the freedom to choose their own physicians, just like their American counterparts. One key difference occurs at the point of consumption, where unlike Americans, Canadians have free access to health care; Alberta and British Columbia are the lone exceptions, as they charge a nominal premium which is not based on risk, and therefore it is in effect a tax. A core principle of the Canadian health care system, universal coverage, entitles all residents of Canada to coverage for hospital and physician services under Medicare, the national health insurance plan. Equality among persons is the cornerstone of the Canadian philosophy of health care. In Canada, "it is felt that need, not financial position, should be the basis on which the allocation of health care resources is decided" (Johnson and Stoskopf 2010, 75).

One substantial difference that exists between the two systems of health care delivery, relates to their systems of financing. Similar to the U.S., in Canada there are multiple sources of funding that finance its health care system, except in Canada the public sector plays a more important role. For example, in the United States, the government finances 46% total health care expenditures, while in Canada, the public sector contributes roughly 70%. The three primary sources of funding are the Medical system, out-of-pocket payments by individuals, and private insurance. In the United States, other than Medicaid, and Medicare, health care is privately financed “via a multitude of insurance companies, or as they are often referred to as, third-party payers” (Cust 1996, 25). This method of financing leaves nearly more Americans uninsured, 31 to 37 million, than the entire population of Canada, 33,212,696 million (Johnson and Stoskopf 2010, 60). Although the U.S. has a large private system of financing, the federal and state governments still play an important role in health care delivery, as they “finance health care services for publicly insured patients, such as those covered under Medicare and Medicaid” (Johnson and Stoskopf 2010, 381).

Regarding technology and equipment in both countries, although the United States “has been a hotbed of research and innovation in new medical technology,” it lacks controls that almost all nations have in trying to limit the diffusion and utilization of technology (Johnson and Stoskopf 2010, 381). Without limits, the overuse of technology leads to negative outcomes. For example, the cost of highly technical interventions tend to increase insurance premiums. The U.S. health care system, driven primarily by the acute-care model, has an oversupply of specialists, which compounds the rate of technology diffusion. In order to prevent the health care system from being overburdened by the growing number of older persons who have chronic conditions and co-morbidities, resources in the U.S. must shift from acute to chronic care.

Concerning the quality of care and physician services received in both countries, “Americans were more likely to be "very satisfied" with their health care services, including physician services, while Canadians were more likely to be "somewhat satisfied" with their health care services” (Ng and Sanmartin 18, 2002-03). In general Americans and Canadians share similar health statuses, although they differ regarding access to a regular medical doctor and regarding unmet health care needs. While Canadians and insured Americans are for the most part the same, Canadians face significantly fewer barriers to care when compared with uninsured Americans. The greatest differences between the two relates to differentials in health by income. For instance, “Americans in the poorest income quintile report fair or poor health, obesity and severe mobility impairment more frequently than their Canadian counterparts” (Ng and Sanmartin 19, 2002-03).

**Table 1.1**

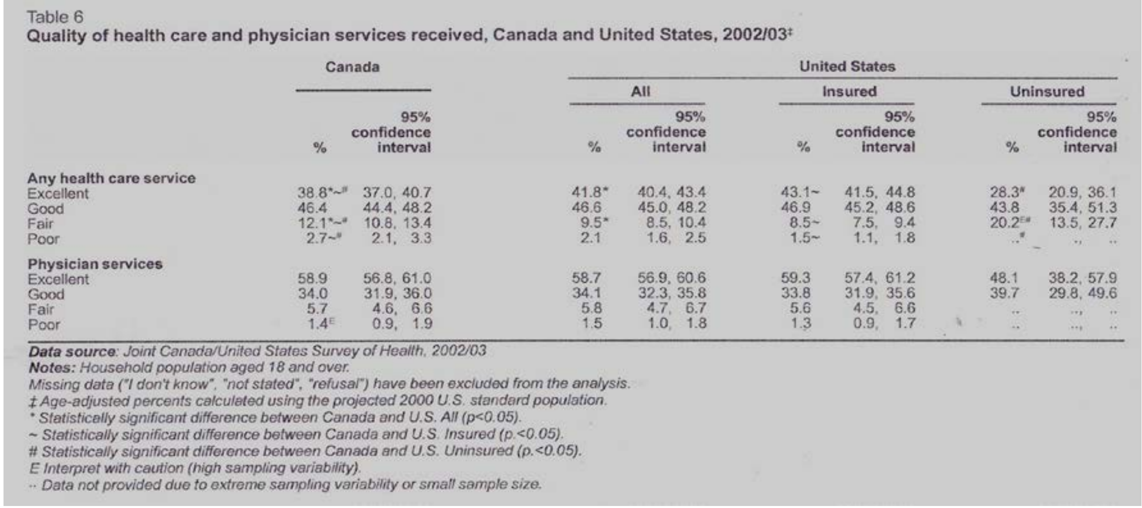


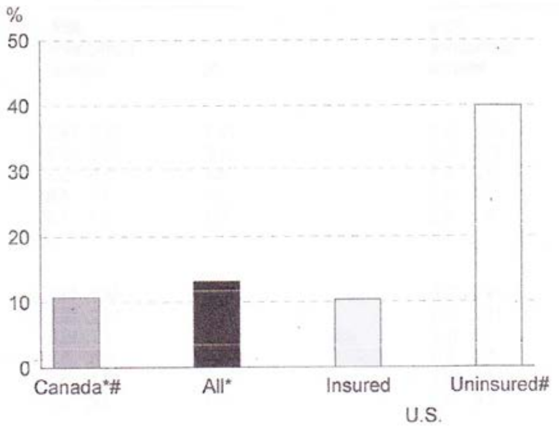
Table 6
**Quality of health care and physician services received, Canada and United States, 2002/03‡**

| | Canada | | United States | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | All | | Insured | | Uninsured | |
| | % | 95% confidence interval | % | 95% confidence interval | % | 95% confidence interval | % | 95% confidence interval |
| **Any health care service** | | | | | | | | |
| Excellent | 38.8*~# | 37.0, 40.7 | 41.8* | 40.4, 43.4 | 43.1~ | 41.5, 44.8 | 28.3# | 20.9, 36.1 |
| Good | 46.4 | 44.4, 48.2 | 46.6 | 45.0, 48.2 | 46.9 | 45.2, 48.6 | 43.8 | 35.4, 51.3 |
| Fair | 12.1*~# | 10.8, 13.4 | 9.5* | 8.5, 10.4 | 8.5~ | 7.5, 9.4 | 20.2$^{E}$# | 13.5, 27.7 |
| Poor | 2.7~# | 2.1, 3.3 | 2.1 | 1.6, 2.5 | 1.5~ | 1.1, 1.8 | ..# | .., .. |
| **Physician services** | | | | | | | | |
| Excellent | 58.9 | 56.8, 61.0 | 58.7 | 56.9, 60.6 | 59.3 | 57.4, 61.2 | 48.1 | 38.2, 57.9 |
| Good | 34.0 | 31.9, 36.0 | 34.1 | 32.3, 35.8 | 33.8 | 31.9, 35.6 | 39.7 | 29.8, 49.6 |
| Fair | 5.7 | 4.6, 6.6 | 5.8 | 4.7, 6.7 | 5.6 | 4.5, 6.6 | .. | .., .. |
| Poor | 1.4$^{E}$ | 0.9, 1.9 | 1.5 | 1.0, 1.8 | 1.3 | 0.9, 1.7 | .. | .., .. |

***Data source**: Joint Canada/United States Survey of Health, 2002/03*
***Notes:** Household population aged 18 and over.*
*Missing data ("I don't know", "not stated", "refusal") have been excluded from the analysis.*
*‡ Age-adjusted percents calculated using the projected 2000 U.S. standard population.*
** Statistically significant difference between Canada and U.S. All (p<0.05).*
*~ Statistically significant difference between Canada and U.S. Insured (p.<0.05).*
*# Statistically significant difference between Canada and U.S. Uninsured (p.<0.05).*
*E Interpret with caution (high sampling variability).*
*.. Data not provided due to extreme sampling variability or small sample size.*

**Chart 1.2**

Chart 13
**Individuals reporting an unmet health care need, Canada and United States, 2002/03‡**



***Data source:*** *Joint Canada/United States Survey of Health, 2002/03.*
***Notes:*** *Household population aged 18 and over.*
*Missing data ("I don't know", "not stated", "refusal") have been excluded from the analysis.*
*‡ Age-adjusted percents calculated using the projected 2000 U.S. standard population.*
** Statistically significant difference between Canada and U.S. All ($p < 0.05$).*
*# Statistically significant difference between Canada and U.S. Uninsured ($p < 0.05$).*

One of the most significant differences between the United States and Canada is however political. Compared to Canadians, Americans have a greater individualist ethic. Thus, conflicts in the United States between individual needs and group needs tend to be resolved in favor of the individual. On the contrary, in Canada, where there is a strong social democratic tradition of redistribution "so as to maximize the common good…Canadians have come to accept and except social policies that embody this individual/ group relationship" (Barr 2007, 21). Americans also distrust the government more so than do most Canadians, who accept the need for strong central government.

In regard to claims that the United States would save on administrative costs by implementing a system similar to that of Canada's, recent studies challenge those earlier findings, by arguing that those earlier findings "fail[ed] to include 'many of the overhead costs associated with administering the program in Canada, such as buildings, equipment, fringe benefits and personal services'" (Cust 1996, 27). There are also several other factors that must be taken into consideration. For instance, there are substantially more veterans in the U.S. than in Canada. The U.S. also has a substantially higher rate of violent crime, homicide, drug abuse, AIDS, divorce rate, drug exposed babies, which added up, exceeds the total amount of Canada's national health care expenditures.

Compared to the United States, Canada has its own unique set of problems. Canada has substantially less high-tech equipment and procedures per capita than the United States. Canadians also suffer from other costs, which include having to wait for surgeries, or even having to leave the country, to have others performed. In both countries, there is growing concern about the escalating costs for health care services, physician-induced demand for medical care, the amount and cost of medical fraud, as well as the problem of self-referral and physician ownership of medical diagnostic and therapeutic centers and equipment. Due to these concerns, "the question of justice in health care arises" (Cust 1996, 85).

According to the results from a cross-national population-based survey, in which health status, access to care, and utilization of medical services, along with disparities according to race, income, and immigrant status were compared in the United States and Canada, Canadians "are less likely [than Americans] to have a regular doctor, more likely to have unmet health needs, and more likely to forgo needed medicines" (Lasser etal 2006, 1). Although disparities on the basis of race, income, and immigrant status were present in both countries, in the United States they were more extreme. The study revealed that while Canada spends far less on health care than does the United States, although this affects levels of satisfaction among Canadians, it does not affect their health outcomes. Barriers to care in both countries differed according to the findings. In the United States, cost was the principal barrier to care, whereas in Canada it was wait times. Wait times, which have received substantial press attention in the United States, only led to a small percentage of unmet health needs, 3.5%. The study suggests that a universal health care system should be implemented in the United States; however, adequate funding is needed to avoid waits for care. Universal coverage does not eliminate all health disparities, and therefore "policies to address unfavorable social conditions that impact health care sorely needed" (Lasser etal 2006, 7). Policies aimed at reducing income inequality, improving housing, and expanding education and employment opportunities for the poor are those that would likely have the greatest impact at eliminating all health disparities.

## Reasons as to why the United States Should not Adopt a System Similar to that of Canada

Current and emerging issues that relate to Canada's health care system are questions of availability, including distance, travel times, and wait times. The problems that Canadians have with access to care, "do not refer to the same financial access (insurance coverage) issues that exist in the U.S and in many other nations" (Johnson and Stoskopf 2010, 76). Rather, what has been well-documented are the wait times that for a number of services and procedures are significantly longer in Canada than they are elsewhere. The wait times, which have been attributed to supply and demand factors, it seems will actually lengthen, due to greater demands placed on the health care system by an aging population.

Enthoven and Kronick (1997) argue that there would be major difficulties if the United States tried to adopt a system like Canada, where the government is the sole payer for physician and hospital services. To do so, would require "a political sea change" in the United States (Estes and Lee 1997, 332). It is also important to consider government regulatory policies which tend to freeze industries and often penalize efficiency. Due to the proximity to the United States, Canada's system is not as frozen as it might be; however, if the United States were to adopt such a system "the negative effects of regulation would likely loom larger" (Estes and Lee 1997, 333).

Rhodes (1992), who shares similar findings with Cust (1996), points out how although Canada and the United States are similar in many respects, culturally Americans are very individualistic and prefer to choose their own hospitals and physicians. Americans expect more specialization than what the Canadian system offers. Besides just cultural barriers, the United States would also need to overcome structural barriers as well if the Canadian system were to be imported into the United States. Unlike Canada, which was a homogenous nation at the time its health care system was organized, the United States is a pluralist nation. Due to the U.S. health care system being "a patchwork of institutions, with ties to different local governments... it would be difficult to negotiate operating budgets and fees for each region's profession and institutions, when all would likely protest" (Rhodes 1992, 112).

## The British NHS

The British National Health Service is characterized as being not only the envy of the world, as it provides a comprehensive service to the entire population of Britain, but also troubling as it "provides care that if usually high in quality, is delivered in an often dreary environment to patients trained to defer to the discipline of the queue and service routines" (Powell and Wessen 1999, 281). It is a system that since its creation "has always been undercapitalized and dominated by providers who have defined need of patients rather than responding to the demands of consumers" (Powell and Wessen 1999, 281). Its achievements are extolled by those who believe the NHS demonstrates the virtues of the national health care model, while its failings are excoriated by those who use them to "chill American spines about the dangers of socialized medicine" (Powell and Wessen 1999, 282).

Unlike the health care systems of Canada and Germany, Britain's National Health Service "is often presented in the U.S. as an example of the negative consequences of government ownership and control of health care" (Graig 1991, 211). In many countries, not just in Britain, deliberate rationing is either under way or under consideration, as there is a greater demand for advanced technology than available resources can supply. Technological problems are a common challenge to national health care systems. Issues like cost-related and ethical limits on technological growth and innovation in health care must be addressed, "if citizens, health care providers and governments are to be satisfied with provision of health care" (Lassey 1997, 2). Concerning what the basis of rationing should be, from an egalitarian perspective, "medical care should be distributed according to that need" (Dworkin 2000, 310).

The British health care system, which "set a precedent as the first comprehensive, nationalized system of health care" is also the most centrally managed and financed health care system in the world (Graig 1991 212). The NHS is divided into three distinct components. The first component, the hospital sector, has 12 Regional Health Authorities.  Each RHA is responsible for 4-5 million people. The Regional Health Authorities are then also divided into 15 District Health Authorities. The District Health Authorities not only finance the care, they also provide health care services to the entire population.

Managed by Family Practitioner Committees, the primary sector is another distinct component of the NHS. The Family Practitioners that make up the primary sector, General Practitioners (GPs), dentists, pharmacists, opticians, etc. "are not government employees but work on contract to the NHS" which is one of the reasons why, unlike the hospital sector, the primary sector has an open ended budget (Graig 1991, 221). A large portion of the FPC's budget goes towards prescription drugs, which is another reason why the primary sector's budget is open ended. Through the Pharmaceutical Price Regulation Scheme, the central government controls the prices and profits of domestic and foreign drug companies. The drug companies are guaranteed a return of approximately 19 percent on capital by the government. The Pharmaceutical Price Regulation Scheme ensures that the NHS is able to purchase drugs at a reasonable price. Basically the FPC's budget is open ended, "because 'one element is determined by the number of contractors and the type and level of care they provide, and the other is determined by the rate of return to the pharmaceutical industry'" (Graig 1991, 221).

As a unitary state, Great Britain's power is expressed on behalf of the Crown at the will parliament. In Great Britain, "regional and local governments are creatures of the larger state with no constitutionally guaranteed rights" (Powell and Wessen 1999, 375). Unlike Sweden, a unitary state that has chosen over the years to decentralize its health care system, the British Parliament which "has changed the boundaries and responsibilities of counties and municipalities to suit its pleasure," has yet to hand over the responsibility of administering the NHS to local government authorities (Powell and Wessen 1999, 375). In Great Britain, change has been dictated and monitored by the central authorities. The most radical decentralizing reform in Great Britain was the institution of GP (General Practitioner) fundholding, an innovation misleadingly described by Americans as the development of "mini-HMOs". GP fundholding transferred a share of purchasing responsibility from NHS administrative units (the DHAs) to practitioners, and resulted in "a number of geographic subunits of the districts carrying out purchasing functions independently of their district authorities" (Powell and Wessen 1999, 376). This division of purchasing responsibility between DHAs and practitioners led to the unification of family health service authorities, who supervise GPs, and the DHAs, in an attempt to coordinate decision making.

## **History of the NHS**

Following WWII, the British launched their National Health Service, which became a health model for the entire world. The origins of the British health system date back more than a century ago. Beginning in 1911, under the leadership of the Liberal Party's Lloyd George, the first National Health Insurance Act was passed by the British Parliament. The act was opposed by doctors, who, as in other countries, favored "the continuation of the voluntary health insurance programs for the self-supporting, coupled with a strengthened public medical service for the very poor" (Roemer 1991, 192). The act made it to where if manual workers, earning less than 160 pounds per year, were to get sick they would receive insurance protection against what it would cost them for ambulatory medical care and wage loss.

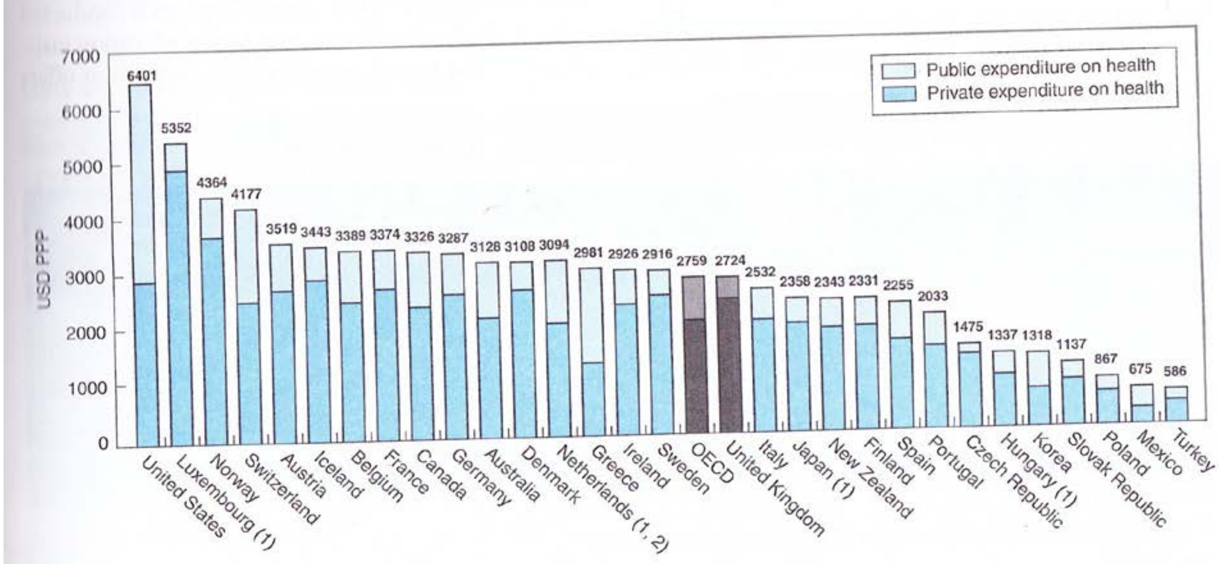
In July 1948, the National Health Service Act took effect. This sweeping social legislation caused intense debate from the moment it was introduced until the final law was enacted. Although there was a threat by doctors to strike, compromises were made and universal population coverage was retained. This program represented a "quantum leap from the former limited health insurance for low-paid workers" (Roemer 1991, 194). Now everyone would be covered, services would be comprehensive, and financial support would no longer depend upon insurance. The NHS legislation of 1946 intended to convert health service from a market commodity, purchased by individuals and families, into a basic social entitlement of everyone that would be financed principally from public sources. Even though public support has fallen short of total needs, the intent of this legislation has been substantially achieved.

## **How Well the NHS Preforms**

Roemer (1991) finds it remarkable that the British NHS can provide so much care for so little a price. That is not to say that there have not been difficulties resulting from frugal expenditures. Compared to the U.S., the rate of elective surgery is significantly lower in Great Britain. This fact likely relates to Great Britain's different methods of paying surgeons: "high fees for each operation in the United States and fixed salaries based on merit in Great Britain" (Roemer 1991, 19). Compared to the U.S., where there is an abundance of unnecessary surgeries, in Great Britain there is the problem of having too few. As Great Britain's population has grown, as technology grows even more advanced, and while people's confidence in medical science has strengthened, demands for health care have risen. During the 1980s, due to political constraint on health care expenditures in the public sector, there was an enlargement of the private sector in the British health system. Thus, "over the last several decades, a move toward fee-for service has emerged" (Johnson and Stoskopf 2010, 108). For illnesses like end-stage renal disease, once classified as a terminal illness, Britons that can afford the treatment are increasingly willing to accept the concept pay-as-you-go that offers them the necessary treatment and care. The NHS has in response moved towards covering the illness; however, as health care costs increase, and become more complex, the United Kingdom's struggles continue as it tries and decide which services should be covered.

Concerning the adequacy of the NHS, before 1974, only a small percentage of people sought care through private arrangements. One of the benefits Britons enjoy by having private insurance is a reduction in the waiting time for elective surgery which, as previously noted, is especially bad in the United Kingdom. By 1969, less than 2 percent of the population, or 883,000 people were enrolled with private carriers. Based on these findings, it seems that only a small proportion of the population “were displeased enough with the limitations of the NHS to the point of paying for private medical care” (Roemer 1991, 201). Presently that number has increased to 10%, while “8% of the United Kingdom’s health care is paid through the private system” (Johnson and Stoskopf 2010, 107). **Figure 1.2** compares health care expenditures by source of funding and unsurprisingly, in the U.K, public expenditures on health far exceed private expenditures. In the U.S. there is a nearly 50/50 split between private and public expenditures.

**Figure 1.2**



Healthcare Expenditure per Capita by Source of Funding, in 2005

1. 2004.

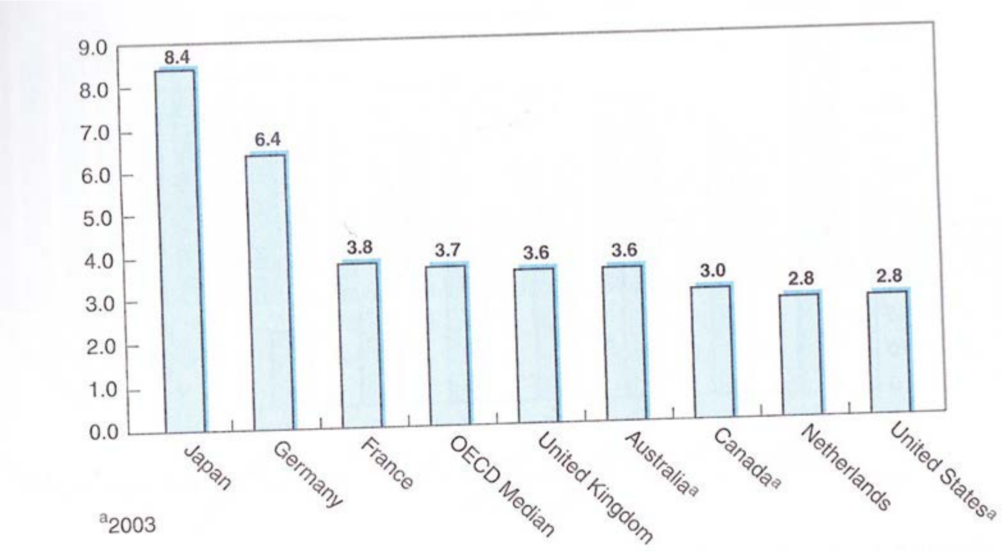
2. Public and private expenditures are 2006 expenditures.

Data are expressed in US dollars adjusted for purchasing power parities (PPPs), which provide a means of comparing spending between countries on a common base. PPPs are the rates of currency conversion that equalize the cost of a given “basket” of goods and services in different countries.

Source: *OECO Health Data 2007*, July 2007.

Regarding health care facilities in the U.K., **Figure 1.3** illustrates just how many hospital beds the NHS is able to provide per 1,000 population. According to the multinational comparison of health systems data, the U.K. provides 0.8 more hospital beds per 1,000 population than the United States. Germany was the only country from the case studies to exceed the OECD median.

**Figure1.3**



Number of Hospital Beds per 1,000 Population, 2004

Cylus, J. & Anderson, GF. *Multinational Comparisons of Health Systems Data, 2006*. Johns Hopkins University, May 2007. From the Commonwealth Fund. Calculated from OECD Health Data 2006.

Although equality of distribution was one of the early objectives of the NHS, the NHS lacks a “conceptual basis on which to allocate resources between patient groups” (Raffel 1984, 228). Without objective criteria for setting health priorities, decisions are mostly a matter of judgment. Health ministers have a significant amount of influence in setting priorities for the NHS; however, ultimately parliament decides what goes where. Attempts have been made by the government “to shift resources away from the expensive ‘high technology’ acute medicine, to services of the elderly, the handicap, the mentally ill, children and the ‘Cinderella services’” (Raffel 1984, 229). In the deprived urban areas of the inner cities, problems with the NHS are at their worst as the provision of services in these areas are at their weakest. There are more accidents and more patients commit suicide or die from pneumonia or bronchitis in these areas than anywhere else in Great Britain.

Health planning, or the “decision making about the future development of resources and services, adjusted to meet estimated future health needs,” is considered most influential in comprehensive and welfare oriented health systems, which is what Great Britain has. On the contrary, in entrepreneurial systems, which is what the U.S. has, health planning is less influential. Regardless of how influential health planning is or is not, it “plays a part in all types of national health systems and in countries of every economic level” (Roemer 1993, 164). In the U.S., health planning, as a result of the Hill-Burton Hospital Survey and Construction Act, led to the construction of hospitals, as the act required state planning of all facilities as a condition for federal grants. In Great Britain, health planning led to the reorganization of the NHS, which was done to achieve greater efficiency and effectiveness. A white paper, issued by the government in 1974, outlined the scheme for reorganization, which would integrate responsibilities for all parts of the NHS under 200 Health Districts.

One of the greatest achievements of the NHS has been its removal of the financial fears of illness. The NHS has also retained its simplest principle: “everyone who is ill has the right, irrespective of his means, to whatever treatment is available” (Raffel 1984, 243). The NHS might not provide the latest and greatest medical care, but at least, as the evidence suggests, no one has ever been denied because of financial circumstances. Considering the distribution of wealth and income in Great Britain, and the belief that no group should ever be at a disadvantage in receiving health care, it is according to Raffel (1984), hard to find a better system at providing health care than the NHS.

In relation to the amount of wealth countries devote towards their national health systems, the U.K. in 2005 spent 8.3% of its GDP on health care (Johnson and Stoskopf 2010, 105). In comparison, the U.S. spent the greatest percentage of gross domestic product on health care, 15.3% (Johnson and Stoskopf 2010, 105). The shares of GDP that countries now devote to their national health systems have substantially risen, due to numerous factors. These factors include costly advances in health science, a larger proportion of the population being sick and elderly, a rise in education which has led to a heightened demand for services, and the urbanization of populations which makes health care more readily available. If private sector expenditures are a measure of potential inequities, than those countries with comprehensive health systems would have very small proportions of them. Regarding health expenditures by purpose, in quite a few industrialized countries, including the U.S. and Great Britain, hospital care accounts for most health spending, 39.2 percent in the U.S., and 46.6 percent in Great Britain.

Policy analysts who support an American National Health Service, argue that current "American health care delivery is expensive, consumes close to 12 percent of GNP, is not accessible to millions who cannot afford it, and has for the past twenty years experienced costs growing faster than the rate of inflation" (Rhodes 1992, 269). When comparing the health of Americans with that of Canadians and Britons, Canadians and Britons have better infant mortality rates, as well as age/sex specific mortality rates, which relate to the homicide and suicide rates of youth. It is however unlikely that the United States would ever implement a national health service. One reason is that Americans fear that by doing so they would likely net losses. If state-owned health care institutions were to provide free health care, it is likely that the low-income people would benefit, while those with means would not. The benefit of having state-owned health care delivery in countries like Canada and Great Britain is that income no longer represents a barrier to reasonable, adequate health care. On the downside, in countries that have a National Health Service, like Canada and Great Britain, unlike the U.S, elective surgery is likely delayed by months or even years. In Great Britain, for example, renal dialysis is not provided for individuals over the age of fifty-five. There is no such rule in the U.S. system of health care.

It is very likely that the quality of health care that requires highly skilled specialization is also lower in systems that emphasize universal access rather than market orientations. Unlike in the U.S., where physicians who have superior medical reputations command higher fees, in Great Britain and Canada physicians have fixed incomes set by fee or salaries. Thus highly skilled physicians have been known immigrate to the United States from Great Britain and Canada, as the U.S. system attracts the most competent physicians. The argument is made that those who do decide to immigrate are primarily interested in maximizing their income, and therefore have flawed judgments as physicians.

Outside the United States, virtually all medical delivery is heavily controlled by the government and therefore must run off of government-established budgets. The United States, by providing open ended financing with little control over expenditures, caused a rapid increase in prices from hospitals, physicians, and other sectors of the health care industry. As a result of applied technologies and specialization, which made treating the elderly more effective, costs also went up in Great Britain and Canada. Canada however was able to contain personnel costs, while Great Britain saved by investing very little in the construction of hospitals. According to Rhodes (1992, 271), both countries had “disciplined operational costs because they knew in advance what they had to spend”. Americans on the other hand lack such discipline, and instead are willing to borrow rather than adopt fixed budgets, as they prefer to choose their own physicians, hospitals, even their own medical theories. When it comes to medical need, Americans have the attitude that “if you cannot afford it and have not made provisions in savings or insurance, no government should provide it” (Rhodes 1992, 271). As universal coverage in a national health care system would require higher taxes and substantial income redistribution, it is unlikely that the general public would ever support such redistribution.

## **Budgetary Constraints**

Budgetary constraints have been questioned by the medical profession in Britain even after the reorganization of the NHS in 1974. Faced with charges of underfunding, as patients were dying for lack of care, former Prime Minister Margaret Thatcher conducted a surprise review of the NHS in 1988, which concluded that by inducing competition, efficiency would be greatly increased. Thus, the “internal market” era was born. Outlined in two White Papers produced in 1989 (Working for Patients and Caring for People), the “internal market” transformed the NHS into a system of managed markets. A significant amount of time and money went into making hospitals ready for self-governance, while fewer resources went towards general management. The conversion represented “a return to the top-down, management–led orientation of management budgeting on a sweeping scale” (Powell and Wessen 1999, 334).

On the subject of the NHS, charges of underfunding should come as no surprise, considering that in 2006, the U.K. spent only $2,760 on health care per capita, nearly $4,000 less than what the U.S. spent. The two systems of health care delivery do however share similarities, like for instance, competition in the market place. Due to cultural differences the possibility that the United States would ever adopt such a system remains remote. Although a national health service is an alternative for the United States it is however unlikely “for it would amount to socialized medicine, which, contrary to socialized education, still raises the hackles of Americans” (Powell and Wessen 1999, 37). Taking into consideration American political and economic traditions, it does not seem likely that the United States would ever nationalize the health care industry. According to polls, the concept of a national health service is supported only by about 10 percent of the American population. Not only is socialized medicine associated with communism, one of America’s traditional foes, “there also exists a fear that a national health plan would give too great a role to the government, particularly the federal government, which, after the collapse of the Soviet Union has become, for many, the new enemy” (Powell and Wessen 1999, 37).

## German Health Care

Contrary to other nations who have introduced “internal markets” or “managed care” based on the superiority of market forces, although it has been restructured, Germany has managed to retain its 100-year-old national health insurance program (Powell and Wessen 1999, 47). While Canada has monopolized the attention of U.S. medical professionals, health experts, policy makers, and business leaders, as a result of the Physician Payment Review Commission, Germany has made an imminent ascendance into the center of U.S. health care reform debate. Germany’s health care system more closely resembles the U.S. health care system than does the Canadian system. Health care is provided by private hospitals and physicians, while “tight control is exerted over hospital budgets, physicians’ fees and capital investment” (Graig 1991, 114). The German system merits a close examination by the U.S., as it has been able to reign in health costs through the implementation of certain policies. Unlike the British National Health Service, the German health care system is neither government owned nor government-run. Instead there is public regulation and oversight of the system. Despite its fragmented federal organization, the German health care system has been able to achieve a high degree of equity and justice.

Contrary to the American stereotype that National Health Insurance invites constant regulation by the government, the German system has shown that “government can enact the rules and then leave the doctors and the insurance funds to carry out the program with little government intervention” (Graig 1991, 114). In Germany, for example, “no single group is in a position to dictate the terms of service delivery, reimbursement, remuneration, quality of care, or any other important concerns” (Johnson and Stoskopf 2010, 159). Regarding the ongoing American health care reform debate, it would be wise for Americans to consider that the Germans health care system, as it has nearly achieved universal coverage, meaning less than 1 percent of the population in Germany is uninsured. Like the Canadians and Britons, German citizens also a right to health care. The quality of health care provided in Germany is also quite high. For instance, “the German infant mortality rate is on par with longstanding EU members, such as France and Spain, and higher than in Scandinavian countries” (Johnson and Stoskopf 2010, 160).

Even though Canada and the U.S. share cultural, geographic, and linguistic characteristics, there are quite a few parallels that exist between the U.S. and Germany, which suggests that the two have more in common than one may care to think. First off, both systems of health are a mix of public-private financing and federal state responsibility. Employers are also directly involved in the financing of both systems. Both systems also have a federal system of government “whose constitution proscribes responsibilities for local, state, and federal government” (Graig 1991, 114). Like U.S. Medicare and Medicaid, while its coverage has expanded over the years, German national health insurance was also designed to address the needs of a specific population. Regarding access related to timeliness of care, unlike in Canada where wait times for elective surgery have garnered considerable attention, in Germany they are not a problem. In fact, “more Germans (72%) than U.S. patients (62%) who had elective surgery in 2007-2008 reported waiting less than a month” (Johnson and Stoskopf 2010, 161). Lastly, the two systems share similar infrastructures with regard to their public health systems. Like in the U.S., Germany’s public health system “is responsible for protecting public health, including water systems, sewer systems, other forms of environmental protection, food safety and health promotion” (Johnson and Stoskopf 2010, 160).

Germany first pioneered national health insurance when in 1883 Otto von Bismarck implemented a system of health care for workers under certain incomes. The health care scheme became the first pillar of the German social security system, which like the U.S. Social Security system, is also financed by employees and employers through contributions. Entering the 1990’s the German system has shown its resilience as it has stood the test of time for over a century including two world wars. Structural reforms have been proposed, debated, and implemented, which has helped to preserve and strengthen the German system, as it has had to adapt to changing demographic needs as well as economic requirements. A couple of other factors make Germany an interesting subject for analysis. For one Germany, following the reunification of East and West, has become an economic colossus: “the undisputed powerhouse of Europe, accounting for more than one-quarter of the Gross Domestic Product of the 12-nation European community” (Graig 1991, 117). How Germany finances and provides health care is of keen interest, when one considers a U.S. manufacturer like Chrysler, who spends $700 per capita on health care costs, which is twice the amount a comparable German automaker spends.

The German health care system, which has managed to achieve comprehensive coverage at a lower overall cost than the U.S., shares many similarities with the U.S. "particularly in terms of health care delivery, limited role of government in the health care system, and prominent role of the employer" (Graig 1991, 117). Thus the two systems of delivery make for an interesting and worthwhile comparative analysis.

## **The Roots of German National Insurance**

Otto von Bismarck, who devised the first system of social insurance in Europe, did so as a manifestation of his government's concern for the health of its citizens. As a concept, the German "social security" system created has since been adopted to some degree in most countries of the world. Beginning in 1854, Prussia, a region of present-day Germany, "passed a law making membership mandatory in mutual-aid societies that provided health care" (Lassey 1997, 130). These societies had been organized voluntarily by workers as well as employers, prior to the government requirement.

After Germany became a nation in 1870, Emperor Wilhelm recommended permanent status for sickness insurance funds, and then in 1883 new legislation passed (Sickness Insurance Act), in response to the growing needs "generated by the interrelated forces of "industrialization, population growth, urbanization, increasing wage dependence and the geographical concentration and political awareness of new industrial workers" (Graig 1991, 121). Surprisingly, the fundamental structure of German health insurance coverage has since remained largely unchanged following its inception.

The newly founded German Reich of the late 19th century was guided by two forces: social solidarity and the concept of a strong state. During this time, the state was heavily involved in all aspects of the industrializing process, especially in the area of workers' welfare. The challenge of "encouraging industrial development while not disrupting the political status quo" was answered by Bismarck, who brought about "reform from above" (Graig 121, 1991). This way, the state, by supporting industrialization it could "better control not only the pace but also the mode of development" (Graig 1991, 121). Contrary to different strategies that occurred throughout Europe during the industrial revolution, in Germany, industrialization differed significantly due to the role of its state, which protected the old social elites and guaranteed new economic development. Unlike in England, where Social Darwinism was applied, public agencies in German consistently felt responsible for the welfare of their workers. By advocating for national health insurance, Bismarck, who believed in a strong benevolent state, hoped he would make loyal followers of the state out of the factory workers in newly industrializing Germany, and also "preempt the growth of a nascent socialist party in Germany" (Graig 1991, 122).

Although Bismarck wished to centralize power at the federal level of government, state legislators wanted the responsibility for social programs to remain at the state level. Prior to the establishment of national health insurance, mutual aid societies, created by guild and later union members, felt they "had the exclusive right to head the new insurance program" (Graig 1991, 122). Mutual aid societies, which were run on local basis, provided access to medical services for members who paid for care through subscription. The new national health insurance was built basically on top of the foundation laden by mutual aid societies, who had already introduced the concept of premiums to workers. Following the introduction of the 1883 Sickness Insurance Act, which made Germany the first country in Europe to offer compulsory social health insurance, workers below a certain income, would be insured by a sickness fund, and would therefore receive physicians' services, medication, eyeglasses, and hospital treatment without charge at the point of service. The sickness funds were also to provide income replacement benefits, which were at the time, most important, as medical care was considered secondary.

To get an idea of how far the German health care system has progressed, consider that in 1885 the Health Insurance Act covered only 10% of the population (or 26% of blue-collar workers), while in 2003, 90% of the population were covered through a sickness fund. The success of the German health care system is also evidenced by "the longevity of the policies and programs first developed and implemented under Bismarck," who was "able to advance his political and social agendas with no input from individual physicians or medical organizations" (Johnson and Stoskopf 2010, 154).

## **Three Powerful Ideas**

According to Powell and Wessen, "three powerful idea or principles underlie the development of German health insurance and medical care policy" (1999, 52). These principles have not only shaped developments, but are institutionalized in law and in practice and have set limits on acceptable policy options. Solidarity, the first of these three principles, "is considered to be significant in the pursuit of distributive justice" (Segall 2010, 149). In health care, solidarity "elicits the willingness of the healthy to pay for the sick, the single for those with children, and the young for the old" (Powell and Wessen 1999, 52). In Germany, solidarity "has been embedded in literally hundreds of decisions on financing, organizing, managing, regulating, and delivering medical care" (Powell and Wessen 1999, 52). By offering universal coverage and comprehensive benefits to its population, Germany has expressed its commitment to solidarity, which binds every federal, state, and local body, governmental and nongovernmental. From a luck egalitarian perspective, social solidarity is significant in the pursuit of distributive justice. Thus, weakening it can have a detrimental effect on the pursuit of distributive justice across society.

Subsidiary is another powerful idea or principle that is actually reinforced by the principle of solidarity. Subsidiary basically means “building social organization and society from the bottom up rather than from the top down” (Powell and Wessen 1999,). In Germany, the concept of subsidiary originated with the sickness funds, which were decentralized voluntary mutual aid societies, prior to the implementation of national health care policy. The concept of subsidiary is associated with the regional identities, and the political forces in Germany, that have over the years resisted “centralizing pressures of nation building and surviving totalitarian regimes (Powell and Wessen 1999, 54).

The fundamental principles of subsidiary and solidarity “have been endorsed by left, central, and right parties across the political spectrum and are secured in Germany’s Basic Law of 1949” (Johnson and Stoskopf 2010, 158). These principles closely relate to the concept of generalized reciprocity or the willingness to give without expecting anything in return. In the context of health care, generalized reciprocity “is the agreement among insured persons to share health risks and to assess contributions commensurate with one’s ability to pay, while discharging government functions which could be solved better, or at least equally as well, via private efforts and responsibility” (Johnson and Stoskopf 2010, 158). The German belief in generalized reciprocity provides the conceptual basis for the evolution of its modern health insurance system.

The last principle, corporatist organization, has also fundamentally influenced German health policy. In Germany, this dual form of political organization entails representation based on occupation and professional groups and also representation based on elections. Not only does the dual system of representation enhance effective participation in policy formation and implementation, it also “contributes to the political feasibility and social acceptability of health care reforms, thereby strengthening the capacity of the federal system to formulate and implement health policy” (Powell and Wessen 1999, 55).

## Overview of the German Health Care System

Germany combines a free market economy, with extensive social programs. Among the OECD countries, Germany stands out as being one of the highest spenders on social security programs. When one adds up expenditures for social security, plus total health care, the two are equal to almost a third of Germany’s GNP, which is “approximately one-and-a-half-times the amount dedicated by the U.S. to such social programs” (Graig 1991, 118). Table 1.3 reveals just how much Germany spends of its GDP on health care, in relation to Canada and the United States. Germany is the second closet country to the United States with a total expenditure of 11.1 percent.

**Table 1.3**

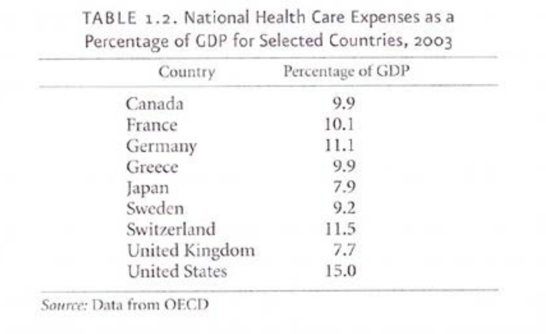


TABLE 1.2. National Health Care Expenses as a Percentage of GDP for Selected Countries, 2003

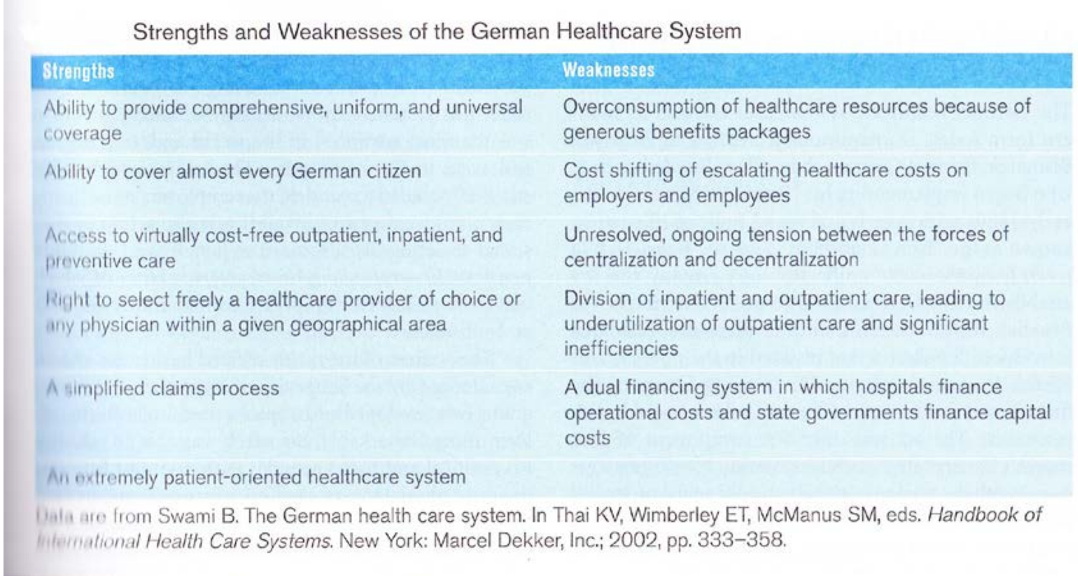
| Country | Percentage of GDP |
|---|---|
| Canada | 9.9 |
| France | 10.1 |
| Germany | 11.1 |
| Greece | 9.9 |
| Japan | 7.9 |
| Sweden | 9.2 |
| Switzerland | 11.5 |
| United Kingdom | 7.7 |
| United States | 15.0 |

*Source:* Data from OECD

One of the characteristics of German health insurance is collectivization, meaning most people insured are mandated by federal law to become a member of a sickness fund, or non-profit, quasi-public insurance company. Membership is compulsory for all employees who do not gross more than" a little less than €40,000 in income annually in the western parts of the country and around €32,000 annually in the parts of the former GDR and is voluntary for those above that level" (Johnson and Stoskopf 2010, 159). Health care providers are paid from these funds which act as depositories for payroll taxes levied on employers and employees. Unlike Canada's health care system which is primarily financed through general taxation, in Germany, employment-related contributions provide the bulk of health care financing. There are approximately 1,150 sickness funds that provide coverage for about 92 percent of the population. The German sickness funds have been likened to the Blue Cross/Blue Shield groups in the U.S. which are decentralized and are governed by independent administrative boards. The role of government in the decentralized public/private German system, "is limited to three major areas: delineating broad legal parameters within which the system operates; acting as the final arbiter in deadlocked negotiations; and financing capital expenditures for the hospital sector" (Graig 1991, 118).

With regard to decentralization, it remains as one of the weaknesses of the German health care system as is shown in **Table 1.2**. Luck egalitarians do not favor a decentralized or devolved system of health care. Although unity is not a necessary condition of universality, a devolved system is not as egalitarian as a unitary system is. For, example, consider two communities, A and B. There are 5 individuals in each community. Now suppose that each member in community A has a medical need of 20 units, while members of community B each have an annual need of only 10 units. In a unitary system, goods and services are distributed across society according to medical need, whereas in a devolved system, distribution takes place in accordance with the principle of equal shares; “that is the previously centralized health care budget is divided up and each regional health care authority receives a budget proportional to its size of its population” (Segall 2010, 143). The society in question has a total health care budget of 120 units. As goods and services are distributed according to need in a unitary system, members of society A would receive 16 units, and members of society B would receive 8 units, meaning society A members would receive 4 less than what they actually require, while society B members would receive 2 less than what they actually require. Under a unitary system, in both communities, 4/5 of each member’s needs are met. Under devolution, the distribution of goods and services would be less egalitarian than what it was under a unitary system. In a devolved system, communities receive a budget proportional to their populations, and therefore members of both societies would receive 12 units each, meaning citizens of society who require 20 units, would only have 3/5 of their needs met, while members of society B would end up with a surplus of units which they might use for other medical purposes.

**Table 1.3**



Strengths and Weaknesses of the German Healthcare System

| Strengths | Weaknesses |
|---|---|
| Ability to provide comprehensive, uniform, and universal coverage | Overconsumption of healthcare resources because of generous benefits packages |
| Ability to cover almost every German citizen | Cost shifting of escalating healthcare costs on employers and employees |
| Access to virtually cost-free outpatient, inpatient, and preventive care | Unresolved, ongoing tension between the forces of centralization and decentralization |
| Right to select freely a healthcare provider of choice or any physician within a given geographical area | Division of inpatient and outpatient care, leading to underutilization of outpatient care and significant inefficiencies |
| A simplified claims process | A dual financing system in which hospitals finance operational costs and state governments finance capital costs |
| An extremely patient-oriented healthcare system | |

Data are from Swami B. The German health care system. In Thai KV, Wimberley ET, McManus SM, eds. *Handbook of International Health Care Systems*. New York: Marcel Dekker, Inc.; 2002, pp. 333–358.

Thus, regarding the decentralized sickness funds, although inequities exist between them, by merging or integrating them, it may help to make them more equitable and more manageable. It would also likely help if the more affluent members of German society were required to join the sickness funds, as their membership would likely increase revenue as well as public resources for the less affluent.

# Chapter 4

## Conclusion

In conclusion, the United States ought to provide its citizens with universal health care coverage, as it is unjust for people to be penalized for circumstances, like their current state of health, for which they may have little control over. In relation to the distribution of health benefits and burdens in society, the three most prominent perspectives on justice are libertarianism, egalitarianism, and utilitarianism. The libertarian perspective of fairness "requires a maximum of social and economic liberty for individuals" (Longest 2006, 104). The libertarian perspective of fairness is found in most Western nations, particularly in the United States. According to one libertarian:

> The answer then to America's health problems lies not in heading down the road to national health care but in learning from the experiences of other countries, which demonstrate the failure of centralized command and control and the benefits of increasing consumer incentives and choice (Johnson and Stoskopf 2010, 51).

The problem with market justice, which is what the libertarian perspective prescribes, is that it results "in the unequal allocation of health care services, neglecting critical human concerns that are not confining to the individual but have broader negative impacts on society" (Johnson and Stoskopf 2010, 384). In the United States free competition generally exists among health care providers, except the buying power of private health plans has forced providers to form alliances, which makes the system a quasimarket or an imperfect market. To be a free market, unrestrained competition must occur among providers on the basis of price and quality. Due to giant medical systems that restrict competition in certain geographical sectors of the country, only in metropolitan areas will there be more than one integrated system competing to get the business of the health plans.

Contrary to the libertarian perspective, the egalitarian perspective of justice favors social justice. Social justice considers it unjust when people are unable obtain medical services due to a lack of financial resources. Therefore a just distribution of benefits is one based on need, not one's ability to purchase it in the marketplace. Regarding the U.S. health care system, market justice and social justice often operate side by side, except market justice principles tend to prevail.

Utilitarianism, which is outcome oriented, offers its own interpretation of justice, as it argues for the greatest good for the greatest number. According to utilitarianism, the morality of an act is measured not by theoretical claims about the rightness or wrongness of the nature of the act in and of itself. Rather it is the empirical upshot of the act that matters. For example, lying would not be considered wrong by its nature but by virtue of the bad consequences usually generated by lies. Lies are wrong when they produce moral disutilities. Health policies pertaining to pollution, workplace safety, and communicable diseases, "have been heavily influenced by a utilitarian view of what is just in the distribution of the benefits and burdens arising from the American pursuit of health" (Longest 2006, 104). Utilitarianism fails to provide a secure foundation for a universal right to a decent minimum of health care for everyone. The theory justifies excluding individuals who require a large expenditure of social resources over a lifetime from even the most minimal health care provided to others as a matter of right, when their contribution to social utility is not large.

Unlike in the United States, elsewhere "nearly every developed nation is committed to providing health insurance to it population, regardless of the individual's ability to pay" (Johnson and Stoskopf 2010, 51).  The policy position adopted by the U.S. to approach medical care as a market commodity that can be bought or sold is unique among developed countries. Contrary to the U.S. “all other developed countries have adopted national health plans that assure citizens access to basic medical” (Barr 2007, 2). Due to the growing number of uninsured Americans, as well as escalating health care costs in the U.S., it is important to examine the effects of approaching medical care as a market commodity. That policy has had a profound impact on the development of the U.S. system and has differentiated it from those of other industrialized countries.

Concerning the current system of health care in the United States, it is unique considering that unlike all other developed countries it does not have national health insurance that assures citizens access to basic medical care. Rather it excludes the largest number of people from care. Besides, a lack of access to care, the U.S. health care system is also plagued by rising costs. The cost of health care in the U.S. increases more rapidly than does its GDP, which leads to a rising percentage of GDP going to health care. For instance, in 1987 less than 11 percent of the GDP went towards health care, while according to projections, that number is likely increase to nearly 19 percent, meaning nearly one dollar out of every five in the economy will be spent on health care.

Based on studies done by Victor Fuchs, the United States spends more on health care per patient than does Canada, even though people in the United States visit the doctor less often. Concerning quality of care in the U.S., “Americans were more likely to be very satisfied with their health services including physician services, while Canadians were more likely to be “somewhat satisfied” with their health care services” (Ng and Sanmartin 18, 2002-03). Contrary to the U.S. system of health care, health care is a basic right of all Canadians. Based on this right, in Canada “payment for health care is through taxes, with no direct connection between receiving care and paying for care” (Barr 2007, 27). The biggest differences that were seen between the two relates to differentials in income: “Americans in the poorest income quintile report fair or poor health, obesity and severe mobility impairment more frequently than their Canadian counterparts” (Ng and Sanmartin 19, 2002-03).

While Canada and the United States share cultural, geographic and linguistic characteristics, between the U.S. and Germany there also exist quite a few parallels upon closer inspection. For instance, both systems are a mix of public – private financing. In Germany approximately 10% of the population is insured privately, while in the U.S., the private sector plays the dominant role, as it accounts for approximately 54% of total health care expenditures (Johnson and Stoskopf 2010, 381). Compared to Canada, the U.K. and the U.S. health care systems, the German health care system has achieved not only a high degree of equity and justice, but also ranks high for access related to timeliness of care. According to a Commonwealth comparison, more Britons(55%) and Americans(67%) reported having “thought it was somewhat or very difficult to get care on nights or weekends without going to the emergency room” than did people living in Germany(50%) (Johnson and Stoskopf 2010, 161). Like Germany, the U.S. health care system does not have a central agency to govern the system. In the United States government spending for health care is largely confined to filling in gaps that include environmental protection, support for research and training, and care for vulnerable populations, left by the private sector.

Decentralization, which upsets distributive justice, is one of the weaknesses of the German health care system. Unlike a unified system of health care, that distributes goods and services across society according to medical need, a devolved system divides up a health care budget and gives each regional health care authority a budget proportional to the size of its population, which ends up having an anti-egalitarian effect. Decentralization also risks undermining social solidarity, “which is crucial for the attainment of distributive justice” (Segall 2010, 152). Although decentralization is praised as an instrument for improving efficiency and quality, unless local leaders “have the training necessary to carry out the complex activities of finding resources, deciding on their use, and providing a range of health services while meeting the hugely diverse needs of the population being served” issues are likely to arise (Johnson and Stoskopf 2010, 405).

Consider, for example, the laws that were passed in forty states between 1911 and 1920 that allowed local jurisdictions to give benefits to impoverished widowed mothers in charge of dependent children. These pensions, whose benefit levels and administrative procedures were decentralized, “evolved into one of the most socially demeaning and poorly funded parts of modern U.S. social provision” (Skocpol 1995, 254). Not only were the pensions starved for funds by communities reluctant to spend taxpayers’ money, they also were only implemented in certain jurisdictions “leaving many widowed mothers, including most nonwhites, unable even to apply for benefits” (Skocpol 1995, 255).

## What Is Being Done?

To address the growing number of uninsured Americans, President Barack Obama signed into law the Affordable Care Act. According to the president, the bill enshrines “the core principle that everybody should have some basic security when it comes to their health care” (Jacobs and Skocpol 2010, 1). That does not mean however that Affordable Care provides citizens with universal health insurance. Rather, by the year 2014, “every American will be required to use a combination of subsidies, employer support, or personal income to obtain an acceptable insurance plan, or else pay a financial penalty of up to $2,085 for a family ($695 for individuals)" (Jacobs and Skocpol 2010, 129).

Many have argued that the health reform is, in one way or another unconstitutional. For example, "the most serious line of legal challenge to Affordable Care questions whether Congress has the authority to require individuals to obtain health insurance or pay a fine if they decline" (Jacobs and Skocpol 2010, 153). The McCollum lawsuit claims that Congress oversteps its powers by regulating interstate commerce, which although it enjoys constitutional authority over, that authority, according to reform opponents, applies only to "fungible items", like wheat or marijuana. Affordable care oversteps, because "it seeks to convert 'the inactivity of not buying insurance into commercial activity'" (Jacobs and Skocpol 2010, 153).

## What Needs to be Done?

The luck egalitarian perspective, considers it unfair when one person is worse off than another, due to reasons beyond his or her control. Therefore, "society ought to compensate individuals for whatever disadvantages result from conduct that it would be unreasonable to expect them to avoid" (Segall 2010, 21). Although a strict interpretation of luck egalitarianism is incapable of justifying treatment for imprudent patients or those who can be said to be responsible for their ailment, "luck egalitarians aspire to say something about distributive justice alone, rather than about the whole of justice let alone morality" (Segall 2010, 64). Since egalitarian distributive justice is but a narrow slice of morality, at times it must be traded off with other moral considerations when it does not produce a determinate and desirable policy. For example, the concern for meeting basic needs overrides luck egalitarian distributive justice and mandates meeting the basic medical needs of the prudent and the imprudent.

According to the luck egalitarian perspective a just health policy is one that rectifies any-health related disadvantaging condition that the individual could not have reasonably avoided (Segall 2010, 127). The luck egalitarian approach therefore advocates creating a two-tiered health care system. A publicly financed system, in which the government would be responsible for funding treatment of any condition that is either: disadvantageous, could be fixed by biomedical intervention, or would be unreasonable to expect the individual to avoid. The second tier would be a residual layer of mandatory social insurance that would be privately financed and would cover incidents of bad option luck that lead to destitution and loss of basic capabilities.

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