

The Social Contract, Distributive Justice, and Health Care in the U.S.

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By

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Abstract

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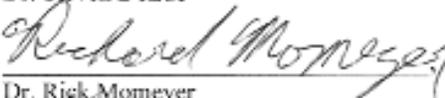
The President's Commission, released in 1983, studied the ethical implications and unintended consequences of the disparity in health care availability in the U.S. and concluded that health care is a special type of commodity, and thus, it is unethical to leave health care subject to market forces. Their recommendation was that society as a whole has a social obligation to ensure equitable access to health care and that the federal government does not maintain the largest responsibility to guarantee success. The aim of this thesis is to show that Americans live under a system of social contract, albeit, a system that requires extreme amounts of tinkering, and as such, the government is failing its citizens by not providing adequate incentive for them to leave the state of nature, such as a protection of equitable access to health care would do. This paper will attempt to use modern liberal theory to show why health care is a social good that should be protected by the government and why individuals should see access to health care as an essential component of individual dignity.

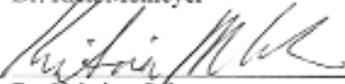
The second task of this paper is to compare the United States and French systems of health delivery and health insurance in order to decide what an ideally ethical system of health distribution would be. The conclusion of this thesis is that the U.S. system is too riddled with bureaucratic inefficiencies and political timidity to function as an ethical and just scheme. In order to correct for disproportionate levels of care, minorities being further disadvantaged, and unfair political rhetoric, this thesis recommends adopting a single-payer, government run system of national health insurance that is predicated upon membership in our society alone and ending the current use of employment-based health insurance. In conclusion, President Obama's Patient Protection and Affordable Care Act does not go far enough without creating a national health insurance to ensure equitable access to health care and needs to be revisited if the U.S. truly lauds a system of equitable distribution and justice as fairness.

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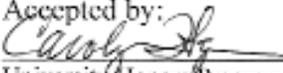
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Introduction: *The President's Commission and its Error*

In 1983, the President's Commission for the Study of Ethical Problems in Medicine published a report to the President on securing access to health care in the United States. In the Commission's introduction to the President, the chairman of the committee wrote that the focus of their investigation was on the "differences in the availability in health services among various groups," and the ethical implications that follow from this disparity.¹ This report questioned whether or not health care is special, and thus, should be exempt from market forces and require government regulation to ensure equity. The Commission decided that health care is indeed a special "commodity," because health is special for some of the following reasons: many health problems are beyond the control of people; health marks the most spectacular moments in life; and health affects individual opportunity to pursue 'life plans.'² Because health care is deemed special, the Commission concluded that the consequences of leaving medical care subject to market forces are unethical and unacceptable when over 40 million Americans lack health insurance.

Following this conclusion, the Commission reasoned that because it is unjust to leave health care open to market forces, society, not solely or predominantly the government, has a moral responsibility to ensure equitable access to care, free from excessive burdens. They recommended a pluralistic approach to solving this distribution problem, with an unspecific commendation of "coordinated contributions of actions by both the private and public sectors."³ Notably, the President's Commission also refused

to define what a societal obligation actually means, not taking a position on whether or not an obligation to ensure equitable access to health care should be read as a *right* to equitable access. Thus, this government report does not claim that individuals have a moral right to equitable access to health care, with or without the ability to pay for medical procedures or insurance. Also, the report does not state that the government has a responsibility to provide access to these services; the government does not have an obligation to be the sole, or even the predominant party with the responsibility to provide these services; it is, in their view, a societal obligation alone. However, what is the federal government's role as an overseeing and coordinating body with the resources to combat national problems in the interest of individuals if not to ensure this prescribed obligation society has to ensure equitable access to health care? These are problems that if left to society, which is fragmented and multifaceted, fail. After the conclusion that society has an obligation to provide equitable access to health care, the Commission's statement that government does not have an obligation to provide this as a moral right seems contradictory at best, and disingenuous and politically timid in reality. The federal government has the resources to combat this problem better than a fragmented collection of public and private societal bodies. Ensuring delivery of rights to individuals is one of its main functions.

If it can be effectively shown that each individual possesses a moral right to equitable access to basic health care through such theorists as Rousseau, Rawls, and Daniels, then the President's Commission was incorrect and unjust in stating that the government does not have a predominant obligation in ensuring equitable access to it.

First, this paper will attempt to establish that a social contract system does exist in America and that citizens would expect certain services, such as internal and external protection against aggression or undue harm. Next, this paper will show that a right to protection can be characterized in ways to include protection of a right to access to health care. And finally, it will attempt to demonstrate what an ultimately ethical system of health care would look like in order to provide pragmatic recommendations following a comparison of the U.S. and French systems.

¹ President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavior Research. 1983. *Securing Access to Health Care: The Ethical Implications of Differences in the Availability of Health Services*. Washington D.C.: Library of Congress.

² President's Commission, 16-7.

³ President's Commission, 22-3.

Chapter 1: *Rousseau's Social Contract in America*

Jean-Jacques Rousseau was a social contract theorist who attempted to show why people would voluntarily leave the state of nature to live in a civil society under a rule of law that would restrict human action. In his work *On the Social Contract*, Rousseau argued that individual people can be as free in a structured, governed communal society as they were in their state of nature. By limiting some rights that allow people to haphazardly do as they wish, citizens can still maintain their inalienable rights and receive protection and resources that they themselves could not furnish. He claimed that humans were not good or bad in the state of nature, but that they were simply animals acting on instinct. Because of this limitation, only so much progress could accumulate from this type of situation, and thus, people gave up their complete independence because of the necessity of cooperation for advancement.¹ The contract that these individuals enter into with their state is mutual: they agree to abide by the rule of law, if and only if, the government provides them with securities that could not be attained individually in the state of nature.

According to Rousseau, the first step in this contractual process is for the people in the state of nature to assent to being regulated by a common government. If one person does not consent, then he is not under jurisdiction of that government as long as he does not reside within the governed land. After the people have agreed to enter into this contract and leave the state of nature, they must come together and agree upon what every person requires to be dignified and treated with respect: the general will, which

could include national defense, internal protection, education, etc. Rousseau wrote, “There is often a great deal of difference between the will of all and the general will. The latter considers only general interest, whereas the former considers private interest and is merely the sum of private wills.”² A collective of individual wants is how Rousseau saw the will of all, riddled with self-interested desires. The general will is something different, something that would benefit individuals, yes, but because it would respect individual dignity, while being rid of private interests that would burden the rest. To Rousseau, all of these principles will be agreed upon unanimously; these protections are basic. If rational people were to decide what they needed in the beginning of time, this is the list that they would have comprised. By forming the general will, “Each of us places his person and all his power in common under supreme direction of the general will; and as one we receive each member as an indivisible part of the whole.”³

After the general will is decided upon, all people must meet in an open, deliberative forum to decide which actions can best instrument and implement the general will. After much deliberation, the people will vote and then it becomes a situation where the majority vote wins the day in creating the laws that will best employ the general consensus. On the idea of laws from this debate Rousseau wrote that, “A state thus governed needs very few laws; and in proportion as it becomes necessary to promulgate new ones, this necessity is universally understood. The first to propose them merely says what everybody else has already felt.”⁴ The context of our modern society makes this last concept a little more difficult, and perhaps, overly optimistic and unattainable.

A large obstacle exists within this system today, standing as a barrier to its complete implementation in our society in contrast with 19th century Europe: namely, Rousseau's idea was created in view of a smaller sovereign people like Athens. It would be impossible to collect the peoples of America into an auditorium and peacefully debate topics and come to a uniform conclusion of the correct list today without removing personal interests as necessitated by Rousseau's theory. Another problem with making Rousseau's system work today is the fact that ours is not a society free from all dishonesty and self interest. While Rousseau would not have said that Athens was perfectly free from corruption, their small, direct democracy stood a better chance of avoiding the self-interested plague than the U.S. system does today. For the general will and majority rule voting to actually work the way he describes, we would have to eliminate corruption: "For by its nature the private will tends toward having preferences, and the general will tends towards equality."⁵

Contemporary America is much larger and much less culturally homogeneous than a place like Athens. This creates a problem for Rousseau's ultimately ideal system. More diversity and a larger population generate more opportunity for lobbying and corruption of the general will. Special interests develop as a result of the complexion of the population. If people are going into the debates with personal interests in mind, then the general will is not being represented. In order for success, every person would need to check their private interests and have faith in the social contract view that they will be taken care of by the general will. If Rousseau's social contract theory is to be successfully employed to discuss health care reform and the consent of the American people to be

governed, these obstacles would need to be overcome, so that a proper and legitimate general will could be formed that would represent what each person would need the government to furnish in order to maintain their individual and collective dignity.

¹ Rousseau, Jean-Jacques. 1987. *On the Social Contract*. Trans. Donald A. Cress. Indianapolis: Hackett Pub, 17.

² Rousseau, 31.

³ Rousseau, 24.

⁴ Rousseau, 80.

⁵ Rousseau, 30.

Chapter 2: *Rawls's Theory Saves the Social Contract through the Veil of Ignorance and the Difference Principle*

Rousseau's theory requires that individuals of a state actually come together to form the collective general will. While practical problems have already been identified for utilization in the United States, a theoretical list created by a hypothetical ultimate rational human such as in John Rawls's theory might be enough to make his political theory of the social contract employable today. It might be enough to salvage Rousseau's theory, so that we can discuss health care reform in the U.S. with use of Rousseau's conception of why individuals enter into a governed society and what they deserve in return. This is important for this project because while wealth disparities could exist in this type of system of government, disparities in opportunity would not if we utilized Rousseau and Rawls. By thinking of the public will and not the private as Rousseau recommended, the greatest good commonly will be met and equality of opportunity could prevail where it could not in the state of nature. This is why it will be useful to consider Rawls in terms of modern political theory and this paper. If we want to further examine the President's Commission's claim that a societal obligation exists to ensure equitable access to health resources, then parity of opportunity is the place to begin this discussion.

John Rawls presented his theory of justice as a continuation of contract theory. He attempted to discern the conditions that would be necessary to establish the original agreement between humans and government. He stated that if people could come to the initial position in an equal way, then the guiding principles they would decide upon would be called justice as fairness.¹ Rawls believed that there are no grounds for

justifying advantages that nature has afforded certain individuals through what he calls the “natural lottery.”² In order to correct for this injustice, Rawls wanted the original position to be negotiated under his veil of ignorance, where a person would know nothing about himself or the conditions he would be under in his society. This “rational man” would know nothing about himself under the veil—not his talents, skills, class position, abilities, or even his conception of the good.³

“The idea of the original position is to set up a fair procedure so that any principles agreed to will be just. Somehow we must nullify the effects of specific contingencies which put men at odds and tempt them to exploit social and natural circumstances to their own advantage.”⁴ Rawls believed that the veil of ignorance would prove to be successful in this goal, no matter who, when, or where this thought experiment took place. The restrictions under the veil must always be the same, so that a highly rational person would always come to the same conclusions.⁵ For the veil to yield agreements that are fair and just, Rawls’s two principles of justice come into play: liberty and equality.⁶ By adjusting these situations, citizens would be able to enter into a social contract with the state that would correct for the natural lottery and provide each citizen that is comparable in skills and talents, to begin at the same starting line to compete for the goods society has to offer. Arbitrary social position would no longer play such a role with the difference principle in use.⁷

John Rawls can show that Rousseau’s general will could possibly be accomplished in a hypothetical way, with Rawls’s superior rational man under the veil of ignorance, instead of in a collective assembly where everyone must agree, making it

more plausible for our present society and for this project. It is possible to contend that under the veil of ignorance, all people would concede that health care is important to leading a quality life. Individuals would not want such a thing as poor health, which is largely not under individual human control, to influence their ability to compete for the same social goods. As such, access to health care is imperative, regardless of social standing. Once this theory can be shown as promising to the rational human, it follows that the difference principle, where the best well off contribute to access to health care for the least well off, must be employed. The quandary of the social contract predicament can be solved with Rawls's theory, thus allowing us to see that the government has a moral obligation to secure the right to access to health care for every American.

If the ultimately rational human were to participate in the veil of ignorance experiment, he would arrive at the same basic protections for his dignity, what he would need protected in order for his dignity as a citizen to be protected, each and every time. This is the nature of the veil experiment. If this is then applied with Rawls's concept of the difference principle, where the best well-off would then be "taxed" to benefit the least well-off, a right to equity of access to health care can be shown. If this rational man knew nothing about his talents or place in society, he would still think that such ideas like education, defense, internal protection against others, and health care would be pertinent to the maintenance of his dignity.

Now, with the difference principle under the veil of ignorance, the rational man would only create a list of the basic ideas he thinks are necessary. This is true because if in reality he was at least moderately well-off in society, he would then be required to pay

a tax towards creating an opportunity for the less well-off to have all of the objects on his list. While the veil of ignorance is not precluding the amount of goods that should be distributed to people, it is a hierarchical system where first-order priorities would be secured by taxes and state subsidy first and subsidies for second-order preferences disturbed later, if resources to do this still exist. So while the rational man might think that a right to education is valuable to dignity, and necessary to his dignity, he would not place owning a Porsche on his list under the veil. Because while the rational man would want someone to help him pay for an education and would also want someone to pay for his Porsche, he could see the reciprocal benefit in helping pay for someone less well-off's education, but probably not the benefit for helping pay for his Porsche, thus showing how the veil experiment only leads to a basic and essential list of first-order social obligations necessary to ensure individual dignity.

This is the manner in which the veil of ignorance and the difference principle can come together to eliminate advantages based on the natural lottery and to create equal opportunity to compete for social goods. I have argued that the rational man would value education and basic necessities like food, water, and protection. However, I have yet to define protection for the benefit of this argument. Protection would most certainly include national defense, but it also includes internal protection within the state. Part of the reason people were shown by Rousseau to enter into the social contract was for the limiting of personal rights to eliminate bodily harm based on competition and animal instinct in the state of nature. Rule of law was created to keep citizens safe from one another and to enforce contracts and promote cooperation for progress within the society.

These protections that the individuals could not achieve by themselves in the state of nature are important for the social contract to function. The term *protection* can be seen as a protection of life—from inside and outside forces. If a protection of life is argued, then a moral right to equality in access to food, water, shelter, and health care naturally follows and would be perpetuated by Rawls's rational man through the veil of ignorance and justice as fairness. I argue that access to health care constitutes a kind of protection, and thus, the government has a responsibility to fund, safeguard, and promote it.

Although Americans did not actually come together to forge an overall agreement pertaining to the articles that are necessary to secure dignity, and we would not want to require them to do so due to the infeasibility, it is entirely likely that if such a convention were held for this purpose, Americans would affirm the need for a system that protected individuals' health. This statement does not yet necessarily claim that they would want government to be the system that protected their health. However, it does claim that if people chose to leave the state of nature for the advantages that society as a whole could afford them and which they could not establish individually, health would be an advantage they would request to maintain their dignity as people. In this recipe for dignity and individuals coming together to form a whole, just health care would be at the top of society's list of protections, along with others such as defense and education because it cannot be effectively secured by individuals; people, in general, need outside assistance in living long, being pain free, and staying healthy and happy.

I maintain that there is a shared belief held by most American citizens, whether they want government involved in delivering health care or not, that each is to be

provided adequate health care as a right of citizenship, as a right of joining the communal body outside the state of nature. As Rawls's veil of ignorance shows, one can never know when he will need health care he cannot provide himself, and as such, will have an interest in a base level security of health for all. Without high enough incentives, individuals would choose to stay out of government control when it was not necessary. Protection would be one of the major attractions of leaving the state of nature. The President's Commission was correct: health, and in turn, health care is special, and Americans would want to have access to it free from excessive burdens. In this way, Rousseau's social contract theory demonstrates the need for social justice in access to health care. If indeed the aforementioned argument on universal health care as part of the general will of the people is true, then the social contract is failing in the United States where universal health care is still just a dream, even with the passage of the new Patient Protection and Affordable Care Act.

Using Rousseau's theory helps to identify a failing contractual system in the U.S. It shows how individuals valuing health creates an obligation for the state to secure equal access to health care free from excessive burdens in our social contract organization. This is because it is the *state* that has the power, time, and financial and institutional resources to prove successful in the feat, not individuals, or even fragmented social groups across the country. However far Rousseau's theory could be pushed, it does not necessarily provide an adequate ethical framework for delivery of health care. The aim of this project is to provide an ethical analysis of the American health care system through social contract theory and determine whether it is a moral basis for ethical care, or whether the

system's structure in itself is conducive for ethical medical practices in a world with limited resources. Is there a universal principle of right which can be used to justify a system of health delivery? Modern liberal theory, with Rawls as my example, can be used as a test to see if the U.S. system is compatible with distributive justice and if Rousseau's social contract could be utilized in the U.S. today.

In understanding that our social contract entitles us to just health care, some ethical questions that can be foreseen deal with the following topics: what does each of us owe to a fellow citizen who has fallen ill? What responsibility do the sick have to ensure they are covered by health insurance? Should the medical system be allowed to profit off the sick? And how can we ensure justice in health care through political policy? As the United States moves forward and improves its system of social justice, the debate on health care will be paramount with dwindling resources and a progressive population and government. With the recent attention drawn to the health care debate, a revisiting of social contract and modern liberal theory à la Rawls can help to steer public policy in the correct direction.

¹ Rawls, John. 2010. *A Theory of Justice*. New Delhi: Universal Law, 11.

² Rawls, 12-3.

³ Rawls, 136-7.

⁴ Ibid.

⁵ Rawls, 139.

⁶ Rawls, 60.

⁷ Ibid.

Chapter 3: *The Conflict between Limited Resources and Justice in Health Care*

So far we have established the following: 1. People enter into a social contract and leave the state of nature, giving up their absolute right to freedom to gain the protections of the state; and 2. Under the veil of ignorance, a general will would be established which would include protection of the right to access to health care. The next task is to decide what would be an ideally ethical system of distribution. Norman Daniels begins his work by asking what sort of inequalities are morally acceptable and if health care is a special good. He believes that the only starting point to show that health care is a right is to take it from a general theory of distributive justice as I have previously attempted to do with Rawls's theory.¹

Daniels's answer is to explain the moral importance of the need of health care by showing how the lack of health care or good health can affect opportunity.² While American society exalts inequalities in distribution of most social goods under the capitalistic system, many people feel "there are reasons of justice for distributing health care more equally."³ Daniels uses a truncated scale to show how injury of normal species functioning reduces a person's range of opportunity in which he creates his life plan, where happiness is the completion of his life plan. This argument shows that the needs necessary for normal species functioning are in turn necessary for attaining a normal opportunity range.⁴ "Health care needs will be those things we need in order to maintain, restore, or provide functional equivalents to normal species functioning;"⁵ health is necessary to normal species functioning; health care is necessary for equity in

opportunity. Daniels goes on to demonstrate what equality of opportunity means: it does not mean leveling or eliminating all differences in individual diversity, but it does mean that opportunity be equal for all the persons with similar talents, skills, and dispositions as Rawls states.⁶ It requires that we bring similarly talented people to the same starting line so they have equal opportunity to compete for goods in society. Daniels employs John Rawls's theory of "economic" inequality in the difference principle, where advantageous inequalities must be maximally beneficial to the worst-off individuals in society⁷ (i.e. if the wealthiest business man could afford the best health insurance possible, there should be a tax on his premiums to provide health insurance for those who cannot afford insurance at all). Daniels's conclusion is: "restoring normal functioning through health care has a particular and limited effect on an individual's share of the normal range. It lets him enjoy that portion of the range to which his full array of skills and talents would give him access, assuming that these too are not impaired by the special social advantages."⁸

Given this *limited* and *particular* effect that Daniels claims, what sort of inequalities in the distribution of our health care are morally acceptable when there is a distinct shortage of resources to be provided? The rapid and exponential increase in U.S. health care expenditures has posed a further barrier to the equitable distribution of these goods and needs to be acknowledged in policy decisions. There are at least four factors that are primary in the discussion of rapidly increasing health care expenditures: technological innovation and change, an aging population, third party payment schemes insulating the real cost of procedures from patients and physicians, and the increasing

demand for more health care as a parallel to the increasing amount of income in the United States.⁹ This project will focus mainly on the issue of third-party payment schemes and the unintended moral consequences of our current insurance system.

The authors of *The Painful Prescription: Rationing Hospital Care*, Henry J. Aaron and William B. Schwartz, discuss the hypothetical effects of budget limits in health care under a belief that the U.S. has no interest in creating a national health service, or a single payer system. While the authors believe that mild budget cuts would, “do little more than subject hospitals to some of the cost discipline that competitive businesses routinely face, but from which hospitals are sheltered by present methods of reimbursement,” they also believe that the potential savings are inflated.¹⁰ They state that the elimination of inefficiencies, bureaucratic disorganization, duplication in facilities and procedures, and judicious reductions in examinations are overoptimistically identified as important sources of potential savings, and instead, the only real way to seriously curb rising costs in the system would be to reign in the advancement and use of new technologies.¹¹

Aaron and Schwartz instead propose that radical budget limits would best act as triage on the battlefield does, where the most care would be provided to those who could benefit the most, and aggressive terminal care would be greatly reduced. The probability of increased litigation efforts to this sort of rationing is inevitable, but over time, Aaron and Schwartz believe that there would be a redefinition of negligence and doctors would create new professional norms and standards of treatment.¹² This would mean fewer claims to lawsuits as a patient, but more security for physicians who would have more

discretion in choosing when and how to treat their patients. While overly aggressive terminal care is a topic that needs revisiting in the U.S. culture of fearing death, Aaron and Schwartz's prescription seems like it would have terrifying consequences for patients today. In a matter of years, hospital budgets would shrink drastically so that the type of care that patients are accustomed to in our culture would vanish. Those that would have the least hope of survival would be treated the least and the amount of aggressive terminal care would decline rapidly. It is foreseeable that U.S. citizens and, in turn, policymakers would not support this type of drastic health care reform; also, it cannot be effectively shown that this recommended policy would be completely effective in driving down costs and/or improving quality of care.

I disagree with Aaron and Schwartz's conclusion that the potential savings based on reorganization, elimination of inefficiencies, duplication of technologies and procedures, and removing a pay-per-service reimbursement scheme are overinflated. An inherent conflict exists between the current physician reimbursement, insulated third-party payment, and the overuse of some medical treatments. Rationing is inevitable and necessary in health system reorganization, and judicious decisions in the morality of the criteria will need to be pertinent in revamping health care delivery; this means that cutting overly aggressive terminal care would improve the system and unnecessary and unhelpful treatments would most likely benefit our health care delivery. However, discussing drastic-enough rationing to fully balance the health care cost in the United States seems unethical in the face of all the inefficiencies that currently exist in the system. While rationing will always need to be a part of the political discussion, rationing

based on an arbitrary criterion such as age, disease, or quality of life, appears an unacceptable starting point, but not an unacceptable final resort for later health care reform.

Rationing will continue to be an essential feature of political and health care policy. Any current or future health care plan will involve rationing at some point and to some degree. However, what I am claiming here is that instead of creating a calculated list of when doctors should treat and when they should ration, we should address other considerations through policy first. No health reform plan will eliminate the entire need for at some point deciding who and when to treat, but these decisions should be made after all possible inefficiencies are cut from the medical and insurance delivery schemes. Without incentive of profit or disincentive of being sued if physicians do not act in certain ways, we stand a better chance of making good, ethical, and just decisions on how to ration limited resources and provide better quality of care at lower prices.

Instead of focusing on creating an idea of a “natural life span” and limiting aggressive terminal care to someone post middle-age as Daniel Callahan¹³ and Aaron and Schwartz seem to imply with their thick theory of the good, it seems that this sort of rationing is an easy solution for politicians, physicians, and doctors to be let “off the hook, to give them a formulistic approach to these morally and emotionally difficult choices.”¹⁴ And while the importance of rationing in today’s world need not be underestimated, I see a more ethical and straightforward policy approach to instead begin discussing how health insurance, and in turn health care, is delivered and paid for. If this can be reformed, many of the inherent inefficiencies and trends toward exploiting

patients can be eliminated so that it can then be discussed how to practice rationing in a just, limited, and politically restrained way. The argument that is more sympathetic to this cause of beginning to reform the system before drastic rationing is a later argument of Daniel Callahan and Sherwin Nuland. In a recent *New Republic* editorial, the two wrote that, “Medicine cannot continue trying to serve two masters, that of providing affordable health care and turning a handsome profit for its middlemen and providers.”¹⁵ This approach is controversial because it is contrary to the current U.S. system of health delivery being involved in the capitalistic system that leads to profit and return on investment. However, it does seem in fact to get at the heart of opening the door to equal access to health care.

Chris Hedges argues that the real problem in the health care debate is distorted and covered by the media who have large corporations, like the insurance industry, as its main advertisers. He argues that the real problem is not even addressed by the Patient Protection and Affordable Care Act, but that until America is free from a for-profit health care system, where both political parties are subject to corporations, we will not be free, have the health care we need, and live the lives that will make us happy.¹⁶ Hedges writes: “The dizzying array of technical loopholes in the bill—written in by armies of insurance and pharmaceutical lobbyists—means that these companies, which profit off human sickness, suffering, and death, can continue their grim game of trading away human life for money.”¹⁷ Hedges wants to replace private insurance companies and a system of employment-based health care coverage with a government run, single-payer, universal right to treatment, regardless of chosen career or immigration status, to cut costs and save

lives. While the U.S. spends close to twice as much per capita on health care than any other industrialized nation, such as France, 31% of every health care dollar goes to pay for the large, unorganized bureaucracy and multitude of paper. This fact shows that while cutting inefficiencies in the system might not completely balance the medical care budget, Aaron and Schwartz's statement that the potential savings is overestimated is absurd. Hedges argues that the only way to accomplish justice in health care is to establish a single nonprofit payer system and establish health care as a human right, not an employment based perk.¹⁸ In the following chapters I will attempt to formulate a model that keeps Hedges' recommendation at heart and relies on a principle of justice as fairness which respects human dignity.

¹ Daniels, Norman. 1985. *Just Health Care: Studies in Philosophy and Health Policy*. Cambridge: Cambridgeshire: Cambridge UP, X.

² Daniels, 39.

³ Daniels, 11.

⁴ Daniels, 26-8.

⁵ Daniels, 32.

⁶ Daniels, 33.

⁷ Ibid.

⁸ Daniels, 34.

⁹ Aaron, Henry J., and William B. Schwartz. 1984. *The Painful Prescription: Rationing Hospital Care*. Washington, D.C.: Brookings Institution, 117-9.

¹⁰ Aaron and Schwartz, 123-6.

¹¹ Ibid.

¹² Aaron and Schwartz, 131-3.

¹³ Daniel Callahan. 1988. "Rationing Health Care by Age and Economic Status: Aging and the Ends of Medicine." From *The Annals of the New York Academy of Sciences* 530, 125-33.

¹⁴ Christine K. Cassel. 1990. "The Limits of 'Setting Limits.'" From *A Good Old Age? The Paradox of Setting Limits*. Edited by Paul Homer and Martha Holstein. New York: Simon and Schuster, Inc., 196-206.

¹⁵ Daniel Callahan and Sherwin B. Nuland. 2011. "The Quagmire." *New Republic* 242, no. 8. *Academic Search Complete*, EBSCOhost, 16-8.

¹⁶ Chris Hedges. 2010. *The world as it is: dispatches on the myth of human progress*. New York: Nation Books.

¹⁷ Ibid.

¹⁸ Ibid.

Chapter 4: *The Similarities and Differences in Theory of Health Delivery in the United States and France*

“What the French and U.S. health care systems share, as well as what divides them, is reflected in the various interpretations of their eighteenth-century revolutions. Both the American and French revolutionaries hailed the Enlightenment ideals of individual rights and popular sovereignty, leading to an inherent tension between personal liberty and social equality in the republics they formed.” Paul Dutton¹

A recent Brookings Institution article claims that the most prominent factor in the U.S.’s dismal ranking in health care at 37th among 191 countries, is the large number of uninsured Americans whose access to care is thus limited.² While many Americans consider the French health care system socialized medicine, like British or Canadian medicine, a term that has serious negative connotations here, the French system is actually a mixed public and private system, similar to that of the United States’.³ Their system just happens to be more effective at controlling costs and improving health. Paul Dutton attributes the similarities in the French and U.S. system to a shared history of Enlightenment-era revolutions, upholding ideas such as liberty and social equality.⁴ Dutton enumerates the differences between the two systems, but also shows how the shared history could contribute to easier piecemeal health insurance reorganization in the U.S., with the end goals of achieving individual liberty and social equality for all.

In both the United States and France, the debate over health care reform has been viewed in the form of binary extremes for centuries. The central question of health care distribution has been viewed as a process to reconcile the concepts of equality and liberty.⁵ While opponents of health reform argue that making a compulsory system is an unconstitutional intrusion on personal autonomy, worker rights, and liberty, the

proponents of reform make a parallel argument: by giving up complete and total autonomy for something slightly more restrictive, more liberty can be the outcome by ensuring access to care and a life free from excessive medical burden.⁶ Dutton writes that, “The tension between liberty and equality has been characterized in different ways over the course of the twentieth century: as personal responsibility versus social welfare, private enterprise versus communism, voluntarism versus compulsion, and individualism versus interdependent citizenship, to name a few.”⁷ This depiction of two extremes on the end of a spectrum confuses the complexity of reality because it suggests that there are only two choices, which happen to be polar opposites. All of these binary classifications distort the truth of the social-political debate by making it an “us versus them” game of winner takes all spoils. By removing this type of unhelpful, and inaccurate, rhetoric from our political discussions, the historical similarities between the United States’ and French systems will become clear and debate on true reform and compromise will become possible.

A century ago the French and U.S. systems looked more alike than they do today in terms of health insurance, employer-based coverage, and socialized costs of care.⁸ Why did they take such a drastic turn away from each other in the last hundred years? Dutton’s answer is that they did not. Because serious health care costs, such as in the case of a drastic accident, are so far out of proportion with what normal citizens are able to pay, most health systems have been “socialized” for a long time, including the United States’ system.⁹ By creating pools of resources and paying into the collective system, when medical attention that is needed (that goes beyond the price of our deductible), the

cost is covered by the pool of money that many contributed to in some way. This is a version of socialism—insured patients in the United States have not, and still do not, pay for their own procedures. The risk pools that the covered pay into pay for procedures well beyond the price of premiums and deductibles. Our current system socializes the cost of getting sick because individuals typically do not have the resources to pay themselves. While the United States and France share a common Enlightenment-Revolutionary history of championing liberty and equality, and while the American system is not as un-socialized as first thought, what makes them different? Who gets what aspects of the system correct and more conducive to equality? And how can each country learn from the other to promote the correct balance between liberty and equality?

Many differences exist between the current American and French systems of health insurance and their medical fields. This section of the project will enumerate some of the differences in preparation for pragmatic recommendations on which aspects of each system should be utilized in American health care reform. To begin the discussion, in response to rising health costs across the developed worlds, two approaches have been created by governments to ensure that the costs of medical care are socialized, and thus, attainable for the general citizenry. These methods for medical payment typify the differences between a truly “socialized” system of health care and those that respect individual autonomy to a greater degree. The first approach is that of a health service in which the support for the medical industry is paid for directly by the government treasury. Great Britain exemplifies this system.¹⁰ The second solution is one of health insurance, which both the United States and France utilize. In this system, reimbursement

for doctors and support of medical infrastructure and resources takes place in both public and private spheres and is paid for by both public funds that do not flow directly from the government treasury and private insurance companies.¹¹ France has a system of a mostly large, public health insurer, which is then complimented by private insurers providing supplementary coverage, whereas the reverse is true in the United States. The U.S. has a large system of private health insurers, supplemented by public programs, like Medicare and Medicaid.¹²

A direct comparison can be made between the supplementary public insurance in the U.S., like Medicare, and how the French system of health insurance functions: the healthy pay for the sick, and every employer and employee contributes to the pool. If a citizen is unemployed, the government finances his medical costs.¹³ However, this comparison of French insurance being the same as Medicare is indeed flawed in some ways. There are no deductibles in the French system, but small copayments do exist. Also, supplemental insurance is available to all French, which in turn lowers the copayments further. Also, chronic illness reduces payment, and critical surgeries can be covered completely in France.¹⁴ Several crucial practices allow France to be able to pay for this kind of universal coverage; they will be identified later in this work. This comparison can begin to show that it is possible that government intervention can continue to provide incentives for high quality of care, while increasing the number of insured citizens and reducing costs.

An article from the *American Journal of Public Health* expands on this comparison and shows that supplementary insurance could still be offered by private

insurance companies in the U.S., even with successfully implemented French-like reforms and a single-payer, nonprofit, government run insurance scheme. This article comparing the French health care system to the U.S. Medicare system argues that a step-by-step reform of a partial program, like Medicare covering the elderly, could eventually lead to universal coverage in the U.S. system.¹⁵ The French National Health Insurance (NHI) is paid for by employer payroll taxes, “general social contributions” on all earnings, special taxes, subsidies from the state, and a specific tax on the pharmaceutical industry.¹⁶

This article by Victor G. Rodwin concludes that there are five lessons that the U.S. can learn from the French health care system, which will be an integral part of my comparison between the two systems and the evaluation of their effectiveness and equity and equality for all citizens. First, he argues that universal coverage is possible without a single-payer insurance system, but does require legislative framework and active state intervention; second, it is possible to achieve this kind of coverage through piecemeal reform over time; third, universal coverage can be achieved without the demise of private insurance companies; fourth, it is more equitable to have national control over the uninsured than state-based control because of the resources and cohesion of the federal government; and finally, it is possible that NHI can be achieved before the task of reorganizing the health care system is attempted.¹⁷

While there is a large difference in how French and American citizens are insured, in reality, the systems are mirrors of each other. What makes these two systems shockingly alike is their shared heritage of recognizing individual liberty and equality and

the fact that their citizens fear “socialized” medicine in both countries. American consumers dread this type of labeled system because of a concern that medical attention will resemble an industrialized assembly line where a distant, complicated, government bureaucracy would interfere with physician selection, would create a more convoluted system of paperwork, and would force medical personal to hold allegiance to the government over the patient.¹⁸ The French have this same fear, with severe apprehension of the British and their truly socialized system of health care.¹⁹

While both France and America are terrified of completely socializing the costs of their health care systems, reform is necessary because currently they both top the charts of some of the most expensive health care systems in the world.²⁰ The important question henceforth is if both countries are far more expensive than the average system, what does each system get in return for its investment? Does spending more money get the citizens better health? How is the money spent differently?

In a 2004 Harris poll 65% of French citizens were reported to approve of their health care system, as opposed to only 40% in the U.S, while France spends less than 11% of its GDP on health care, as opposed to 16% in the U.S.²¹ In 2006 the average per-capita health expenditure in the U.S. was \$6,714, as indicated in Figure 1.²² In 2009 that figure rose to \$7,410 in the United States.²³ In 2009, the average per-capita health expenditure in France was only \$3,934.²⁴ These figures need to be weighed next to the fact that the U.S. also has a lower average life expectancy and a higher rate of infant mortality than the French.²⁵ These statistics are depicted below in Figures 1-4. The

following discussion will center on how French and U.S. money is spent differently and the degree of effectiveness of this outlay.

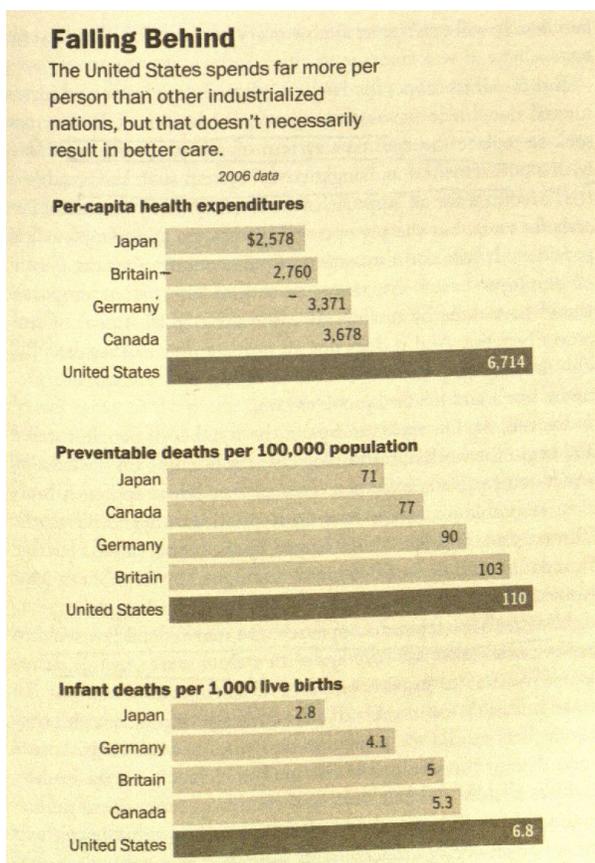


Figure 1: Cost versus Quality of Care Globally²⁶

Indicator	France	United States
<i>Demography and Economics</i>		
Total population (2004)	60,200,000	293,655,000
Population over 65 (2004)	16.3%	12.4%
GDP per capita (purchasing power parity) (2004)	\$29,600	\$39,700
GDP growth average (1994–2004)	2.3%	3.3%
Unemployment rate (2004)	10.1%	5.5%
Personal income tax of total receipts (2002)	17.3%	37.7%
Taxes on goods and services of total receipts (2002)	25.4%	17.6%
Average production worker's disposable income of gross pay (2002)	73.2%	75.7%
<i>Health Care System</i>		
Health care spending of GDP (2003)	10.4%	15.2%
Health care spending per capita (purchasing power parity) (2003)	\$3,048	\$5,711
Public portion of total health care spending (2003)	78.3%	44.6%
Practicing physicians per 1,000 residents (2004)	3.4	2.4
Physician consultations per capita (2003)	6.7	3.9
Acute care bed days per capita (2004)	1.0	0.7
Acute care beds per 1,000 residents	3.8	2.8
MRI scanner units per million residents (2004)	3.2	5.0
<i>Health Status of Population</i>		
Life expectancy at birth in years (2003)	79.4	77.5
Female life expectancy at 65 in years (2002)	21.4	19.5
Male life expectancy at 65 in years (2002)	17.1	16.6
Infant mortality per 1,000 live births (2003)	4.0	6.9
Tobacco consumption (percentage of population 15 years or older smoking daily) (2002)	26.0%	18.4%
Obese as percentage of population (body mass index > 30 kg m ²) (2002)	9.4%	30.6%

Figure 2: American and French Demographic, Economic, and Health Indicators²⁷

France

Map	Statistics	
 <p>This map is an approximation of actual country borders.</p>	Total population	62,343,000
	Gross national income per capita (PPP international \$)	33,280
	Life expectancy at birth m/f (years)	78/85
	Probability of dying under five (per 1 000 live births)	4
	Probability of dying between 15 and 60 years m/f (per 1 000 population)	117/54
	Total expenditure on health per capita (Intl \$, 2009)	3,934
	Total expenditure on health as % of GDP (2009)	11.7
	Figures are for 2009 unless indicated. Source: Global Health Observatory	
Data from the Global Health Observatory		

Figure 3: French Health Expenditures compiled by the World Health Organization²⁸

United States of America



Figure 4: U.S. Health Expenditures compiled by the World Health Organization²⁹

As indicated in the above figures, the U.S. spends close to twice as much per capita on health care than other industrialized nation, like France, but 31% of every health care dollar goes to pay for the large, unorganized bureaucracy and multitude of paper.³⁰ The United States has less administrative efficiency because we utilize a mass of private insurers that has to be organized at individual medical facilities.³¹ It has been shown that the costs of running a public system of medical administration are well below the costs of coordinating a private system. In France the efficiency of administrative costs is 13% for the private system of insurance augmentation versus only 6% for their National Health Insurance. The same has shown to be true in the U.S.—running Medicare and Medicaid are far less costly than the 31% of every health care dollar that goes towards running our private system.³² This is interesting in light of the fact that public perception is often just the opposite, thinking that the private is always more efficient.

By the outbreak of the Second World War, both France and the U.S. had socialized their medical fields by creating risk pools for costs and established a tradition

of employment-based health insurance benefits. They began using employers, which were not supposed to profit off this exchange, as intermediaries between recipients and private insurance firms. Creating larger risk pools drove down the cost of insurance coverage and allowed employees and employers to share the risk of illness on a new massive scale.³³ Beginning in the 1800s, the private insurance industry began to increase in power, and during WWII businesses were fixed with price and wage controls, but were exempt from controls on medical benefits, providing the employers with an edge over competition. Since mid-20th century, employer-based health insurance has been a staple of society, but with some very serious and unintended consequences.³⁴

By tying a central social benefit like health insurance to something that partially remains outside of the control of the individual citizen, like employment and the national economy, a negative social impact is likely to follow. This system of employment-based coverage once again creates a binary way of classifying people that distorts and masks the complexities of reality. By lauding the capitalist system in America and supporting such concepts as “rugged individualism,” a side effect of employment-based health benefits is that it creates a view of those “deserving” coverage, i.e. those that work the hardest, versus those who are undeserving of coverage.³⁵ Unfortunately, those who look the worst in this scheme and who could be viewed as “undeserving” are those social groups that are already disproportionately under represented and overly criticized. It strengthens conceptions of minorities and women being less hard working and less deserving of social benefits because they often do not receive adequate coverage.³⁶ The connection between minority groups and poor coverage continues to persist in the U.S.,

where minority groups are already disproportionately poor. Studies show that the poor are less likely to receive coverage and more likely to get less quality in the medical care that they do receive.³⁷

In France, the story is slightly different. In response to these negative social impacts of the wide spread employment-based coverage, the French government began a series of reforms in the 1945 to dissolve the connection between health security and employment.³⁸ Now, in France, public health insurance is guaranteed, and the sicker one becomes, the greater the amount of health benefits he receives for no cost to himself. Those that do not have health insurance, the sick, and the unemployed automatically qualify for NHI benefits, unlike in the U.S. where there are strict stipulations to qualify for Medicare and Medicaid.³⁹ In the U.S. it is not at all guaranteed that the sicker you become the more coverage you receive. Medical bills today are a leading factor in more than half the country's personal bankruptcies, and most of these people *had* health insurance.⁴⁰

However, the French tie to their employment-based days of health insurance still remains strong and affects their modern system. Places like Great Britain use property and diverse income taxes to pay for over 80% of their health insurance system. In France, the NHI is paid for through paycheck deductions, much like the U.S. system for private insurers through employers.⁴¹ After the money is deducted from payroll in France, the money funnels directly into public insurance funds and does not have the intermediary step of entering the national government treasury, unlike in the U.S. where individuals are taxed, the money goes to the treasury, and then is appropriated to cover the public

social programs legislated. The French NHI funds are run jointly by union representatives and employers, not government officials.⁴² The French physician reimbursement plans are extremely similar to the American system. In France, conventions, or national medical fee schedules, are negotiated by the government and a NHI committee with physician organizations. In the U.S., fee schedules and HMOs exist for public and private insurers. These reimbursement constraints confine physicians in both countries. However, physicians in the U.S. do not have to accept Medicare, Medicaid, or lower reimbursement patients, thus often giving low income citizens worse medical care. This choice does not exist in France, legislatively cutting part of the prejudice out of the system.⁴³

Another negative social consequence of employment-based coverage is the way it intertwines with capitalism. The American labor system is to a large degree unregulated because of a push for corporate and individual autonomy and the feeling that economic competition will work best to ensure individual success; this unregulated system leads to higher employment levels than more economically regulated states, such as France. However, as Paul Dutton writes, the increase in health costs and our current private insurance system leads to what he calls “job lock.”⁴⁴ He claims that, “Job lock occurs when a worker makes career decisions based on the imperative to maintain affordable medical insurance coverage or to avoid the exclusion of a preexisting condition for herself or for a family member.”⁴⁵ Because of guaranteed coverage through French NHI, workers are not forced to factor in health or insurance needs to their career choices. By tying health insurance to employment and not universally or guaranteed high levels of coverage, studies indicate that it affects standard of living for families, causes economic

growth to suffer, decreases worker efficiency, and severely cuts down small business creation.⁴⁶

While employment mobility can be shown to decrease by up to 40% because of this health insurance caused “job lock,” employers too are being negatively affected. Employers are forced to change their practices to minimize the risk to their business of providing good, comprehensive health insurance to all employees. Between 2000 and 2005 businesses that offered health insurance to their employees fell from 69-60%,⁴⁷ and premiums that employers and employees had to pay for rose 7.7% in 2006 alone, which was twice as fast as wages rose to combat inflation.⁴⁸ Dutton claims that the rising health costs and lack of incentive, in reality the *disincentive*, for employers to provide coverage for their employees is the reason that prior to the passage of the Affordable Care Act, the number of uninsured Americans was on the rise.⁴⁹

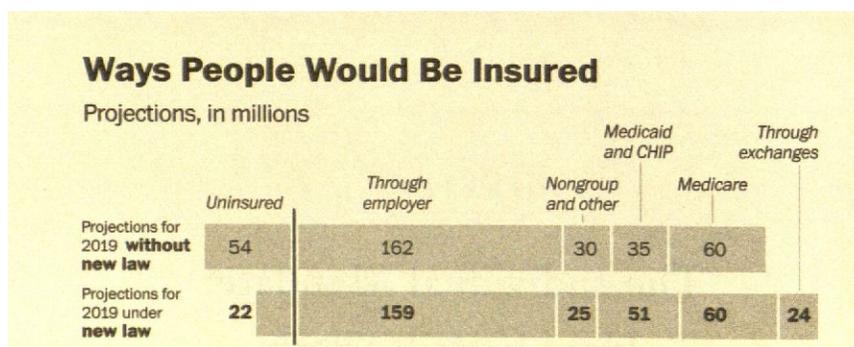


Figure 5: Ways People Would Be Insured⁵⁰

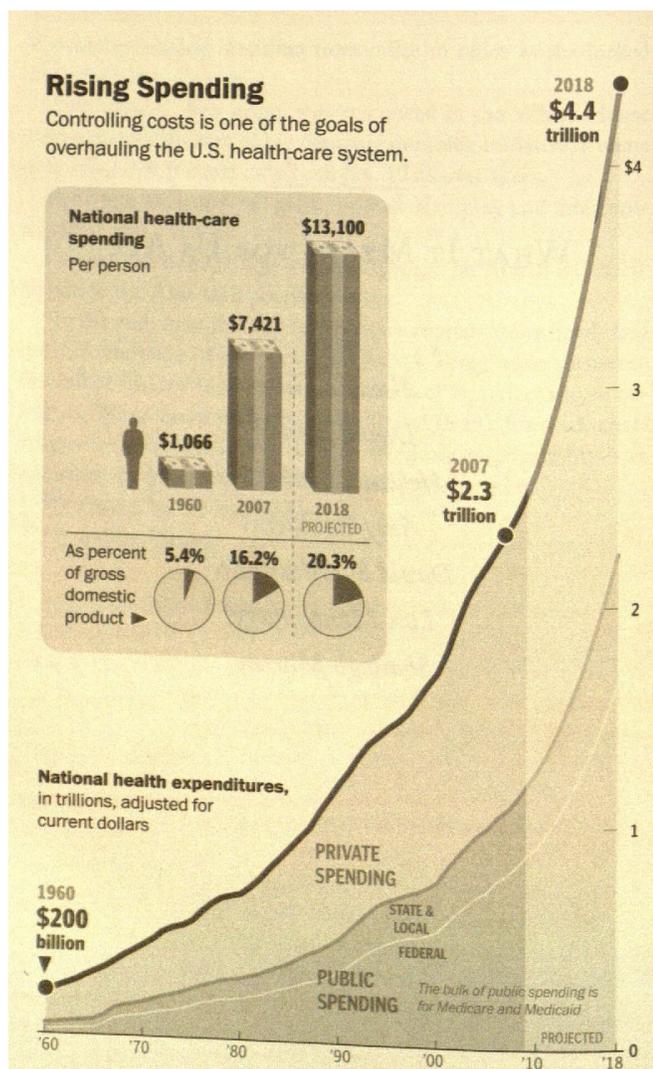


Figure 6: Rising Spending for Health Care in the U.S.⁵¹

¹ Dutton, Paul V. 2007. *Differential Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*. New York: Cornell University Press.

² Dutton, Paul V. "Health Care in France and the United States: Learning from Each Other Brookings Institution." *Brookings*. July 2002. Web. 23 Sept. 2011. <http://www.brookings.edu/articles/2002/07/france_dutton.aspx>.

³ "Health Care Lessons From France : NPR." NPR : National Public Radio : News & Analysis, World, US, Music & Arts : NPR. 11 July 2008. Web. 23 Sept. 2011. <<http://www.npr.org/templates/story/story.php?storyId=92419273>>.

⁴ Ibid.

⁵ Dutton, *Differential Diagnoses*, 3.

⁶ Ibid.

⁷ Ibid.

⁸ Dutton, *Differential Diagnoses*, 4.

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- ⁹ Ibid.
- ¹⁰ Dutton, *Differential Diagnoses*, 4.
- ¹¹ Ibid.
- ¹² Dutton, *Differential Diagnoses*, 5.
- ¹³ "The French Lesson in Health Care." *Businessweek - Business News, Stock Market & Financial Advice*. 9 July 2007. Web. <http://www.businessweek.com/magazine/content/07_28/b4042070.htm>.
- ¹⁴ Ibid.
- ¹⁵ Rodwin, Victor G. "The Health Care System Under French National Health Insurance: Lessons for Health Reform in the United States." *National Center for Biotechnology Information*. U.S. National Library of Medicine, 10 Sept. 2002. Web. 23 Sept. 2011. <<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447687/>>.
- ¹⁶ Ibid.
- ¹⁷ Ibid.
- ¹⁸ Dutton, *Differential Diagnoses*, 5.
- ¹⁹ Ibid.
- ²⁰ Ibid.
- ²¹ "The French Lesson in Health Care."
- ²² *Landmark: The Inside Story of America's New Health Care Law and What It Means for Us All*: From the Staff of the Washington Post. 2010. New York: Public Affairs., 67.
- ²³ "WHO | United States." *World Health Organization*. Global Health Observatory, 2011. Web. 23 Sept. 2011. <<http://www.who.int/countries/usa/en/>>.
- ²⁴ "WHO | France." *World Health Organization*. Global Health Observatory, 2011. Web. 23 Sept. 2011. <<http://www.who.int/countries/fra/en/>>.
- ²⁵ Dutton, *Differential Diagnoses*, 7.
- ²⁶ *Landmark*, 67.
- ²⁷ Ibid.
- ²⁸ "WHO | France."
- ²⁹ "WHO | United States."
- ³⁰ Chris Hedges. 2010. *The World as it is: Dispatches on the Myth of Human Progress*. New York: Nation Books, 117.
- ³¹ Dutton, *Differential Diagnoses*, 8.
- ³² Ibid.
- ³³ Dutton, *Differential Diagnoses*, 10.
- ³⁴ Starr, Paul. 1982. *The Social Transformation of American Medicine*. New York: Basic.
- ³⁵ Dutton, *Differential Diagnoses*, 11.
- ³⁶ Ibid.
- ³⁷ Dutton, *Differential Diagnoses*, 13.
- ³⁸ Ibid.
- ³⁹ Ibid.
- ⁴⁰ *Landmark: the inside Story of America's New Health Care Law and What It Means for Us All*: From the Staff of the Washington Post. 2010. New York: Public Affairs.
- ⁴¹ Dutton, *Differential Diagnoses*, 14.
- ⁴² Dutton, *Differential Diagnoses*, 15.
- ⁴³ Ibid.
- ⁴⁴ Dutton, *Differential Diagnoses*, 16-7.
- ⁴⁵ Dutton, *Differential Diagnoses*, 17.
- ⁴⁶ Ibid.
- ⁴⁷ Ibid.
- ⁴⁸ Dutton, *Differential Diagnoses*, 14.
- ⁴⁹ Dutton, *Differential Diagnoses*, 17.
- ⁵⁰ *Landmark*, 86.
- ⁵¹ *Landmark*, 64.

Chapter 5: *The Differences in Practice of Health Delivery in the United States and France*

The difference in theory of the French and American systems of health coverage certainly leads to differences in practice. I will only highlight a few for the purposes of this project. To achieve the high amount of efficiency that the French health insurance has in comparison to the U.S., a single non-profit system, the NHI, is utilized to streamline the bureaucracy. Instead, the American system is stuck with a labyrinth of obstacles inhibiting efficiency. These include: a multitude of private insurance companies, coupled with the public insurance options for the poor and elderly, a system of deductibles and co-payments, and insurance networks restricting the medical facilities individuals are allowed to use.¹

By using the NHI and microchip cards that record all patient information, the French system is streamlined. This is part of the reason that physicians agreed to insurance reform in the 1930s in France. The government guaranteed that patients would be allowed to utilize the physician of their choice and doctors would be allowed to negotiate to set reimbursement rates and exercise freedom in medical practice if the physicians agreed to cooperate with an individual mandate for industrial workers.² The same sort of reform practice happened in the U.S. in the 1960s; although initially opposed, physicians finally agreed to Medicare reform. This was because, “private insurers—not the state—have historically posed the greater threat to physicians’ sovereignty over medical decision making and to a patient’s choice of health care provider.”³ While physicians make less in France than in the United States, the above

example demonstrates that there is more patient autonomy in France in many ways and practicing medicine is more efficient and less riddled with hassle.

A recent *Business Week* article identifies some crucial practices that allow France to be able to pay for their universal coverage. One of the critical factors in paying for this is far lower reimbursement for physicians, which ends up being roughly a third of what American physicians make annually. However, this “loss” for physicians is offset by huge incentives the state provides for them. These include the following: physicians pay far lower malpractice premiums; medical school is paid for by the state for every physician, so specialization is not required to pay for excessive medical school loans; two-thirds of doctors’ social security tax is paid for by the government; and there is an “unspoken” self regulation in what specialists can charge, where specialists do not try to charge more than their competitors, keeping costs for patients affordable.⁴ The data aforementioned about the practices of the French health care system shows that even if government intervention exists, incentive can still exist for high quality of care, the amount of insured citizens can be made marginal, and costs of delivering adequate health care to citizens can plummet.

The final difference in practice that I wish to highlight here is the United States’ interesting and unique history of practicing “defensive medicine” because of tort law and the American cultural attitude toward death.⁵ The American legal system is far more welcoming of tort claims than the French system, and because of this, malpractice insurance premiums are far higher in the United States.⁶ The French premiums are nominal in comparison with premiums in the U.S. that can reach up to 30% of income in

some states.⁷ This makes health delivery more expensive and more burdensome for physicians and patients in many cases. The necessity of seeing a sort of “natural life span” and rationing radical end of life treatments is inevitable, but must be accompanied by a redefinition of negligence and a system of new professional norms and standards of treatment by physicians⁸.

The beginning of this kind of reform needs to be accompanied by an increasing acceptance of death in the United States, which is no small task. Patients and their families often have a difficult time accepting the finality of a terminal illness or condition, and more treatment is often requested that has a negligible possibility of improving the patient’s life expectancy. Because of this and the kinds of lawsuits that are possible under U.S. tort law, physicians often perform procedures they know are useless and expensive to ensure they will not be sued and to comfort the patient and his family. This drives up costs of health delivery and hinders the process of accepting a certain death and beginning grieving.

Because of their cultural construction, the French are more able to accept death instead of aggressive terminal treatment. They treat terminal illnesses with palliative care more regularly than extreme life-prolonging treatments. And, as Figures 7 and 8 below begin to show, the French tend to treat minor illness/injuries more acutely and with more attention and resources than end of life care. Instead of trying to get patients out of the hospital as quickly as possible because of insurance limitations like in the U.S., the French keep a watchful eye on hospital admitted patients and tend to release patients later than in the U.S. This leads to a higher healing rate in France, and also, a lower

readmission rate in the hospitals. This difference in medical culture contributes to a lower cost per capita during the normal life span and a lesser need for rationing of care.

Resources	France	US
Active physicians per 1000 population	3.3 ^a (1998)	2.8 ^a (1999)
Active physicians in private, office-based practice per 1000 population	1.9 ^b (2002)	1.7 ^c (1999)
General/family practice, %	53.3 ^b (2002)	22.5 ^c (1999)
Obstetricians, pediatricians, and internists, %	7.5 ^b (2002)	35.6 ^c (1999)
Other specialists, %	39.2 ^b (2002)	41.0 ^c (1999)
Nonphysician personnel per acute hospital bed ^d	1.9 (2001) ^e	5.7 (2000/01) ^f
Total inpatient hospital beds per 1000 population ^g (1998)	8.5 ^a	3.7 ^a
Short-stay hospital beds per 1000 population	4.0 ^h (2000)	3.0 ⁱ (1998)
Share of public beds, %	64.2 ^h (2000)	19.2 ⁱ (1999)
Share of private beds, %	35.8 ^h (2000)	80.8 ⁱ (1999)
Proprietary beds as percentage of private beds (1999), %	56 ^j	12 ⁱ
Nonprofit beds as percentage of private beds (1999), %	44 ^j	88 ⁱ
Share of proprietary beds, %	27 ^k (1998)	10.7 ⁱ (1999)

Figure 7: Health Care Resources: France and United States, 1997-2000⁹

Use	France	US
Physician office visits per capita ^a (1999)	6.0 ^b	2.8 ^c
Specialist visits per capita (1999)	1.9 ^b	1.4 ^c
Hospital days per capita (1999)	2.4 ^d	0.9 ^d
Short-stay hospital days per capita (1999)	1.1 ^d	0.7 ^d
Admission rate for short-stay hospital services per 1000 population	170.1 ^e (2000)	118.0 ^f (1998)
Average length of stay for all inpatient hospital services (1999)	10.6 ^b	7.0 ^g
Average length of stay in short-stay beds (1999)	6.2 ^e	5.9 ^f
Per capita spending on pharmaceuticals, PPP, \$ (1999)	484 ^h	478 ^h
MRIs per million population	2.5 ⁱ (1997)	7.6 ⁱ (1998)

Note. \$PPP=purchasing power parity; MRI=magnetic resonance imaging unit.

Figure 8: Use of Health Services: France and United States, 1997-2000¹⁰

¹ Dutton, Paul V. 2007. *Differential Diagnoses: A Comparative History of Health Care Problems and Solutions in the United States and France*. New York: Cornell University Press, 8.

² Dutton, 19.

³ Ibid.

⁴ "The French Lesson in Health Care." *Businessweek – Business News, Stock Market & Financial Advice*. 9 July 2007. Web. <http://www.businessweek.com/magazine/content/07_28/b4042070.htm>.

⁵ Dutton, 23.

⁶ Dutton, 8.

⁷ Dutton, 23.

⁸ Aaron, Henry J., and William B. Schwartz. 1984. *The Painful Prescription: Rationing Hospital Care*. Washington, D.C.: Brookings Institution, 131-3.

⁹ Rodwin, Victor G. "The Health Care System Under French National Health Insurance: Lessons for Health Reform in the United States." *National Center for Biotechnology Information*. U.S. National Library of Medicine, 10 Sept. 2002. Web. 23 Sept. 2011.

¹⁰ Ibid.

Chapter 6: Idealistic Recommendations for U.S. Health Care Reform

“Suffice it to say that there is agreement that health care is a public good, but major disagreement on whether the government or the market should be the allocator of health care services. In many European countries, government-managed or nationalized health care systems have looked to the market for efficiency-based reforms while holding on to the role of government in assuring equity... In contrast, the United States is looking to national (federal) direction to solve the problems of the uninsured and the underinsured...” Frank W. Musgrave¹

As the President’s Commission wrote, when over 40 million Americans lack health insurance, our current scheme is failing and needs to be revisited. On top of that, lack of health insurance, lack of adequate health insurance, and lack of quality health care further disadvantage those that are already disadvantaged to a higher degree, as Figure 9 below indicates. These characteristics show that in 2002 the uninsured were already some of the worst off populations in America. It is important to note that more than half of the uninsured are in fact those that are employed in full time, full year positions.² As mentioned in Chapter 5, tying health benefits to employment no longer works in the free market because of rising prices of care and a lack of incentive for employers to provide coverage. By classifying those that receive coverage as deserving versus non-deserving, the multifaceted system of the U.S. brand of capitalism, attempts at social justice, and traditions in America fails to recognize the complexities of the current situation. The cultural perspective in the U.S. orients capitalism in a manner that fails its citizens. When over half of all uninsured Americans participate in full time work, and yet we categorize those individuals as not deserving or hardworking enough, our arbitrary binary

classification must in fact be incorrect and prejudiced. To solve the problems of U.S. health care delivery all this needs to change.

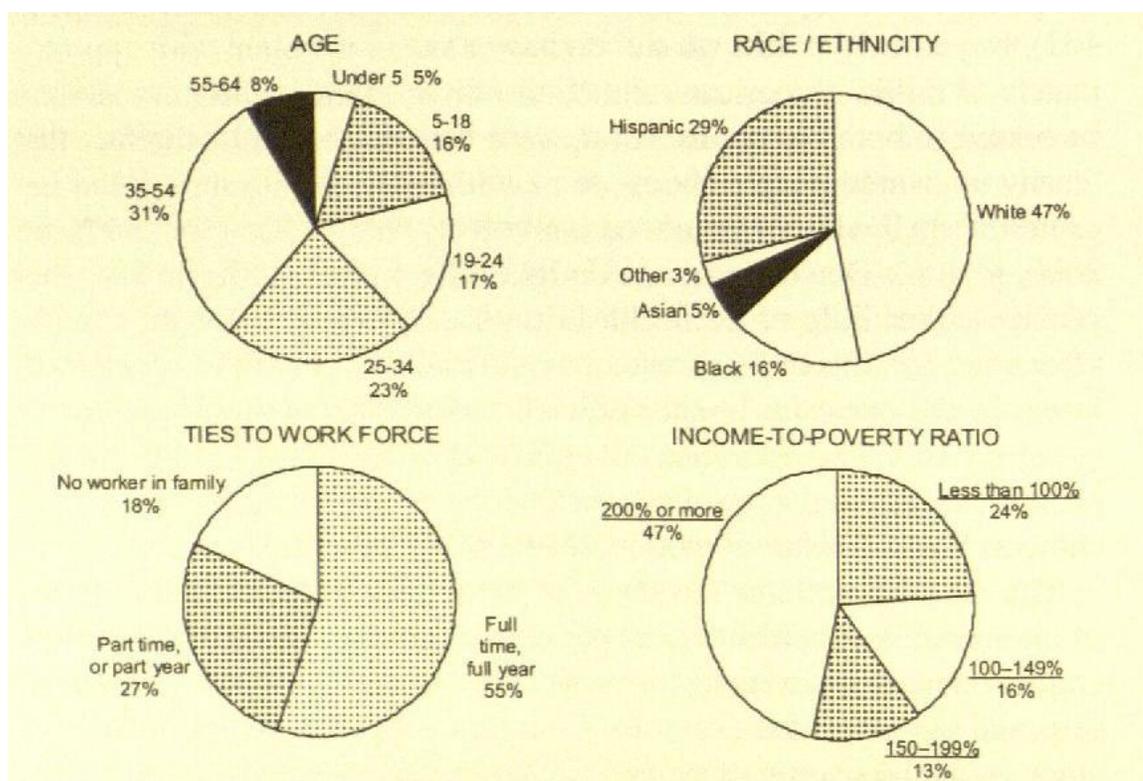


Figure 9: Characteristics of the Uninsured Population Under Age 65, 2002³

Another key lesson to be taken from Figure 9 is that there is a large correlation between race/ethnicity and lack of health insurance. While whites comprise 47% of uninsured Americans, uninsured whites are only 12% of the white population; while blacks comprise 16% of uninsured Americans, uninsured blacks are over 20% of the black population; and while Hispanics comprise 29% of uninsured Americans, uninsured Hispanics are close to 35% of the Hispanic population.⁴ The correlation between lack of health insurance in the United States and race/ethnicity is striking and indicates that a

system of racial, economic, and social prejudice lingers in the United States. As mentioned in chapter 4, there is a connection between minority groups, which are already disproportionately poor, and lack of quality coverage and care in the United States.

The final characteristic of this chart that I wish to discuss is the tie between wage of workers and lack of health insurance. While low wage earners make up about one-third of all individuals that earn a wage in the United States, they also make up over two-thirds of the individuals who are uninsured in the United States; of those wage earners below the poverty line, only 20% received health insurance through their employer, while 44% utilized public sources of insurance, like Medicaid.⁵ Those that are low wage earners are also more likely to have multiple jobs and less likely to be given full-time status by their employers, further hindering their ability to receive an adequate level of health insurance.

If we employ a social contract argument, the President's Commission Report, and the veil of ignorance dictated in earlier chapters, a just health care system which was removed from the uncertain and largely uncontrollable market would be available to all of the individuals of a society, based on their membership in our society alone. The government would take an active role in regulating the insurance, pharmaceutical, and medical fields because that task is outside the skill set of society as it is fragmented. These are the conditions for a new social contract, one that incorporates capitalism in a way beneficial to U.S. citizens. The role of government in the U.S. is to provide regulation and security where individuals could not in a state of nature, and then protect these individuals from internal and external harm. Distributive justice is necessary

because no one can claim an inherent right to the skills, talents, or social standing we are given at birth as Rawls showed. If the natural lottery were to be eliminated so that all citizens with similar characteristics could begin at the same starting line of opportunity, equality in access to health care would need to be paramount in our fight against undeserved advantages.

In this theoretical, hyper-just health care distribution scheme, those that were the worst off in health would have to pay the least for care. There would be the fewest barriers to access for people with cancer, heart disease, and physical disabilities. Hospitals and physicians would no longer be allowed to profit unreasonably in a system that encourages over testing and over treating and where Americans actually have a lower life expectancy than many other industrialized nations. A government-run, single payer insurance system would be the most effective way to cut inefficiencies, so that a just rationing program could begin. If 31% of every medical dollar is going to pay for the bureaucracy, and millions of Americans cannot afford health insurance or medical care, then the system of competition and deregulation in the market is failing, and the government has a duty to intervene and protect its citizens.

This complete renovation of health care delivery in our country is being characterized by opponents as controversial at best, and as liberal terrorism at worst. President Obama's Patient Protection and Affordable Care Act includes an individual mandate and compulsory compliance with the new health insurance standards. The fear of "socialized medicine" is so rampant that even the ACA is being criticized with this rhetoric because Americans claim it is violating their right to individual liberty. However,

it is interesting that the employer-based system of health benefits and a lack of “public option” arose as a response to history. In the 1800s, employers began providing health insurance to their employees serving in rugged careers on the frontier, where without this practice, no one would have been able to access health care. Beginning there, the “public option” was criticized openly as socialist and the private insurance industry rose into power because of this strong opposition. During WWII businesses were fixed with price and wage controls, but were exempt from controls on medical benefits, providing the employers with an edge over competition.⁶ Since the mid-20th century, employer-based health insurance has been a staple of society, and as such the public option and a national health insurance scheme has remained unknown, even while the employment-based system of insuring workers has declined at staggering rates.

While Aaron and Schwartz think that the United States has no interest in adopting a single-payer, national government run system of health insurance because that would fall into the ugly abyss of “socialized medicine,” the fact is that as long as health insurance is tied to institutions like employment, and higher level, blue and white collar employment at that, distributive justice cannot exist in health care in the United States. Until the government is willing to accept the President’s Commission’s conclusion that equity in access to health care is an obligation of someone, be it society or the state, the social contract and distributive justice cannot prevail in our society. The President’s Commission stated that because health care is special, the consequences of leaving medical care subject to market forces are unethical and unacceptable when 40 million Americans lack health insurance⁷. If this conclusion and the veil of ignorance experiment

are taken seriously, then a for-profit, basic coverage scheme of health insurance and a pay-per-service reimbursement plan for hospitals and physicians is unethical and unacceptable.

¹ Musgrave, Frank W. 2006. *The economics of U.S. health care policy: the role of market forces*. Armonk, N.Y.: M.E. Sharpe, 7.

² Musgrave, 96.

³ Ibid.

⁴ Musgrave, 97.

⁵ Musgrave, 102-3.

⁶ Starr, Paul. 1982. *The Social Transformation of American Medicine*. New York: Basic.

⁷ President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavior Research. 1983. *Securing Access to Health Care: The Ethical Implications of Differences in the Availability of Health Services*. Washington D.C.: Library of Congress, 22-3.

Chapter 7: Pragmatic Recommendations for U.S. Health Care Reform

“Major health care reform is virtually impossible: difficult to understand, swarming with interests, powered by money and resonating with popular anxiety. The first key to success is a president who cares about it deeply. Only a president with real commitment will invest in such a dangerous and risky venture. It costs time, energy, and political capital. This is no arena for half-hearted efforts.” James A. Morone¹

Franklin D. Roosevelt initiated an economic security initiative for individuals in 1935. However, he ended up removing the health care provisions from the bill before it was sent to Congress,² showing that even the New Deal president was unable to initiate health care reform in the U.S., knowing how unpopular it would be in Congress. Following FDR’s start in health care reform consideration, President Eisenhower expanded tax breaks for employers paying into employee health insurance and created the Federal Employees Health Benefits Program.³ It was not until Lyndon B. Johnson entered office that Medicaid and Medicare were created in 1965, measures that were in the works since Truman.⁴ In Nixon’s 1974 State of the Union he proposed a bill that would require employers to offer coverage to their employees.⁵ President Reagan was able to pass legislation that included catastrophic coverage in Medicare, but it was soon repealed under George H. W. Bush’s presidency over public outcry.⁶ And with this event and the next president’s term, health care reform was halted and negatively impacted during this era. President Clinton drafted a bill that set forth the health care reform he, his wife, and his health advisor wanted passed, with grievous effects. Not only was his form of health reform not passed, it never even went to vote in the House of Senate, and the Democrats lost control of both houses in the following midterm elections.⁷ If the Clintons were not

able to get health reform through, it was thought that it would be impossible for any other president in the modern era. George W. Bush passed his prescription drug benefit expansion of Medicare.⁸ After attempts to pass health reform by almost every Democratic president, it was left to President Obama to try to pass his bill.

President Obama passed the Patient Protection and Affordable Care Act without a single Republican vote. His strategy accomplished what every Democrat since FDR was unable to do, and is thus quite notable and important to understanding the bill itself.⁹ The Ted Kennedy and President Obama coalition launched a gigantic advertising campaign and used the party's high popularity ratings and majorities in Congress to squeak the bill through.¹⁰ *Landmark*, written by the staff of the *Washington Post*, tracks the negotiations not only with Congress, but also with the third-party insurance industry, hospital industry, and pharmaceutical industry, showing how the administration was able to use the promise of 40 million new customers to leverage the negotiations toward cutting federal subsidies and tax credits for these industries, while ensuring that the entire new program was paid for before it was passed.¹¹ However, Joe Lieberman was able to single handedly block the public option,¹² which is the largest obstacle standing in the way of reforms to make the U.S. system of health care more akin to the French NHI.

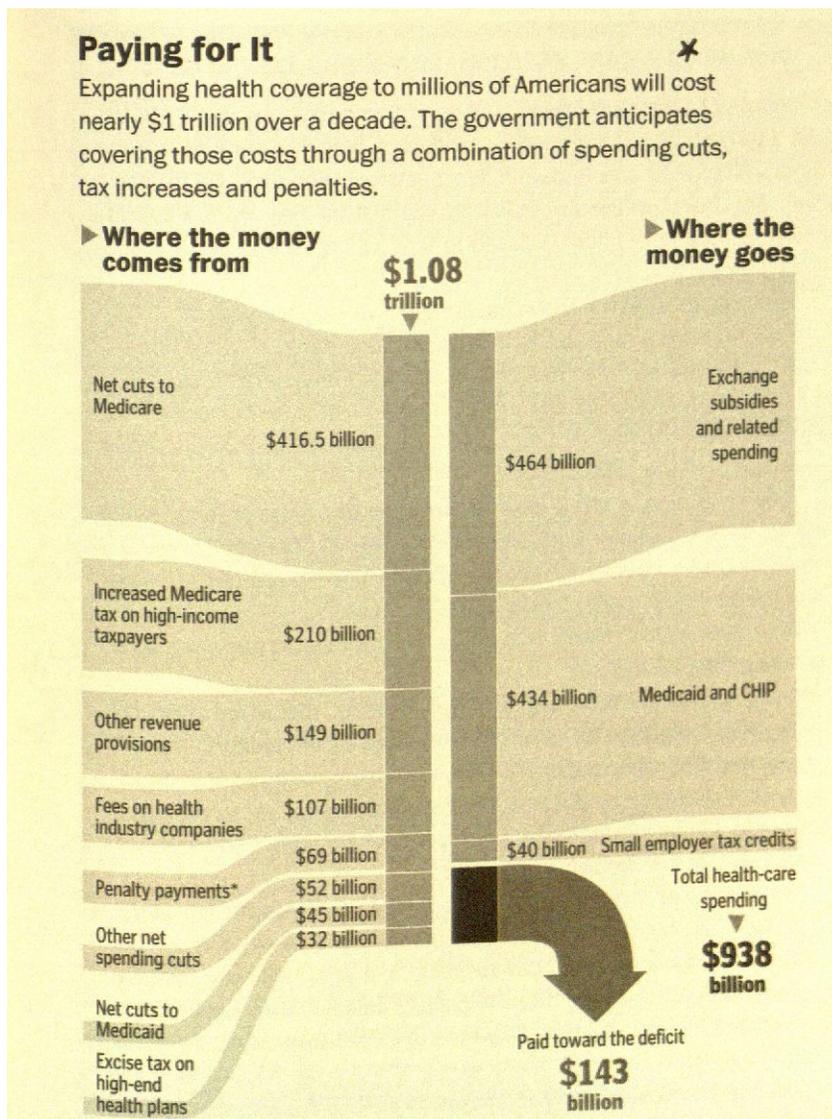


Figure 10: How the ACA is Paid For¹³

With over 40 million Americans lacking coverage today, the ACA opens the doors and broadens Medicaid, creates public marketplaces or exchanges where people can obtain affordable insurance coverage, and provides most of the people who go to the exchanges with vouchers to help pay their premiums. Alec MacGillis of the *Washington Post* describes how the new law is supposed to function: “Like the Massachusetts approach, the new federal law seeks to achieve near-universal coverage with a three-part

formula. It requires insurers to provide coverage to anyone who wants it. To make it feasible for insurers to offer coverage to people with existing medical conditions, it requires everyone to obtain health insurance, thereby broadening the risk pool to include both the healthy and less healthy. And, to make sure that people can afford insurance they will be required to have, it provides subsidies to help them buy private insurance.”¹⁴

If the ACA is effective, by 2016 95% of Americans and legal residents will have insurance, contributing to better buying power and making insurance more affordable to all.¹⁵ The individual mandate is the pivotal component of the legislation. Without the individual mandate, experts agree that the risk pool will not be big enough, and insurance will thus not be affordable by all who seek it. This provision is especially important to understand because without it, the legislation will fail, and it is the main component of the case the Supreme Court is now expected to rule on the constitutionality of in late spring 2012.

Even given the tremendous benefits that President Obama and Nancy Pelosi were able to pass through Congress, the ACA is still fairly moderate in terms of Western countries and their approaches to health care. It lacks a public option, as blocked by Joe Lieberman. After the bill passed in the House of Representatives with a vote of 220-215, Lieberman appeared on *Fox News Sunday* saying, “I will not allow this bill to come to a final vote.”¹⁶ With that statement and the fact that the Senate did not currently have the 60 votes needed to pass the bill with a filibuster-proof majority, Joe Lieberman became all powerful in controlling the content of the bill. The public option was removed, Joe Lieberman voted in favor of the bill, and the ACA was passed. However, without the

public option, this new legislation does not seek to overhaul the U.S.'s health system, but instead, simply expands Medicare and Medicaid coverage and armors individuals with the ability to seek better deals with the established private insurance companies.

President Obama's Patient Protection and Affordable Care Act was an excellent and necessary start to health reform in the United States. He, and the largely Democratic Congress under Nancy Pelosi, was able to do what every Democratic American president since FDR was unable to accomplish: serious health care reform. The insurance exchanges will open doors to people who do not receive insurance benefits through their job or whose premiums are unaffordable at their level of income. The exchanges, along with the individual mandate, will create larger risk pools, hopefully increasing bargaining power with private insurance companies and driving down insurance premiums for those who before could not collectively bargain. These measures, along with the fact that barring people from affordable coverage because of preexisting conditions is no longer acceptable, will begin the transformation of American health care delivery, its equity, and its affordability.

While the ACA passed by Congress and President Obama was an excellent kick-off to true health care reform, the conclusion of this project is that it was not liberal enough; the legislation still fails to ensure equity in access to health care for all Americans. If we take the social contract and veil of ignorance experiments seriously, true health care reform will need to no longer be tied to any consideration besides membership in our society, including citizenship or participation in the workforce. It is here that I believe we can receive the biggest lesson in health care delivery that the

French system has to offer: the single payer, government run system of national health insurance. While the individual mandate and insurance exchanges go a long way toward helping more people attain coverage in the United States, for many people that still do not qualify for Medicare or Medicaid, the exchange prices will still be too high and the financial penalties for not attaining insurance under the individual mandate will be too low to convince them of the necessity.

Because currently 31% of every health care dollar goes towards funding the large, unorganized bureaucracy of health delivery in the United States, the only way that we can truly control costs while necessitating everyone to possess some form of health insurance is through a public insurance scheme. Victor Rodwin suggested that there were five lessons that the U.S. could learn from the French health care system: First, that universal coverage is possible without a single-payer insurance system, but does require legislative framework and active state intervention; second, that it is possible to achieve this kind of coverage through piecemeal reform over time; third, that universal coverage can be achieved without the demise of private insurance companies; fourth, that it is more equitable to have national control over the uninsured than state-based control because the federal government is the coordinating body; and finally, it is possible that national health insurance can be achieved before the task of reorganizing the health care system is attempted.¹⁷

A perfectly just system of health care distribution will always remain elusive to the American public, as it will all over the world. However, until we remove the majority of market influence from providing health insurance and care, the dream will be all the

more elusive. Callahan was right: “Medicine cannot continue trying to serve two masters, that of providing affordable health care and turning a handsome profit for its middlemen and providers,” as evidenced by the unintended consequences of our system today. I think that Victor Rodwin is correct in many regards. We do have many lessons to learn from the French health care system, but it is his systematic approach to which lessons should be utilized and how they should be implemented that is incorrect. Universal coverage is not in fact possible without a single-payer, government-run, national health insurance scheme. The individual mandate is projected to entice 95% of Americans to obtain health insurance of some sort, but that is still not universal coverage. Until the United States government is willing and able to have insurance affordable or provided to all and they make the fine for not complying with the mandate higher than the cost of the lowest level of individual insurance, some Americans will not have health insurance because it will not be in their economic favor and/or would violate some arbitrary line of personal liberty they cherish more than the success of health care reform.

The public option would provide more people with the ability to become insured, but the public option would still remain an option among a sea of private alternatives. The public option would most likely cause the private insurance options to lower premiums and increase quality of coverage to remain competitive with the public option; however, the mixed system of private insurance companies with an included public option would still be a bureaucratic nightmare that would not be the most efficient, and thus the most affordable health delivery possible. Negotiating power with medical facilities for reimbursement schemes would still be fractured and less powerful than

possible, and the organization of the numerous insurance options would still cost a large amount of every health dollar spent. The most efficient, the least expensive, and thus, the most equitable source of health insurance delivery would be national health insurance.

This does not mean, as Rodwin also recommends, that private insurance companies need to be obliterated in the United States. The best reform option for health care in the U.S. that recognizes and protects both individual liberty and equality is one with a national health insurance system, paid for through payroll deductions and government subsidy, and with private insurance companies offering further gap-coverage insurance, like more comprehensive or better calamity plans, or additional service like optometry or dentistry care. This would drastically alter the private insurance companies, though, marginalizing their profits and imposing heavy restrictions on what they are allowed to offer. However, this system would allow individuals to choose their proper level of coverage, while still maintaining a high standard of care for all and would still allow private insurance companies to practice within the competitive market to gain profit.

President Obama has already led national health care reform in the U.S., but it is not complete, and will thus prove to be ineffective in ensuring ultimate equity in health care and distributive justice in the United States. America is lagging behind in global health for industrialized countries' standards and is spending more money than any other country to achieve the levels we are now. There is a startling difference in percent of GDP spent on health care between the U.S. and France, showing that the United States spends far more than France per capita, but still has a significantly lower quality of health

care. France's government employs a similar mixed public and private system of health care policy as the United States'; however, in 2001, France's healthcare system was ranked first among 191 countries surveyed, while the United States' was ranked 37th.¹⁸ The U.S.'s main issue in its health care system is still the lack of universal access to health insurance, which in turn, affects access to care. If the United States system could become the mirror image of itself and use national public health insurance as its main provider with private insurance company additional options, equity and autonomy could both be preserved and cherished and the social contract would be more effectively upheld in our country today.

¹ *Landmark: the inside Story of America's New Health Care Law and What It Means for Us All: From the Staff of the Washington Post.* 2010. New York: Public Affairs, 3.

² Ibid.

³ Landmark, 5.

⁴ Landmark, 4-5.

⁵ Landmark, 6.

⁶ Ibid.

⁷ Landmark, 7.

⁸ Ibid.

⁹ Landmark, 4.

¹⁰ Landmark, 12.

¹¹ Landmark, 16-7.

¹² Landmark, 39-48.

¹³ Landmark, 173.

¹⁴ Landmark, 68.

¹⁵ Landmark, 73.

¹⁶ Landmark, 39.

¹⁷ Rodwin, Victor G. "The Health Care System Under French National Health Insurance: Lessons for Health Reform in the United States." *National Center for Biotechnology Information*. U.S. National Library of Medicine, 10 Sept. 2002. Web. 23 Sept. 2011.

¹⁸ Dutton, Paul V. "Health Care in France and the United States: Learning from Each Other Brookings Institution."

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